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Securitization of HIV/AIDS in South Africa, 2000-2018

Master's thesis

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Declaration

1. I hereby declare that I have compiled this thesis using the listed literature and resources only.
2. I hereby declare that my thesis has not been used to gain any other academic title.
3. I fully agree to my work being used for study and scientific purposes.

In Prague on 31 July 2019 Zuzana Roudnická

References

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Abstract

HIV/AIDS is for many decades one of the major global health issues. It has, therefore, attracted attention of scholars from different fields of study, including security studies. This Master's Thesis seeks to contribute to debates surrounding the issue of securitizing the HIV/AIDS pandemic. The main aim of this thesis is to apply the Copenhagen School's theoretical framework on the case of HIV/AIDS, evaluate the possibility of explaining the international reaction to the pandemic through securitization, and assess whether or not the HIV/AIDS was successfully securitized in South Africa, mainly through effort of the relevant international actors. The case of the Republic of South Africa was chosen because it is one of the worst affected countries by the disease in the world. After discussing the Copenhagen School's securitization theory and its critics, the origins, progression and nature of the disease is explained. The thesis then proceeds with the description and examination of the current state of the epidemic in South Africa as well as the negative influence the segregation and apartheid policy had on the perception of the disease and its spread. The thesis looks at possible securitizing actors of the issue and analysis their discourse in the search for securitizing moves associated with HIV/AIDS. It then discusses the results of these securitizing moves in the context of post-apartheid South Africa.

Abstrakt

HIV/AIDS představuje již po mnoho desítek let jeden z největších celosvětových zdravotních problémů. I proto přilákal pozornost akademiků z mnoha vědních oborů, včetně oboru bezpečnostních studií. Tato diplomová práce chce přispět do debaty, která se rozvinula kolem problematiky sekuritizace HIV/AIDS. Hlavním cílem této práce je aplikace teoretického rámce Kodaňské školy na případ pandemie HIV/AIDS, zhodnotit, zdali je možné vysvětlit reakci relevantních mezinárodních aktérů na tuto pandemii optikou teorie sekuritizace, a poté zhodnotit úspěšnost pokusů těchto aktérů o sekuritizaci na případu epidemie HIV/AIDS v Jihoafrické republice. Případ Jihoafrické republiky byl vybrán, neboť již dlouhodobě patří mezi nejhůře zasažené státy na světě. Po představení teorie sekuritizace Kodaňské školy a jejích kritiků se práce zaměří na HIV a AIDS, vysvětlení virologických a epidemiologických charakteristik tohoto onemocnění, jeho původ a vývoj. Práce dále pokračuje představením současného stavu epidemie v Jihoafrické republice a zhodnocením, jaký vliv měla politika segregace a apartheidu na

jejím šíření. Tato práce poté prozkoumá diskurs potenciálních sekuritizačních aktérů ve snaze nalézt důkazy o pokusech sekuritizovat HIV/AIDS. Následně jsou rozebrány výsledky těchto pokusů v kontextu nové Jihoafrické republiky.

Keywords
Securitization, Copenhagen School, HIV/AIDS, security, South Africa

Klíčová slova
Sekuritizace, Kodaňská škola, HIV/AIDS, bezpečnost, Jihoafrická republika

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Název práce
Sekuritizace HIV/AIDS v Jihoafrické republice, 2000-2018

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Introduction

The peaceful end of the Cold War and "voluntary dismantling of the bipolar order" brought about a dire need of reconceptualising and rethinking institutionalization of security within the international security studies (Buzan and Hansen, 2009, p. 159). Traditionalist approaches, hitherto dominant and more or less unchallenged, were suddenly dealing with lack of sound explanation for the disintegration of the Soviet Union which defied the realist perception of the state driven by want for power. The military-centred security discourse encompassing nuclear deterrence and arms control was found unsatisfactory. Furthermore, the challenges of the post-Cold War era, such as economic deprivation, technological advancement, environmental decay, or spread of epidemics, called for a whole new approach to security studies. Hence, new debate arose revolving around material versus ideational, traditionalist versus widening-deepening, marked by the emergence of critical alternatives to traditional approaches. One of these approaches enriching the theoretical discourse of international security studies is the securitization theory (Charrett, 2009, p. 9).

Since 1998, when the theory of securitization was presented to the world by Barry Buzan, Ole Wæver and Jaap de Wilde, the framework has been applied of variety of issues from religious radicalization to property squatting. It is only natural that some researchers would also try to examine health issues through the lens of securitization. HIV/AIDS as a major health issue for more than three decades has attracted attention of the academia. Even though the HIV/AIDS-security nexus was picked up arguably late by scholars from the field of security studies, the debate surrounding the topic of securitizing HIV/AIDS or other infectious diseases grew immensely, especially in the early 2000s. Many authors (Heinecken, 2001a and 2001b; Elbe, 2002; Ostergard, 2002; Prins, 2004; Feldbaum, Lee and Patel, 2006) examine the impact of the pandemic on security and development of the worst affected countries. Other authors (Elbe, 2006) argue about ethical implications of such action. On top of that, there are some (Vieira, 2007; McInnes and Rushton, 2011) who seek to revise the securitization approach by using the case of HIV/AIDS as an instrument. However, only few authors (Vieira, 2011) focus on the implication of securitization of HIV/AIDS in South Africa. Despite the fact that the attitude of the South African President Thabo Mbeki towards the disease has been discussed by many, the case was sparsely examined through the lens of the Copenhagen School's theoretical framework.

The issue of HIV/AIDS was chosen because the concern about the issue in the academic circles as well as among relevant international actors seems to be fading away. The

disease, however, is still one of the leading threats to global public health that has claimed over 35.4 million lives since the start of the epidemic (UNAIDS, 2018a, p. 1). It is estimated that over two thousand people die every day of AIDS-related diseases worldwide (UNAIDS, 2019c). In comparison, the Ebola outbreak in 2013-2016 in West Africa cost 11,310 lives in total (WHO, 2016). The Ebola epidemic was proclaimed a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO) and Médecins Sans Frontières (MSF) and "a threat to international peace and security" by the United Nations Security Council (UNSC) Resolution 2177 (2014) (Deloffre, 2016, p. 41; UNSC, 2014). The United Nations Mission for Ebola Emergency Response (UNMEER) created through the resolution then undertook coordination of UN agencies, national governments and other actors in order to distribute resources when they were needed the most. A joint effort of all the actors involved helped to contain the epidemic so that on 26 May 2016 the PHEIC could be lifted (WHO, 2016). HIV/AIDS was too addressed by a UNSC resolution but the response was not as decisive as in the case of Ebola and the issue of HIV/AIDS have slowly faded away from the UNSC discourse.

Hence, the aim of the research is to assess the applicability of the Copenhagen School's securitization framework on the case of HIV/AIDS in South Africa. Through this thesis, I am to answer the following research questions:

- **RQ1**: *How can the reaction to the HIV/AIDS epidemic be explained using the Copenhagen School's theory of securitization?*
- **RQ2**: W*ere the attempts to securitize HIV/AIDS by the internationally relevant actors successful in the Republic of South Africa?*

Initially, this Master's Thesis was supposed to encompass the whole region of Southern Africa, as one might observe from the Master's Thesis Summary (Projekt diplomové práce, see p. 77). However, it had to be narrowed down for the sake of the length coherence of the thesis. South Africa was chosen for two main reasons. First, South Africa has the HIV/AIDS prevalence rate in the world. Second, I have previously written a thesis about the apartheid policy in the 1980s so exploring HIV/AIDS-related policies after the transition seemed like a good follow-up and a slight upgrade of the previous research. I have chosen to write this thesis in English primarily because the HIV/AIDS pandemic is an international issue and therefore should be addressed in an international language.

The first chapter of this thesis introduces the methodology and research design used in this thesis. Then it explains the terminology and the methods of data collection. Lastly, the

chapter contains a literature review of the most relevant sources for the chosen case. For better clarity, the sources are reviewed in order of the chapters they are the most relevant for.

The second chapter of the thesis examines the concept of security in relation to the Copenhagen School's conceptualization of the term. Then the chapter explores the theory of speech acts as developed by John L. Austin. From speech acts the chapter moves on to the theoretical framework pivotal for this thesis which is built on philosophy of language and broader understanding of the concept of security, the theory of securitization.

The third chapter is a rather in-depth introduction to HIV/AIDS. Firstly, it is explained what HIV and AIDS is, how it works, how to prevent transmission, and how to fight it. Secondly, the history and evolution of the HIV/AIDS pandemic is presented, from the discovery of first cases of AIDS, through its origins deep in the forests of central Africa, to world's reaction.

After explaining the basics of the HIV/AIDS pandemic, the focus of the thesis shifts to the single case of the South African epidemic. The fourth chapter discusses the current state of the epidemic in South Africa, how the policy of segregation and apartheid shaped and influenced the perception and spread of the disease and how the first post-transition government attempted to handle the issue. Lastly, it is presented what impact on a state the epidemic can have.

The last chapter, then, focuses entirely on the securitization of HIV/AIDS. After presenting the discussion surrounding the topic, the chapter moves to the interpretative part of the thesis. In this part, the results of the research are presented. Firstly, the supposed securitizing moves by the chosen securitizing actors are analysed to see whether they truly are securitizing moves. Secondly, by examining the reaction of the audience – the Government of South Africa – it is evaluated whether or not was the securitization successful.

1. Methodology

1.1. Research Design and Operationalization

The methodological framework of this thesis is an instrumental case study with descriptive and interpretative elements. The interpretative part of this thesis also incorporates elements of discourse analysis. According to Yin (2003, p. 13), "[a] case study is an empirical inquiry that investigates a contemporary phenomenon within real-life context, especially when the boundaries between phenomenon and context are no clearly evident". In other words, it seeks answers to specific research questions by investigating "a unit of human activity embedded in the real world which can only be studies or understood in context[,] which exists in the here and now[,] that merges in with its context so that practice boundaries are difficult to draw" (Gillham, 2000, p. 1). An instrumental case study research design primarily seeks better understanding of a theoretical question. In this approach, the case is only of secondary importance because it is used as an instrument for acquiring a better insight of the theoretical explanation which the case is built upon (Hancock and Algozzine, 2006, p. 32).

The goal of this thesis is to examine the securitization of the HIV/AIDS epidemic using the Copenhagen School's theoretical framework. This is done by investigating how relevant international actors responded to the emerging public health crisis, whether they became securitizing actors and what securitization move they conducted. The government of South Africa, one of the countries most affected by the disease, has been chosen as an audience of the securitization. To answer the research questions, the thesis needs to analyse the theoretical framework and then to conduct an analysis and synthesis of primary and secondary sources in order to see whether and how is the theoretical framework applicable. The primary sources in question are mostly official documents by securitizing actors that will provide the evidence of whether or not the particular actor attempted a securitization move, statistical data on HIV/AIDS, and medical reports to track the early stages of the HIV/AIDS epidemic. The secondary sources provide additional information and insight on the issue.

The interpretative part of the thesis firstly analyses several securitization attempts relevant for the case of South Africa and examines them through the lens of the Copenhagen School's approach. To be classified as a securitization move, the discourse must feature key words associated with securitization as defined by the Copenhagen School. According to Buzan, Wæver and de Wilde (1998), the securitizing actor must speak a certain way in order to move a case into a specific area to claim the right to use extraordinary measures to deal

with the issue. Therefore, the key words that are searched for are 'threat', 'security', 'priority', 'emergency', and 'point of no return'. The act does not have to contain all of these key words (literally or figuratively), but the implication of emergency and urgency must be present. Furthermore, these words must be spoken or written in association with the HIV/AIDS epidemic and address either the international peace, nations of the world, societal (or other kind of) stability, or specifically South Africa as a referent object. By identifying individual securitizing agents and analysing their discourse, it is discussed whether or not the attempt was truly a securitization process. According to Buzan et al. (1998, p. 34), "the designations of what constitutes a security issue comes from political actors" who are in a position of authority. Therefore the main securitizing actors this thesis considers are internationally relevant political bodies like the United Nations Security Council (and the former Secretary-General of the UN Kofi Annan), the Organisation of African Unity (and later the African Union), the government of the United States (in association with the *President's Emergency Plan for AIDS Relief*), and finally the government of South Africa (the former President Thabo Mbeki and his Minister of Health Manto Tshabalala-Msimang in particular) as an actor relevant to this case study.

Lastly, the response of the audience – in this case the South African government – is evaluated in order to see whether the securitization was successful. Because Buzan et al. do not define criteria of audience acceptance in the initial formulation of their theory this thesis sets its own criteria drawing inspiration from the Copenhagen School's original text, from discussions in Balzacq's *Securitization Theory: How security problems emerge and dissolve* (2011a), and from McInnes and Rushton's (2011) multi-level securitization framework. These criteria are: (1) the audience must show signs of acceptance, demonstrated by adopting the securitizing actor's discourse concerning the issue and eventually becoming a securitizing actor (on the next level) themselves, (2) the audience must prioritize the issue over other issues as a result of the securitizing move, and (3) the audience must accept the emergency measures proposed by the securitizing actor (considering the actor makes such proposal).

1.2. Definitions

The terminology related to the securitization theory is in greater detail explained in the next chapter. However, this thesis also works with terminology associated with epidemiology. Epidemiology is a medical science branch that studies the "relationship of various factors in

the incidence and distribution of a disease or of diseases in a human environment" (Watstein and Stratton, 2003, p. 173). The term epidemic refers to a disease which is spread to more cases than (statistically) expected over a certain time period. Pandemic, then, is an epidemic that is stretched over a larger geographical area, usually worldwide, and at the same time affects a large portion of population (Watstein and Stratton, 2003, p. 173 and 363). HIV incidence is a "[n]umber of people newly infected with HIV in the reporting period per 1000 uninfected population" (UNAIDS, 2018b, p. 66). Prevalence is defined as "[t]he total number of cases of a disease in existence at a particular time in a specific area" (Watstein and Stratton, 2003, p. 392). Prevalence rate is then "[t]he frequency of the occurrence of a disease in a population, usually expressed as the number of cases per 100,000 population" (ibid). While prevalence data are essential for understanding the impact of the illness within a society and for targeting and evaluating interventions, the incidence of infection provides information on the rate at which new infected individuals emerge so it is more useful for monitoring the dynamics of disease transmission (Gouws and Abdool Karim, 2010, p. 57-58).

1.3. Methods of Data Collection

Most of the data on HIV/AIDS used in this thesis comes from the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates. Initially, at the early stages of the pandemic, each country collected its own data which were subsequently sent to the World Health Organization (WHO). WHO then gave a report on the state of the pandemic worldwide (Whiteside, 2008, p. 15). Nowadays, the data of the disease is routinely collected only in well-resourced countries. In other countries, the data might be skewed either form political reasons (for example inefficiency, government failure, or a conflict) or due to the general sensitivity of the researched topic. Therefore a researcher must turn to the biannual UNAIDS reports.

In countries with high-level HIV epidemics, the UNAIDS usually creates estimates based on the results of HIV prevalence data from surveillance in antenatal care clinics (ANC) and from nationally representative population-based surveys (UNAIDS, 2016, p. 1). The ANC surveys include only women however are conducted regularly and therefore serve as a better indicator of HIV trends in the population. The main biases of ANC surveillance, except the exclusion of men, are the under-representation of older women (whose fertility might have been reduced due to age and HIV infection) and also the exclusion of women who either cannot afford to access the government ANCs or prefer to get private health care (Whiteside,

2008, p. 18). Population-based surveys, on the other hand, cover much broader sample of population geographically and demographically and thus provide better information on national HIV prevalence levels but are performed less frequently. For some countries of sub-Saharan Africa that do not conduct population-based surveys the UNAIDS calculates the HIV prevalence estimates based on comparisons of ANC surveillance data and data from population-based surveys in neighbouring countries (UNAIDS, 2016, p. 1).

In countries with lower rate of HIV transmissions the studies usually focus on the infection among key populations. Key populations are populations at higher risk of infection, they usually comprises a small percent of the general population. Those groups are at risk because they are often reluctant to seek professional help especially in environments in which their identities or actions might be considered unacceptable or even punishable by law. As a key population are considered sex workers, men engaging in sex with other men, transgender women, people who inject drugs, prisoners, and clients of sex workers and other sexual partners of any key population (UNAIDS, 2018d, p. 8-9). The data from ANC surveillance and population-base surveys are then used to estimate the HIV prevalence in the rest of the population (UNAIDS, 2016, p. 2).

In South Africa, the data is collected in several surveys (Gouws and Abdool Karim, 2010, p. 58-60): (1) the annual anonymous ANC surveillance, (2) population-based surveys (e.g. the Human Science Research Council national population-based surveys, or the Carletonville/urban population survey), (3) other (like survey among sex workers and clients at truck-stops conducted by the South African Medical Research Council). The data used in this thesis also come from the national statistical service of South Africa called Statistics South Africa (Stats SA) which uses the cohort-component method for their mid-year population estimates (Stats SA, 2018, p. 1).

As for the search for evidence of securitization process in the discourse of aforementioned relevant securitizing actors, the analyst conducted a thorough research in databases of meeting transcriptions and documents presented by the said actors. These texts were examined and analysed to see whether they contained the previously defined key words and therefore could be proclaimed a securitizing move. Then the analyst searched documents containing quotations of relevant political figures of South African government relating to HIV/AIDS as well as strategic plans and policy-making decisions of the government at the same time period as said securitizing moves took place to see whether the criteria for successful securitization were satisfied.

1.4. Literature Review

The pivotal source for the theoretical chapter is the work of three representatives of the so-called Copenhagen School of Security Studies Barry Buzan, Ole Wæver and Jaap de Wilde *Security: A Framework for Analysis*. The book was written in 1998 and followed the trend of broadening the concept of security. It immediately resonated with the general audience from the field of security studies and the new theoretical framework became one of the dominant approaches to study security and insecurity in the new millennium. And also one of the most debated, reviewed and criticised. The main arguments of the authors as well as the criticism are further examined in the next chapter.

Since security is perceived as a speech act in the Copenhagen School's framework, another important source of information and better understanding of the topic is the collection of twelve of John L. Austin's lectures delivered at Harvard University in 1955 that was put together by J. O. Urmson after Austin's passing and published under the name *How to Do Things with Words*. Austin drew from Wittgenstein's philosophy of language. The focus of his theory lies on utterances that are not descriptive ('constative' in Austin's terminology) but performative. The key principle of Austin's theory is the nature of these performatives. While by uttering a constative the speaker merely describes a thing, by uttering a performative the speaker actually does a thing. Even though the text could have been compressed into half the pages and would not lost any clarity to the main argument, Austin's philosophical lectures turned out to be accessible and easily understandable even for persons from different fields of study and provided a very helpful insight to the speech act theory that underpinned the theory of securitization decades later.

For the third chapter that serves as an introduction to the HIV/AIDS issue, Alan Whiteside's *HIV/AIDS: A Very Short Introduction* proved to be a useful tool for outlining the text. Even though the book is truly short (only about 130 pages) Whiteside managed to concise the most important data such a way the text does not feel rushed or fragmented. The book covers the most essential topics relating to the illness, from origins of HIV/AIDS through virology and epidemiology to different impacts of the disease the society. However the book pays attention mostly to a broader picture of the epidemic – how it affects population, politics, economy etc. – and omits an impact of the disease on the life of an individual.

HIV/AIDS by Consuelo Beck-Sagué and Caridad Beck is also a great introductory text into the issue however it focuses more on the virological and epidemiological properties of

the disease. The authors explain the basics of how the virus works, how can HIV be diagnosed how to treat the infection and how to prevent it. The text is also very short (some 150 pages) but summarizes the essential knowledge on the behaviour of the disease.

The history of HIV/AIDS is best presented in the book *The Origins of AIDS* by Jacques Pepin, a Professor in the Department of Microbiology and Infectious Diseases at the Université de Sherbrooke, Canada (Pepin, 2011). Pepin traces the virus from the chimpanzee epidemic in central Africa and first inter-species transmissions to the globalization of the disease. Pepin's writing is very thorough, exploring multiple possible scenarios and hypothesis of 'how things could have happened' and by examining the evidence he confirms one and debunks the others. The book fares exceptionally well in explaining all the factors that contributed to the spread of HIV/AIDS, especially the impact of colonialism and subsequent wars in the region.

Watstein and Stratton's *Encyclopedia of HIV and AIDS* is an extensive publication of six hundred pages that has several thousand entries A-Z covering almost every possible term related to the disease. Even though slightly outdated (published in 2003), the book still proved useful for defining and explaining key aspects to HIV/AIDS.

Most information on HIV/AIDS in South Africa, besides statistical data and UNAIDS reports, is drawn from a publication titled *The Political Management of HIV and AIDS in South Africa: One Burden Too Many?* by Pieter Fourie. Fourie's book is a long-winded description of South African HIV/AIDS epidemic since its inception in 1982 to the end of the First Mbeki Administration in 2004 and explanation of policy-related behaviour of relevant actors. The author analyses a wide range of documents, articles and publications and presents a comprehensive interpretation of public policy-making and South African HIV/AIDS experience.

Another important source of information is Ida Susser's book *AIDS, Sex, and Culture: Global Politics and Survival in Southern Africa.* At the heart of the book is gender inequality and discrimination that shapes the whole HIV/AIDS epidemic in southern Africa. The aim of the book is to paint a picture of a life of HIV+ woman in southern Africa while also providing a broader look on the socio-political context.

The main authors that dedicated their studies to securitization on HIV/AIDS are Simon Rushton (together with Colin McInnes), Marco Antonio Vieira, and Stefan Elbe. Rushton and McInnes mostly focus on dissecting the Resolution 1308 and analysing its impact on securitizing the issue. In addition, they develop their own contribution to securitization theory that, in their opinion, is better suited for the purpose of studying HIV/AIDS (McInnes and

Rushton, 2011). Vieira also contributes to the theoretical framework by adding the concept of the *HIV/AIDS securitization norm* (HASN). HASN is supposed to "synthesize under a single analytical concept the myriad of ideas and international prescriptions about HIV/AIDS interventions" (Vieira, 2007, p. 138). Conceptually, it consists of *norm* (definition of the idea of HIV/AIDS as a security issue) and *rule* (prescription of the right policies to fight the epidemic). On the other hand, Elbe draws from the Copenhagen School's framework only to warn about the possible consequences of securitizing the pandemic as he thinks the dangers of securitization are generally overlooked (Elbe, 2006).

2. Security and Theoretical Framework

2.1. Concept of Security

In the mid-1980s the concept of security had been used quite often but subjected to only little reflection. Since then, the concept have become so frequently reflected upon and stretched over many fields of study that it now may feel 'empty'. As the philologist John T. Hamilton (2013, p. 7) puts it, "there are few terms in today's political and cultural lexicon as severely overworked, as multifunctional or potentially ambiguous as *security*". Hence, defining such term has been made very difficult, however necessary.

According to Oxford Dictionaries, the term security represents "the state of being free from danger or threat" (Lexico: Powered by Oxford, 2019). As implied above, it is known to have various forms and dimensions depending on the context. Security can be understood from the perspective of financial security, which describes the state of having the necessary resources and being able to maintain a standard of living; emotional security, which refers to feeling safe or free from anxiety; national security, meaning the safety of a state; and countless other.

The Copenhagen School of Security Studies, whose theoretical thoughts are crucial for this thesis, promotes broadening of the term, shifting from focus on the security of the *state* toward a focus on security of *people*. Buzan, Wæver and de Wilde (1998) argue against the traditional military-political understanding of security in which security basically means survival. In their opinion, the field of security studies should retain a distinctive military subfield while encompassing non-military issues within a wider security studies. Therefore, they study security from the perspective of sectors which they explain as follows (Buzan, Wæver, and de Wilde, 1998, p. 7):

> One way of looking at sectors is to see them as identifying specific types of interaction. In this view, the military sector is about relationships of forceful coercion; the political sector is about relationships of authority, governing status, and recognition; the economic sector is about relationships of trade, production, and finance; the societal sector is about relationships of collective identity; and the environmental sector is about relationships between human activity and the planetary biosphere.

Although Ole Wæver (1995, p. 46) argues that the concept of security bears an inescapable set of connotations given by its historical development so that "[a]t the heart of the concept we still find something to do with defense and the state. As a result, addressing an issue in security terms still evokes an image of threat-defense, allocating to the state an important role in addressing it."

Ole Wæver (1989, p. 4) describes security problems as developments which threaten the independence or sovereignty of a state if they occur in a particularly rapid or dramatic way. From this perspective, security is closely tied to sovereignty. Security, then, is understood as an emergency condition that might advocate the use of extraordinary measures to prevent a threatening development. In this context, security is viewed much rather as a "move that takes politics beyond the established rules of the game" (Buzan et al., 1998, p. 23) than a state. To put it another way, security is conceptualized as a speech act.

2.2. Speech Act Theory

Speech act is a term related to the fields of linguistics and the philosophy of language. Its contemporary use is closely connected to the philosopher J. L. Austin and his student J. R. Searle. Austin began developing views and ideas for the speech act theory in the late 1930s. These were brought forward in a series of lectures he gave at Oxford between the years 1952 and 1954 (under the title *Words and Deeds*), and at the William James Lectures Harvard University in 1955. The latter were subsequently edited by J. O. Urmson and published posthumously in the book called *How to Do Things with Words*.

The theory of speech acts "systematically relates speakers' […] intentions to linguistic activity" (Onuf, 1989, p. 81). It analyses the function of utterances in relation to the speaker and hearer's behaviour. The theory identifies two kinds of utterances. The so called 'constative utterances' denote or describe the situation with regard to whether the fact is true or false. Austin (1962) denies the notion that all statements' purpose is only to state some fact, or to describe some state of affairs, and commits to prove that some utterances are under specific circumstances performing an action. Austin calls such utterance 'a performative'.

Performatives are utterances of not nonsensical nature that usually contain mundane verbs typically in the first person singular present indicative active (although some verbs might take a form of the passive voice in the second or third person, which usually used on formal or legal occasions). They "do not 'describe' or 'report' or constate anything at all, are

not ‘true or false’; and the uttering of the sentence is, or is a part of, the doing of an action, which again would not *normally* be described as saying something” (Austin, 1962, p. 5). As an example could serve such sentences as ‘I bet you five bucks the Red Sox will crush the Yankees tomorrow’, or ‘I bequeath my collection of postage stamps to the local museum’ as written in a last will, or ‘I promise to do the dishes after lunch’.

To function properly (or ‘happily’, according to Austin), there are necessary ‘felicity conditions’ to be satisfied (Austin, 1962, p. 14-15):

(A. 1) 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, and further,

(A. 2) the particular persons and circumstances in a given case must be appropriate for the invocation of the particular procedure invoked.

(B. 1) The procedure must be executed by all participants both correctly and

(B. 2) completely.

(C. 1) Where, as often, the procedure is designed for use by persons having certain thoughts or feelings, or for the inauguration of certain consequential conduct on the part of any participant, then a person participating in and so invoking the procedure must in fact have those thoughts or feelings, and the participants must intend so to conduct themselves, and further

(C. 2) must actually so conduct themselves subsequently.

A total speech act situation consists of three levels of acts: *locutionary*, *illocutionary,* and *perlocutionary*. Locutionary act is the act of ‘saying something’, the focus laying on the surface meaning of an utterance. It is further composed of the phonetic act, the phatic act, and the rhetic act. The phonetic act is a mere utterance of certain noises, the phatic act represents understanding these noises as certain words adhering to a certain language’s grammatical rules, and the rhetic act uses these words with some sense and reference.

Opposed to the (locutionary) act *of* saying something there is the (illocutionary) act *in* saying something. Illocutionary act represents the true meaning of an utterance. In the English language, there are over a thousand verbs that denote illocutionary acts. Among these are verbs such as ‘warn’, ‘command’, ‘order’, ‘apologize’, ‘promise’, ‘object’, ‘demand’, ‘argue’, request’, or ‘state’ (Searle, 1969, p. 23). A special type of illocutionary act is a performative speech act, which makes use of the aforementioned performatives.

Performance of the third kind of act – perlocutionary act – aims at producing certain consequential effects upon the thoughts, feelings, or actions by saying something, and it may be done with the intention of producing them. By carrying out the speech, the speaker affects the hearer. Therefore it is much more of a causal response to a linguistic act than literally a speech act.

Jürgen Habermas (1984, p. 288-289) has summarized Austin's thoughts:

> Through locutionary acts, the speaker expresses states of affairs; he says something. Through illocutionary acts the speaker performs an action in saying something. […] Finally, through perlocutionary acts the speaker produces an effect upon the hearer. […] Thus the three acts that Austin distinguishes can be characterized in the following catch-phrases: to say something, to act in saying something, to bring about something through acting in saying something.

Here is an example of locution – she said to me, "Don't open the door"; illocution – she warned me not to open the door; and perlocution – she deterred me from opening the door. At this point, the use of language is crucial.

Speech act can also be direct or indirect. Whenever the meaning of utterance coincides with the speaker's meaning, it is called direct speech act. However, indirect speech act does not carry this direct relationship between the form and function of the utterance. When asking someone, "Can you open the door?" the speaker is directly questioning the hearer's ability to open the door, while indirectly requesting the hearer to do so.

The theory of speech acts has been explored by many scholars since the days of John Austin. According to Nicholas Onuf (1989, p. 82), it was John Searle, Austin's student, who further developed his predecessor's thoughts and brought speech acts closer to social theory. It was then picked up by philosopher and social theorist Jürgen Habermas. Subsequently, speech acts have found their way into new approaches to study international relations, such as constructivism (elaborated on primarily in the works of Nicholas Onuf and Friedrich Kratochwil), or the Copenhagen School of Security Studies.

2.3. Theory of Securitization

2.3.1. The Copenhagen School

The theory of securitization is associated with the Copenhagen School of Security Studies. The concept was developed and coined by Ole Wæver, based in the Copenhagen's Centre for Peace and Conflict Research, in 1993 and was subsequently further elaborated on in his later works as well as in the Copenhagen School's primary text *Security: A Framework for Analysis* written by Barry Buzan, already mentioned Ole Wæver, and Jaap de Wilde. Since then, this conceptual framework has entered mainstream lexicon of International Relations and security studies thought and has been applied over and over on numerous cases on various occasions (McDonald, 2008, p. 565-566).

It was established above that security is viewed as a (illocutionary) speech act by the Copenhagen School. Wæver (1989, p. 4) stresses that: "By saying 'security' a state-representative moves the particular case into a specific area; claiming a special right to use the means necessary to block this development, but paying the price of some loss of prestige by needing to use this special resort." However, as Buzan et al. (1998, p. 33) later specify, the actor does not literally have to say 'security' when securitizing and saying 'security' does not always compose a security act. It is enough when the security acts "take the form of 'politics of existential threat' with the argument that an issue takes priority over everything else and therefore allows for a breaking of the rule" (ibid). Opposed to traditional approaches to security, securitization accentuates the accountability of political leaders not only for the steps taken when confronting a threat but also for defining the threat, as the threats are the product of their entrepreneurship. Securitization is a further intensified politicization (Buzan et al., 1998, p. 29). To sum up, an issue becomes a security problem when the state and its elites declare it to be so.

Buzan et al. (1998, p. 23-24) theorize a spectrum of politicization that "any public issue can be located on":

(1) non-politicized – the issue is not dealt with by the state and is not included in public debate and decision;
(2) politicized – the issue is part of public policy, requiring government decision and resource allocations or, more rarely, some other form of communal governance; and
(3) securitized – the issue is presented as an existential threat requiring emergency measures and justifying actions outside the normal bounds of political procedure.

The constituent components of securitization are a securitizing actor/agent, a referent subject (which is usually called existential threat in the Copenhagen School's discourse), a referent object, and an audience.

Securitizing actor is a person (or a group), who is also a political actor, attempting to achieve securitization of particular issue by making a securitizing move (Buzan et al., 1998, p. 34 and 40). He is sensitive to both moral and formal support to the extent based on the nature of the target audience. For instance, despite winning social support, breaking social bonds with constituencies can ruin the credibility of political officials. Securitizing actor makes a security argument, which "always involves two predictions: What will happen if we do not take 'security action' […], and what will happen if we do" (Buzan et al., 1998, p. 32). Existential threat is the issue (object or ideal) that has been identified as potentially dangerous by securitizing actor. Referent object is the object or ideal that is being threatened by the existential threat, and also has a legitimate claim to survival. Traditionally, it has been the state or the nation, but using the broader approach to security, securitizing actor can basically try to present anything as a referent object. Referent object might be the securitizing actor at the same time and "speak for itself through its authorized representatives" (Buzan et al., 1998, p. 42). In order to succeed, the securitizing actor must persuade the audience to accept the issue as a security threat, and thereby constructing a shared understanding of what is to be considered and collectively responded to as such. Without achieving such acceptance or understanding, the object has not been securitized, only a securitizing move happened. An audience may also be a referent object at the same time when "the securitizing act attempts to convince [the audience] to accept exceptional procedures because of the specific security nature of some issue" (Buzan et al., 1998, p. 41). Buzan et al. (1998, p. 36) also work with the term 'functional actor', which is an actor that affects the dynamics of a sector by significantly influencing security decisions.

Not surprisingly, not every issue can be securitized successfully. In the words of philosophy of language, the 'felicity conditions' must be satisfied. A successful securitization consists of three components (or steps): a) existential threats; b) emergency action; and c) effects on interunit relations by breaking free of rules (Buzan et al., 1998, p. 26). A sign of successful securitization is that "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, points of no return, and necessity" (Buzan et al., 1998, p. 25).

The most crucial role in successful securitization has the audience, because it has the power to permit the securitizing agent to override rules. In Wæver's words, "[s]uccessful securitization is not decided by the securitizer but by the audience of the security speech act" (Buzan et al., 1998, p. 31). Therefore, the securitizing actor should be able to connect with the feelings, interests, and needs of the audience to increase his chances of persuasion, i.e. to achieve a perlocutionary effect. Effective persuasion requires the employment of terms resonating with the hearer's language. Based on rhetoric theory, this could be done by attitude, gesture, speech, tonality, idea, image, or identifying with the speaker's ways with those of the hearer (Burke, 1969, p. 55)

Wæver (Buzan et al., 1998, p. 32-33) argues that successful speech act is composed of both linguistic (internal) and societal (external) aspects, which he subsequently specifies:

> Among the internal conditions of a speech act, the most important is to follow the security form, the grammar of security, and construct a plot that includes existential threat, point of no return, and a possible way out – the general grammar of security as such plus particular dialects of the different sectors, such as talk identity in the societal sector, recognition and sovereignty in the political sector, sustainability in the environmental sector, and so on […].

Among the external aspects of a speech there are two main conditions. One is social capital of the securitizing actor, who must be in a position of (not necessarily official) authority. The second condition says that objects found generally threatening (e.g. natural disasters, terrorism, weapons of mass destruction) are more likely to create a security threat. If it is not, it should be presented as being "more important than other issues and [it] should take absolute priority" (Buzan et al., 1998, p. 24). Facilitating conditions of a speech act as designed by John Austin have already been listed in previous section. The Copenhagen School have altered those conditions in order to achieve better applicability on their theoretical framework. And thus, Buzan et al. (1998, p. 33) sum up the facilitating conditions of a speech act in following three aspects:

(1) the demand internal to the speech act of following the grammar of security,
(2) the social conditions regarding the positions of authority for the securitizing actor – that is the relationship between the speaker and audience and thereby likelihood of the audience accepting the claims made in a securitizing attempt, and

(3) features of the alleged threats that either facilitate or impede securitization.

The Copenhagen School promotes the importance of including different sectors into security studies and expand beyond the traditional military-political agenda (Buzan et al., 1998), as is evident from the previous article. They identify five types of sectors: military, political, economic, societal, and environmental. The types of interaction differentiate based on the nature of the sector, therefore it can expected "(1) that one will find units and values that are characteristic of, and rooted in, particular sectors […], and (2) that the nature of survival and threat will differ across different sectors and types of unit" (Buzan et al., 1998, p. 27). In order to deal with the much more complex post-Cold War world, they also developed a focus on regions, which in their opinion corresponds with the assumption that the collapse of the bipolar order and weakened leadership at the global level (due to lack of motivation to further pursue wider political engagement) will lead to regionalization of the character of international relations (Charrett, 2009, p. 9; Buzan et al., 1998, p. 9).

2.3.2. Critique of the Approach

While the Copenhagen School's innovative way of understanding of security has been widely accepted, it has also generated some criticism. As Robert Cox stated in his article *Social Forces, States and World Orders: Beyond International Relations Theory,* "[t]heory is always *for* someone and *for* some purpose", and that there is "no such thing as theory in itself, divorced from a standpoint in time and space" (Cox, 1981, p. 128). The theory of securitization falls into the category of *problem-solving theory*. Theories from this category tend to "[take] the world as [they find] it, with the prevailing social and power relationships and the institutions into which they are organised, as the given framework for action" (ibid.) while dealing with problems creating entities in order to create conditions for smooth running of these relationships and institutions. So called *critical theory* falls into the second category. This category "does not take institutions and social and power relations for granted but calls them into question by concerning itself with their origins and how and whether they might be in the process of changing" (Cox, 1981, p. 129).

Many scholars have found at least troubling the absence of critical reflection on origins of problems in the Copenhagen School's discourse (Hansen, 2002; M. Williams, 2003; Booth, 2007; Stritzel, 2007; McDonald, 2008; Charrett, 2009; Huysmans, 2011). Especially authors adhering to Critical Security Studies claim that such heavily discourse-

centric approach is out of touch with reality and that it lacks more solid reflection on conceptual value of security. The overall conservative, state-centric, and elitist outlook has been criticized in particular (see Floyd, 2007). Catherine Charrett (2009, p. 16) mentions that the Copenhagen School's "conceptualization of securitization reinforces traditionalist or realist views of how securitization processes take place" because it draws from Carl Schmitt's concept of the political using the 'us-them' modality (M. Williams, 2003, p. 520). Ken Booth (2007, p. 163) also argues that the concept itself is seriously flawed mostly due to the school's own approach since it has problems to answer the questions it asks. He calls securitization studies a "theoretical mixture of liberal, poststructural, and neorealist assumptions" that rests on a muddled conceptualization of security and denies the existence of threats to security outside discourse, and also accuses the Copenhagen School of presenting security as a negative value – confrontational, zero-sum, militarized, with the implication of a failure of 'normal politics' (Booth, 2007, p. 163-165).

Others (McDonald, 2008; Balzacq, 2011; Léonard and Kaunert, 2011; M. Williams, 2011) argue that the audience, which is crucial for successful securitization, is "one of the least developed concepts in the initial formulation of the theory" (Balzacq et al., 2016, p. 499). The theorists provide the analysts with only vague criteria of audience acceptance which is problematic because the analysts do not know how to tell when securitization actually happens. Some scholars also point out that 'the audience' might in fact comprise of different audiences and settings (Salter, 2008).

In his article *What is an act? On security speech acts and little security nothings*, Huysmans criticizes the Wæver's and Buzan's conceptualization of security speech act because it cannot be folded back into given orders (instituted practices of political legitimization and political responsibilization), which in Huysman's opinion is something the answerability of speech act should do. He also argues that it is the 'little security nothings' that create the securitizing process rather than exceptional speech acts and therefore it would be more meaningful to focus on them. Holger Stritzel (2007, p. 377), on the other hand, argues that "[t]he basic idea of security as a speech act itself is too limited to allow a scholar study 'real-world' securitization".

Some authors criticise the general exclusion of the role of images, bureaucratic practices, or physical action as potential form of securitization (McDonald, 2008; M. Williams 2003). Michael Williams (2003) points out the importance of visual representation of the 9/11 terrorist attacks on the World Trade Center towers in media for creating a dominant perceptions of threat and security in the USA. McDonald (2008, p. 572) also argues

that the Copenhagen School's framework "overwhelmingly focuses on the performative role of the speech act rather than the conditions in which securitization itself becomes possible".

Claire Wilkinson (2007) argues that the approach is suffering from Eurocentrism and therefore it is unsuited for empirical analysis outside the West due to the inability of escaping the 'Westphalian straitjacket' despite their efforts to engage with regionalism. To better explain her point, she uses Campbell's analogy (Wilkinson, 2007, p. 7):

> [F]ew people have considered whether Western cars are the best way to reach a particular destination, particularly when journeying beyond the asphalted roads of Western Europe and North America, nor whether they cope effectively in the terrain. In the same way, it is often assumed that theories and concepts developed in the West can and do accurately portray conditions in the non-Western world, with at best only surface consideration given to precise socio-historical circumstances.

Her arguments are then demonstrated on the March 2005 'Tulip Revolution' in Kyrgyzstan, which shows the complexity of relationship between speech and action in the light of local specificities of domestic policy.

Rita Floyd criticizes the absence of morality and ethical dimension in the framework. In her opinion, "[t]he securitisation theorist's inability to say something meaningful about the moral value of different securitisations and desecuritisations is matched by his inability to theorise why actors securitise" (Floyd, 2010, p. 43). She also points out, that securitization that functions like an illocutionary speech act denies any meaningful role of the audience which it theoretically should depend on, and furthermore abolishes any distinction between a securitization move and a complete securitization (Floyd, 2010, p. 52).

Another valid criticism comes from Lene Hansen in the terms of 'silent security dilemma' and the absence of gender (Hansen, 2000). She demonstrates her argument on the case of honour killings in Pakistan that concerns not only equality issues but also existential threats to Pakistani women's (men's, to a lesser extent) survival. For this purpose, Hansen creates a term 'security as silence' which refers to a situation "where the potential subject of security has no, or limited, possibility of speaking its security problem" (Hansen, 2000, p. 294). The oppression of a particular social group may be incorporated into the social structure to the extent that any attempt to securitize the issue might lead to the exact opposite – even greater insecurity for the group.

However, as implied in this section of the thesis, not all critics meant to discard the securitization theory as invalid. Some of them actually aimed to improve the approach as such. The next section outlines some of the other attempts for revision.

2.3.3. Reconceptualization of the Securitization Theory

Some scholars revise the framework only to a lesser or bigger extent by, for example, creating links between securitization and humanitarianism (Watson, 2011), deepening the connection to the Schmittian logic (Van Munster, 2005; Žilović, 2009), or elaborating on the use of speech and silence (Guillaume, 2018). Others like Brown and Grävingholt (2016) alter the understanding of the term to better suit their arguments. For the purpose of this thesis, only few reconceptualising efforts are presented to present the securitization theory from a broader perspective.

One of the most prominent scholars who attempted to improve the theory of securitization is indisputably Thierry Balzacq. In the book *Securitization Theory: How problems emerge and dissolve* he edited Balzacq (2011b, p. 12) writes that: "[t]he word 'security' does not point towards an objective reality; it is an agency in itself to the extent that it conveys a self-referential practice instantiated by discourse on existential threats that empower political elites to take policy measures (sometimes extraordinary) to alleviate 'insecurity'". To sum up, speech acts cannot construct reality but merely shape our understanding of it.

In short, Balzacq (2011a, p. xiii) defines securitization as "a set of interrelated practices, and the processes of their production, diffusion, and reception / translation that bring threat into being". Due to its parsimony, this definition lacks some important elements of securitization, such as the sense of criticality and time constraint. The author (2011b, p. 3) therefore offers a much more complete definition:

> I define securitization as an articulated assemblage of practices whereby heuristic artefacts (metaphors, policy tools, image repertoires, analogies, stereotypes, emotions, etc.) are contextually mobilized by a securitizing actor, who works to prompt an audience to build a coherent network of implications (feeling, sensations, thoughts, and intuitions), about the critical vulnerability of a referent object, that concurs with the securitizing actor's reasons for choices and actions, by investing the referent subject with such an aura of unprecedented threatening complexion that a customized policy must be undertaken immediately to block its development.

Balzacq further elaborated on the importance of the audience because he felt its role was underspecified in the Copenhagen School's discourse (McDonald, 2008, p. 572). According to Balzacq's writings (2011b, p. 9), the 'empowered audience': a) has a direct causal connection with the issue; and b) has the ability to enable the securitizing actor to adopt measures in order to tackle the threat.

Sarah Léonard and Christian Kaunert (2011, p. 65) also criticise the under-development of the concept of 'audience' and propose to include Kingdon's 'three streams model' into the securitization framework. The model is part of the framework of public policy change and is based upon three streams: the problem, policy and politics streams. By synthesising these two frameworks, Léonard and Kaunert reconceptualise 'the audience' as "comprising different audiences, which respond to different logics of persuasion, but are all inter-linked as they are involved in a single policy-making process" Léonard and Kaunert, 2011, p. 69).

Holger Stritzel was already listed among the critics of the approach. However, he proposes to add more layers to the framework. Stritzel (2007, p. 377) suggests to work with three layers: (1) the performative force of an articulated threat text, (2) its embeddedness in existing discourses and (3) the positional power of securitizing actors. This revised approach would, in his opinion, add more complexity and incorporate more structural, less-decisionist and less-linguistic understanding of security (Stritzel, 2007, p. 373-374).

Colin McInnes and Simon Rushton (2011) also promote the idea of multi-level securitization. However, they perceive the levels as "a series of separate securitizing moves being made to a range of audiences, from the national up to global" (McInnes and Rushton, 2011, p. 123). The levels are determined by the relationship between securitizing agents and their audiences. Usually, the first level audience becomes a securitizing actor at the second level (McInnes and Rushton, 2011, p. 126). As a framework, they use the Balzacq's updated securitization theory and apply it on the case of HIV/AIDS. The authors also elaborate on an idea of a 'security continuum' suggested by Rita Abrahamsen. 'Security continuum' is a notion "that securitization and 'normal politics' are not binary positions but the two end points of a spectrum" (McInnes and Rushton, 2011, p. 123).

Rita Floyd (2007, p. 45-46) links the Copenhagen School's approach with the human security approach saying that "each is important in its own unique way one contributing to our understanding of how security is practiced, the other – on occasion and if successful – to its practice". According to her (2010, p. 53), securitization consists of two parts, which are the

securitizing move (warning or a promise) and security practice ("a change of relevant behaviour by a relevant agent that is justified by this agent with reference to the declared threat" – Floyd, 2011, p. 437). By speaking security, the securitizing actor much rather issues a promise to the referent object or a warning to the source of the existential threat, by "employing a 'specific rhetorical structure (survival, priority of action […])", than actually 'do security' (Floyd, 2010, p. 53). Simultaneously, the demands for the existence of securitizations have been raised and the demands for the securitization to be successful lowered. In addition, she has also attempted to enrich securitization theory by including an ethical dimension into the analytical framework with evaluating moral justifiability of a particular securitization. She argues that this can be determined by following three criteria (Floyd, 2011, p. 428):

(1) there must be an objective existential threat, which is to say a threat that endangers the survival of an actor or an order regardless of whether anyone has realized it;
(2) the referent object of security must be morally legitimate, which is the case only when the referent object is conductive to human well-being defined as the satisfaction of human needs; and
(3) the security response must be appropriate to the threat in question, which is to say that (a) the security response must be measured in accordance with the capabilities of the aggressor and (b) the securitizing actor must be sincere in his own or her intentions.

Floyd (2011, p. 428) proposes to "bracket the audience from the securitization process" because in her opinion they behave much more as a normative concept than an analytical one. "[*O*]*nly* the use of the perlocutionary speech act" as she reflects (2010, p. 52), "can account for the role of the audience in securitisation theory". Then, a just securitization theory (inspired by the just war theory) would morally constrain the securitizing process and also have a potential to democratize it.

To conclude, even though it has its limits, the securitization framework has been "an important and innovative contribution to our understanding of security and its construction" (McDonald, 2008, p. 564) worth of attention. According to Rita Floyd (2007, p. 42), "securitization approach is first and foremost a process tracing tool that helps the security analyst determine when there is/was a process of securitization and/or desecuritization, how

this came about and who were the actors involved". If critically reflected upon, the approach is still relevant and applicable on the challenges of the 21st century.

3. HIV/AIDS

3.1. What is HIV/AIDS?

HIV is an abbreviation for human immunodeficiency virus. HIV is a retrovirus[1] belonging to the family of human T-cell lymphotropic viruses (HTLV). To replicate itself, the virus needs to hijack the reproduction mechanisms of a host cell it has attached and delivered its genetic material to. "Eventually, the cell becomes full of the replicated viruses and its structure begins to fail. The volume of replicated viruses in the cell causes the cell to burst, destroying the cell and releasing the replicated viruses to infect other cells." (Stolley and Glass, 2009, p. 10) HIV infects a particular type of white blood cells – CD4+ T helper cells – that are essential components of the human immune system. The definition of HIV by the World Health Organization (WHO, 2017) continues that the reduction of T-cells "results in progressive deterioration of the immune system, leading to 'immune deficiency'. The immune system is considered deficient when it can no longer fulfil its role of fighting infection and disease. Infections associated with severe immunodeficiency are known as 'opportunistic infections', because they take advantage of weakened immune system."

The most advanced stages of HIV infection are known as 'acquired immunodeficiency syndrome' (AIDS). The overwhelming presence of malignancies and opportunistic infections, which the decreased immunity is unable to fight, are the characteristic traits of this syndrome. It is possible to live for many years with the HIV virus before being diagnosed with "the diseases that make up an AIDS definition" due to weakened immunity system (Watstein and Stratton, 2003, p. 4).

There are two viral types of HIV in the world: HIV-1 and HIV-2. This has been determined based on the similarity between their viral genetic sequences. The genome of an organism is composed of a combination of four types of nucleotides; adenine (A), thymine (T), guanine (G) and cytosine (C). "Sequencing is the identification in their proper order of the series of 'nucleotides' that constitute a gene." (Pepin, 2011, p. 11) The similarity between sequences of two isolates is called 'homology'. The dissimilarity is then called 'divergence'. Sequences of HIV-1 and HIV-2 have more than 50% divergence. The former is divided into four groups: group M (main/major) which has spread all around the world and is responsible

[1] „A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. […]. After a virus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material." (Watstein and Stratton, 2003, p. 425-426)

for 99% of all cases of HIV-1 infection, group O (outlier), group N (non-M non-O), and group P (Pepin, 2011, p. 11). Group M is further divided into nine subtypes (A, B, C, D, F, G, H, J, and K). An organism can also be infected with a combination of subtypes, 'circulating recombinant forms' (CRF). The two recombinants CRF01_AE and CRF02_AG are together with subtypes A, B, C and D the most prevalent strains worldwide (Jacobs et al., 2009, p. 1852). The differences between subtypes are small, for example subtype C is more transmittable and subtype D progresses faster. Others can also be associated with particular modes of transmission in specific locations (Pepin, 2011, p. 12). These mutations are key factor in tracing back the origins of HIV (Yusim et al., 2001). For example, group O can scarcely be found outside West Central Africa, group M subtype B is dominant in North and Latin America, Western Europe, and the Caribbean, subtype C in Southern Africa and Ethiopia, and subtype A in Eastern Europe, central Asia, and some countries of East and West Africa (Hu, Pieniazek and Mastro, 2004, p. 42; Whiteside, 2008, p. 24; Pepin, 2011, p. 13; see Appendix no. 1, no. 2 and no. 3). The HIV-2 type can be found mostly in West Africa where it originates from (Hu et al., 2004, p. 41) and there are five known subtypes. It is less transmittable and progresses at much slower rate than its HIV-1 counterpart (Watstein and Stratton, 2003, p. 235).

When a person becomes infected, he is referred to as being HIV positive (HIV+). However, this person might not have any visible symptoms and may feel and look healthy. Without treatment, the development of HIV-related illness takes about 5-10 years. AIDS is then usually diagnosed within 10-15 years after being infected with HIV, although the actual length can vary from person to person. Some individuals do not progress to AIDS at all. There is approximately 1 in every 3,000 infected with HIV. Researches identify these people by terms such as 'long-term nonprogressors' or 'elite controllers' (Stolley and Glass, 2009, p. 3-4).

Beck-Sagué and Beck (2004, p. 37) identify two patterns of epidemic transmission: Type I is driven by homosexual sex act and injection drug use and therefore affecting mostly men, and it is typical for the HIV/AIDS epidemic in developed countries; Type II is typical for developing countries, where the major mode of transmission is a heterosexual sex act and therefore the number of infected men and women is roughly the same. In some countries, both patterns occur in tandem due to a high degree of socio-economic or racial segregation.

HIV is fortunately not as easily transmittable as for instance influenza or Ebola viruses. Although the retrovirus can be found in all body fluids, HIV is transmitted almost exclusively through a direct exposure to infected blood, vaginal secretions, semen, rectal

fluids, or breast milk. The infection can also be passed by crossing the placenta or during childbirth from mother to infant. According to Beck-Sagué and Beck (2004, p. 12), "[t]he risk of mother-to-child HIV transmission without treatment is about 25% to 40%; […] [w]ith treatment during pregnancy, the risk of mother-to-child HIV transmission can be decreased to less than 2%." However, sexual intercourse and sharing drug injecting equipment are the most common sources of transmission.

Not every sexual intercourse with an infected person, though, results in acquiring HIV. There are many factors that can decrease the risk of transmission (Beck-Sagué and Beck, 2004, p. 104). Apart from abstinence, the HIV transmission can be prevented by basic interventions such as the use of condoms (male or female) and the use of clean syringes, blood supply screening, or general behavioural interventions (e.g. chastity until adulthood etc.). The risk of transmission is also significantly reduced when two uninfected people engage in faithful monogamous relationship, or when the infected partner began ART early (Eisinger and Fauci, 2018, p. 414). Alan Whiteside (2008, p. 37) also points out the efficacy of microbicides (a substance with the ability to kill viruses and bacteria if inserted into vagina or rectum before sexual intercourse) and circumcisions. Especially for women, Beck-Sagué and Beck (2004, p. 119) then propose lactobacilli capsules that recolonize the vagina with lactobacilli, which are microorganisms producing acid that strengthens resistance to sexually transmitted diseases (STDs). However, HIV awareness and understanding is the necessary first step in successful prevention worldwide.

The progression of the disease can be slowed either by basic lifestyle changes such as regular exercise, healthy eating, and reduction of alcohol consumption, which can help prevent acquiring opportunistic infections, or by antiretroviral therapy (ART) (Whiteside, 2008, p. 29). ART prevents the virus from replicating and thus reduces the amount of retroviruses in the blood of an infected person (WHO, 2017). Standard ART usually consists of a combination of two or three antiretroviral drugs such as *didanosine* (ddI), *zidovudine* (azidothymidine, AZT), or *nevirapine* (Watstein and Stratton, 2003, p. 40). Highly active antiretroviral therapy (HAART) is made up of combination of three or more antiretroviral drugs. The treatment, however, cannot terminate the infection, only slow its progression, and therefore must be taken for life. "Moreover, the efficacy of ART depends on adherence to drug regimen […], healthcare infrastructure […], and quality of diets especially intakes of protein […] and micronutrients such as iron" as Bhagrava, Booysen and Walsh (2018, p. 361) point out. On top of that, the virus mutates so it becomes drug resistant. A Whiteside (2008, p. 24) writes: "[f]or an individual, this means the drug combination they take should be tailored

to the variant of virus with which they are infected". Therefore, the drugs used for the treatment are quite complex and expensive so they are not accessible for everyone in need. In addition, not all patients can tolerate the drugs since they are toxic as well (Whiteside, 2008, p. 32). Healthcare infrastructure and quality of healthcare might also be very problematic in some developing countries, which further hinder the people living with HIV from accessing the treatment (Okigbo, Yu and Napakol, 2014). Situation in developing countries also complicates possible drug interactions due to the frequent co-infections with tuberculosis or hepatitis B or C among HIV infected individuals (Kitahata et al., 2002, p. 955). A vaccine would certainly be a smart solution to this problem. And although its development is significantly held back by many scientific and financial difficulties, HIV vaccine research is slowly moving towards its ultimate goal (see Sandiou, 2019; Fauci and Goodenow, 2019).

3.2. HIV/AIDS Pandemic: Origins and Progression

In the 1960s, general euphoria took over the (mostly Western) world. Most of the infectious diseases that the human population suffered from had been tamed. The risk of dying from influenza, tuberculosis, smallpox, meningitis, polio, or pneumonia declined dramatically thanks to antibiotics, vaccination, and new life-improving technologies (Beck-Sagué and Beck, 2004, p. 6). Environmental health and management of chronic diseases were new public health priorities. However, in a few years a new threat in form of an infectious disease emerged.

On 5th June 1981, the first cases of AIDS have been publically reported in the *Morbidity and Mortality Weekly Report*, a weekly newsletter published by the Centers for Disease Control. During 1980-1, five cases of extremely rare kind of pneumonia, *Pneumocystis carinii*, which is "an infection of lungs hitherto seen only in patients with severe impairment of their immune system" (Pepin, 2011, p. 1), have clustered around in Los Angeles, California (CDC, 1981). Those five cases that have been diagnosed not only with *Pneumocystis* but also with candida mucosal infection, also very rare in adults, were young, previously healthy active homosexual men that had not been treated with any medicines suppressing the body's immune defences, nor had been seriously ill before, which was found puzzling (Beck-Sagué and Beck, 2004, p. 14.). According to the CDC's report, "[t]he fact that these patients were all homosexuals suggests an association between some aspect of homosexual lifestyle or disease acquired through sexual contact and *Pneumocystis* pneumonia

in this population" (CDC, 1981). This argument was further supported by other reports of 19 cases in a single year of previously healthy homosexual male inhabitants of the Los Angeles and Orange Counties, California, alone diagnosed with *Pneumocystis* and/or Kaposi's sarcoma[2] revealing that several patients had had sexual contact with other person diagnosed with one of the said diseases (CDC, 1982a). After that, other cases of rare life-threatening opportunistic infections have been reported by many other doctors from all over the United States. The CDC therefore created a *Task Force on Kaposi's Sarcoma and Opportunistic Infections* to establish a case definition and conduct epidemiologic investigations. The term Acquired Immunodeficiency Syndrome (AIDS) was adopted, replacing the terms 'gay-related immunodeficiency', or 'gay plague' that were frequently used before (Beck-Sagué and Beck, 2004, p. 20; Curran and Jaffe, 2011).

Since June 1981 until September 15, 1982, 593 cases of AIDS in the USA had been reported to the CDC, from which 243 cases (41%) resulted in death (CDC, 1982b). By 1983, "the epidemiologic evidence suggested that a new infectious agent was responsible for [these] cases of unusual opportunistic illnesses, indicative of severe immunosuppression" (Fleming, 2004, p. 1). These conditions have subsequently begun to manifest among other members of society, including women and children. The research conducted by the CDC lead to the conclusion that besides unprotected sexual intercourse (hetero-, or homosexual), the agent could also be transmitted through parenteral spread (e.g. sharing paraphernalia for intravenous drug abuse, or transfusion of contaminated blood), or perinatally between mother and her child (CDC, 1983; CDC, 1982c; CDC, 1982d). Thus, other definable risk groups emerged, among which were intravenous drug abusers, recipients of blood transfusion, and haemophiliacs (Whiteside, 2008, p. 1). The syndrome was also detected among heterosexual Haitian migrants to the US (Curran and Jaffe, 2011).

Even though the causative agent of AIDS had not yet been exactly determined, the CDC in cooperation with other health agencies issued recommendations for the prevention of the syndrome based on the collected epidemiologic data. These recommendations did not result in visible decrease of AIDS rates, however, the change of behaviour among risk groups and introduction of 'safe sex' led to immediate decline of other STDs in the US (Beck-Sagué and Beck, 2004, p. 21).

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[2] Under normal conditions, it is a slow-growing skin cancer which mostly affects older men. However, it spreads rapidly in a person infected with HIV, attacking not only skin but internal organs as well (Beck-Sagué and Beck, 2004, p. 16).

There were also reports from all over the World about the spread of AIDS, most prominently from Latin America and Africa. In each region, the risk groups and types of acquired opportunistic infections differed depending on the cultural context and the microorganisms the infected were exposed to. Alan Whiteside (2008, p. 2) writes: "In Zambia, a significant rise in cases of Kaposi's sarcoma was recorded. In Kinshasa in the Democratic Republic of the Congo, there was an upsurge in patients with cryptococcosis, an unusual fungal infection. The Ugandan Ministry of Health was receiving reports of increase and unexpected deaths in Lake Victoria fishing villages." Subsequent research uncovered cases of AIDS taking place years before 1981 in Central Africa, Haiti, North America, Europe, and Israel; the earliest case recorded "was discovered in a blood sample drawn in 1959 from a man in Kinshasa, Democratic Republic of [the] Congo (formerly Zaire)" (Stolley and Glass, 2009, p. 8).

In 1983, the causative retrovirus of AIDS, HIV-1 and later HIV-2, [3] was discovered by Luc Montagnier, Jean-Claude Chermann, Françoise Barré-Sinoussi and their colleagues from the Institut Pasteur based in France (Barré-Sinoussi et al., 1983). The isolation of this retrovirus enabled scientists to develop an antibody test that permitted screening of the blood supply and thus making diagnosing of HIV infection possible. According to James Curran and Harold Jaffe (2011), "[t]he availability of laboratory reagents and techniques to identify HIV led to rapid scientific advances in understanding the natural history of the infection and AIDS." The subsequent research showed that the retrovirus takes years to develop into AIDS after infection. This discovery indicated that most of the patients were infected in the previous decade. Due to the general loosening of social norms and constraints regarding sexual behaviour, the rates of STDs raised dramatically in the 1970s, particularly among the homosexual male community (Beck-Sagué and Beck, 2004, p. 21). Furthermore, the subsequently conducted surveillance of the prevalence of HIV antibodies on the US territory revealed that the virus was more widespread than the AIDS data suggested.

The discovery of HIV and its subtypes allowed the examination of the origins of the disease. Based on a phylogenetic research, HIV is a descendant of the 'simian immunodeficiency virus' (SIV) that has been found in monkeys in central and West Africa. HIV-2 resembles an SIV found in the sooty mangabey, also known as the green monkey,

[3] The retrovirus was initially called Lymphadenopathy-Associated Virus (LAV). When it was isolated in the US a year later by the National Cancer Institute, the researchers named it HTLV-III. The term HIV was adopted in 1987. (Whiteside, 2008, p. 2)

inhabiting the West Africa. As a source of HIV-1 was identified a subspecies of chimpanzees called *Pan troglodytes troglodytes* (or central chimpanzee) that "inhabits an area south of the Sanaga River in Cameroon and extending eastward to the Ubangui and Congo Rivers" (Pepin, 2011, p. 20) with the majority of the population living in Gabon, Cameroon, and the Republic of the Congo. Chimpanzees share approximately 98% of their genes with humans (Marks, 2002). In central and West Africa, chimpanzees and green monkeys were occasionally hunted for food. The transmission of the virus most likely happened via contact with infected blood when handling raw meat of the primates (Beck-Sagué and Beck, 2004, p. 34). It is estimated that the cross-species transmission of HIV-1 group M happened between 1908 and 1933 (most likely 1921) and that the global pandemic was started by a single transmission from chimpanzee to man (Pepin, 2011, p. 41-42). In addition, there must have occurred at least one cross-species transmission for each of the HIV-1 groups over the decades. The date of transmission of HIV-1 group O is also estimated around 1920, common ancestor of group N was traced back to a time period around 1963, and group P was discovered only recently. The groups O and P are most closely related to SIV found in gorillas, although the evidence suggests that gorillas were also first infected from chimpanzees (Pepin, 2011, p. 170).

Due to the policies of colonial powers in central Africa, booming cities (such as Brazzaville and Léopoldville) attracting male workers, and thus creating a significant gender imbalance in said cities, became great hubs of prostitution development and therefore a perfect environment for spread of STDs, HIV-1 included. Jacques Pepin (2011, p. 103) also assigns a great role in the emergence of HIV in Africa to the state of African public health care and the re-use of improperly sterilized injection equipment. Nevertheless, HIV was not very common until the late 1970s in central Africa and the early 1990s in Botswana and South Africa (Beck-Sagué and Beck, 2004, p. 34). Significant change that resulted in rapid spread of HIV came about in the 1980s when the socio-economic circumstances forced rural people to abandon their homes and their traditional customs.

The disease then spread through the Caribbean to both Americas presumably in the late 1960s or in the early 1970s, most likely through blood trade and/or prostitution (Pepin, 2011, p. 195). Subsequently, HIV-1 subtype B was successfully exported from the United States to Western Europe, Canada, Australia, Southeast Asia (and through there to China), most of Latin America, and also Caucasian gay community in South Africa in the early 1980s. Roughly around the same time, other subtypes of HIV-1 group M were transported outside of Africa; the subtype A to East and Southeast Europe, the recombinant CRF01_AE to Southeast Asia, and the subtype C to India (Pepin, 2011, p. 214-215).

It was very soon recognized that the emerging disease demands extraordinary attention. In 1986, a new WHO Global Program on AIDS (GPA) was established under the leadership of Jonathan Mann, a cofounder of 1984 *Projet SIDA*[4] who thus had experience from studying AIDS in the Democratic Republic of the Congo (Cohen, 1997, p. 1566). During his years as the head of the GPA he managed to persuade most of world politicians that was truly a pandemic affecting everybody. AIDS became recognized as a global health problem. Nine years later, in 1995, Belgian epidemiologist Peter Piot, another prominent figure of *Projet SIDA*, helped create a Joint United Nations Programme on HIV/AIDS (UNAIDS) which has under his leadership "become the chief advocate for worldwide action against AIDS" (UNAIDS, 2019a). As Simon Rushton (2007, p. 2) pointed out: "[HIV/AIDS] now finds itself the subject of a Millennium Development Goal, and on the agenda of almost every major international body, from the United Nation to the G8". On 17 July 2000, the United Nations Security Council adopted Resolution 1308 that officially recognized the spread of HIV/AIDS as a threat to stability and security that "can have a uniquely devastating impact on all sectors and levels of society" (United Nations Security Council, 2000b).

HIV also drew an immense attention from the medical community. This induced a worldwide emphasis on HIV/AIDS research. In 1987, an antiretroviral therapy (ART) was introduced, followed ten years later by highly active antiretroviral therapy (HAART), which reduced the chance of the virus developing drug persistence (Doyal and Doyal, 2013, p. 1). "By 2008, over 25 different combinations of medications had been developed as 'second line' therapies and even as 'salvage' therapies to fight these drug resistant strains." (Stolley and Glass, 2009, p. 40) The research on AIDS was beneficial for a deepening of knowledge on autoimmune and chronic diseases, and also contributed to the development of a treatment to diseases such as acute leukemia, some genetic immune disorders or even hepatitis B virus (amfAR, [2019]).

In 2014, UNAIDS issued the 90-90-90 targets by 2020, a goal that should eventually achieve an end to the pandemic in 2030 (Eisinger and Fauci, 2018, p. 415). This triple 90 targets mean that 90% of all infected people would know their HIV status, 90% of HIV+ who know their status would be accessing treatment, and that 90% of people receiving treatment would have suppressed viral loads (UNAIDS, 2018c, p. 66).

[4] French for 'Project AIDS'

It is estimated that 36.9 million people were living with HIV worldwide in 2017, of which 25% did not know their HIV status. About 21.7 million people were accessing ART, this makes only 59% of all people infected with HIV. Since its peak in 1996, new infections have been decreased by 47% (3.4 million in 1996 compared to 1.8 million in 2017) (UNAIDS, 2018a, p. 1-2). To sum up, three years before reaching the 90-90-90 targets deadline, there were globally estimated 75% of people knowing they are HIV+, 79% of which were accessing ART, and 81% of ART receivers had suppressed viral loads (UNAIDS, 2018c, p. 66; see Appendix no. 4).

4. HIV/AIDS in South Africa

4.1. The Republic of South Africa and Current State of the Epidemic

The Republic of South Africa is the southernmost country of the continent sharing borders with Namibia, Botswana, Zimbabwe, Mozambique, Swaziland and enclaved country of Lesotho, that plays a central role as the great power of sub-Saharan Africa (Buzan and Wæver, 2003, p. 233). South Africa is divided into nine provinces: the Eastern Cape, the Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, the North West, the Northern Cape and the Western Cape (see Appendix no. 8). The country is inhabited by over a 57.71 million people, which makes it the 24th most populous nation of the world. Ethnically, the population of South Africa consists of 80.9% of Black African, 7.8% white, 2.5% Indian/Asian, and 8.8% 'coloured' population groups (Stats SA, 2018, p. 1-2). The term 'Coloured' refers to the "population group that emerged in the Cape in the seventeenth and eighteenth centuries as a result of contact between Africans, Malaysians, and Europeans" (Clark and Worger, 2011, p. 13). South African white population comprises mostly of descendants of the British colonists and 'Afrikaners'. Afrikaners are descendants of the former employees of the Dutch East India Company, and people escaping seventeenth-century religious intolerance of Dutch, German, and French origin (Cottrell, 2005, p. 15).

According to the World Bank, South Africa is an upper-middle-income economy with a gross domestic product (GDP) worth of 366.3 billion US dollars (The World Bank, 2019b), however, the distribution of health remains uneven (Whiteside, 2010, p. 419). Unlike the rest of sub-Saharan Africa, South Africa is relatively 'de-agrarianised' due to "the destruction of peasant agriculture under apartheid" (Nattrass, 2004, p. 33), with agriculture, foresting and fishing taking up only 2.2% of GDP (The World Bank, 2019a). The secondary sector of economy (light and heavy industry, and construction) is also shrinking its contribution to national GDP in favour of tertiary sector (services). This trend, however, has a negative impact on unemployment rates, since there is a direct correlation between unemployment and education level[5] (Stats SA, 2019).

[5] The Bantu Education Act (No. 47) created seperate educational facilities for Natives that would „mould Africans into compliant citizens and productive workers" (Clark and.Worger, 2013, p. 55). Higher levels of education (apart from specially established separate colleges and universities for black, Coloured and Indians) were permitted only under special circumstances to other than white South African population during the apartheid era (Clark and Worger, 2013, p. 52-53).

South Africa is also a country with the largest HIV epidemic in the world. In this country alone lives 19% of the total global number of infected people (approximately 7.7 million, which represents 13.3% of the total population of South Africa) (UNAIDS, 2019c). The highest prevalence rate in South Africa is among women over 15 years of age. According to 2018 Mid-year population estimates by Statistics South Africa, "[a]pproximately one-fifth of South African women in their reproductive ages (15-49 years) are HIV positive" (Stats SA, 2018). South Africans also comprise 11% of all AIDS-related deaths (UNAIDS, 2019c). On the other hand, the South Africa's treatment programme is the largest in the world with 62% of all infected receiving ART in 2018, which accounts for 20% of people on ART globally (UNAIDS, 2019c).

In South Africa as well as in all other countries in southern Africa with significant rates of HIV/AIDS epidemic predominates HIV-1 subtype C which accounts for approximately 98% of all infections (Peeters, Toure-Kane and Nkengasong, 2003, p. 2549; Hemelaar et al., 2011, p. 684). However, there is also a significant minority of subtype B infected people. Most of those cases are members of the white male homosexual community, while subtype C can be mostly found among black heterosexuals (Pepin, 2011, p. 12). This supports Beck-Sagué's and Beck's argument about the tandem appearance of Type I and Type II transmission patterns (Beck-Sagué and Beck, 2004, p. 38).

As Eleanor Gouws and Quarraisha Abdool Karim (2010, p. 63), former director of the South Africa's national AIDS program, point out, "[t]here is considerable geographical variation in the distribution of HIV infection in South Africa, with a gradient of infection that is highest in the east coast and lowest in the west coast of South Africa". In 2017, the highest HIV prevalence among adults (15-49 years) was detected in provinces surrounding Lesotho: 27% in KwaZulu-Natal, 25.5% in the Free State, and 25.2% in the Eastern Cape. The Western Cape had the lowest prevalence of 12.6% followed closely by the Northern Cape with 13.9% (HSRC, 2018, p. 2). Gouws and Abdool Karim explain this phenomenon by blaming the uneven distribution of population. This is particularly true in the cases of the Northern Cape with only 2.1% share of the total population on one side and KwaZulu-Natal with 19.7% and the Eastern Cape with 11.3% share of the population on the other (Stats SA, 2018, p. 16). In other provinces, such as the Free State, whose inhabitants account only for 5.1% of all South Africans, or the Gauteng province which by contrast has both the highest share of the total population (25.5%) and also the highest density of people living with HIV per km^2 but simultaneously has the fourth lowest HIV prevalence rate, this assumption seems ill-founded

(Stats SA, 2018, p. 16; HSRC, 2018, p. 2; B. Williams and Gouws, 2001, p. 1079; see Appendix no. 10).

KwaZulu-Natal is especially peculiar location. A survey conducted between the years 2010 and 2014 has revealed "an 'HIV hotspot' where 40.8% [39.5-42.1%] of adults (aged 15 years and older) are living with HIV. People within this geographical area have a 46% higher risk of HIV infection than those living outside of it, and the closer one lives to the hotspot, the higher one's risk of infection" (UNAIDS, 2018d, p. 10). These hotspots also play a key role in the HIV spread and therefore should be primarily targeted by the appropriate authority to intensify HIV treatment and prevention services.

Concerning key populations, it is estimated that 57.7% of all South African sex workers live with HIV. However, buying and selling sexual services is a serious offence against the law, hence the ART coverage is very limited and only 23.6% of them are on therapy (UNAIDS, 2019d, p. 63). South African Law Reform Commission have already recommended the revision of the legal framework prohibiting adult prostitution in 2017 report on sexual offences (South African Law Reform Commission, 2017, p. xxv) which might possibly motivate more sex workers to seek medical help. Other popular movement have been working to decriminalise sex work, but the government has not yet acted on this issue. Similar situation is within the gay community and other men who engage in sexual activities with other men when the HIV prevalence rate is 18.1% but only approximately 28.1% of infected is receiving antiretroviral therapy (UNAIDS, 2019d, p. 63). Same-sex sexual acts are not penalized by law however such a behaviour is considered 'un-African' and so people identifying as LGBT (lesbian, gay, bisexual or transgender) are stigmatized and socially isolated and may experience discrimination by healthcare providers based on their gender identity or sexual orientation (Müller, 2017).

South Africa also works on a progress toward reaching the 90-90-90 target. According to the country data by UNAIDS 2019 estimates, roughly 90% of people living with HIV knew their status in 2018 (UNAIDS, 2019d, p. 63). However, the second and the third 90 are not yet accomplished. Out of 6.4 million people knowing their status only 75% are on ART. However, almost 87% of people on ART already have suppressed viral loads (see Appendix no. 11 and no. 12). In addition, the share of women in these statistics is always higher than of men (UNAIDS, 2019d, p. 62-63). South Africa has come a long way from denial and neglect of the epidemic to a country with the largest ART program in the world, however, the war on AIDS is not yet won.

4.2. Apartheid, Transition, and HIV/AIDS

The history of South Africa is a story of racial discrimination and segregation. The government's official policy of *apartheid* (from Afrikaans, literally meaning 'apartness) that actively shaped the country since 1948 until 1990s (Susser, 2009, p. 67) created an environment of "unequal distribution of resources, widespread poverty, the profligate duplication of civil services, international isolation and regional military insurgencies, the absence of democracy and effective/good governance, domestic political instability and gender inequality" that proved to be "a favourable breeding ground to pathogens" (Fourie, 2006, p. 51).

The ideology of segregation in South Africa was deeply rooted, affected by the mineral discoveries and both Boer Wars. At the beginning of the twentieth century, segregationist precedents were already apparent in all provinces of the newly established Union of South Africa (Dubow, 1989, p. 22). Following the South African War, the Union of South Africa was created within the British Commonwealth on 31 May 1910 by joining together the four British colonies in Southern Africa – Natal, the Orange River Colony (Orange Free State), the South African Republic (Transvaal), and the Cape – with the central legislative, administrative and judicial bodies divided among the three capitals Cape Town, Pretoria, and Bloemfontein (Clark and Worger, 2011, p. 20-21). Usually, policies adopted by the new mostly Afrikaner government benefitted people of European descent to the detriment of natives. As Clark and Worger (2011, p. 32) point out, "[w]hile Afrikaner ethnicity was mobilised primarily against the dominance of English speakers in South African business and politics, Afrikaners and English alike were practically unanimous in support of segregation as the policy of choice regarding Africans". Swayed by the fact that whites (who represented only 20% of the South African population at the time) controlled most of the economic resources, the government implemented these policies in effort to protect political and economic interests of the white population (Clark and Worger, 2011, p. 22). One of the most discriminating was the *Natives Land Act* (1913) that imposed territorial segregation of the races and restricted natives from owning land outside the reservations, which composed only 7% of total South African territory[6] (Cottrell, 2005, p. 68-69). Soon enough, segregation policies affected lives of Africans in both rural and urban areas and at the workplace. Rural areas became unable to support all its inhabitants, which forced more and more people to

[6] The *Natives Trust and Land Act* (1936) added land to the resevations so that they took up 13% of the country (Guelke, 2005, p. 24).

enter a system of migrant labour that stripped them of any rights. During the World War II, the country underwent a social and economic transformation and the restrictive policies were relaxed so that factories could have enough workers to satisfy the wartime demands. This caused a huge boom of the urban African population that most South African cities could not accommodate, thus boosting animosity of the white population towards Africans (Clark and Worger, 2011, p. 38-39).

In 1948, Daniel François Malan's National Party (NP) dedicated to the ideology of apartheid won the general election (Cottrell, 2005, p. 85). The apartheid leant on two legal pillars. The first was a *Population Registration Act* (1950) classified the entire population based on race into three categories: 1) White; 2) Native (later renamed Bantu); and 3) Coloured, which was later subdivided into seven subcategories[7]. The second was the *Group Areas Act* (1950) that racially segregated urban areas and assigned Natives to live in reservations (Guelke, 2005, p. 25-26). Some legislation prohibited mixed marriages or even sex across categories, other restricted the use of buses, park benches, toilets, swimming pools, libraries and so on by making some of them 'Whites-only'. Subsequently, Natives were deprived of South African citizenship and passports, and forced into living in 'ethnic homelands' (also called 'Bantustans') (Susser, 2009, p. 66-67). In 1960, the referendum about the status of the Union of South Africa took place where the white citizens of the country voted whether they want to remain a British dominion. The Republic of South Africa was proclaimed on 31 May 1961 based on the results of the referendum (Cottrell, 2005, p. 97). Even though the United Nations General Assembly labelled apartheid a crime against humanity in 1966, the ruling National Party continued to deepen the existing segregation (Guelke, 2005, p. 1; Cottrell, 2005, p. 102). Ida Susser (2009, p. 69) writes that "[b]y the 1980s, South Africa was ruled by a white supremacist regime in which Africans were not allowed to vote, to attend schools in English, to go to white hospitals or to live in cities unless they could prove they worked there".

As mentioned in the previous chapter, HIV mostly targets individuals with already weakened immune system. During the apartheid era, the South African poor were often afflicted by tuberculosis or STDs leaving them immunocompromised for the rest of their lives (Fourie, 2006, p. 52-53). Unequal distribution of resources made the black African population especially vulnerable. Due to the homeland system and the migration of male workers to and

[7] Cape Coloured, Malay, Griqua, Chinese, Indian, Other Asiatic, and Other Coloured (Guelke, 2005, p. 25)

from larger urban areas out of necessity in the search for work to secure their families provided for the rise of "the 'hostel system' which was set up to accommodate migrant workers […], and burgeoning networks of commercial sex work to service these hostels" (Fourie, 2006, p. 55). In short, three structural conditions of apartheid were crucial for the epidemic: social inequalities, gender violence and migration (Fassin, 2002, p. 64). In the 1980s, two sub-variants of HIV-1 emerged in this environment. Subtype C affected primarily Native heterosexuals, while subtype B predominated among male homosexual community (mostly of people of European descent). The evidence suggests that subtype B was imported to South Africa from the USA. Subsequent infection of a small percentage of Africans (both men and women) with subtype B is attributed to intimate contact between white homosexuals and Bantu heterosexuals (Pepin, 2011, p. 12). The immense genetic diversity of subtype C suggests that it was introduced to the country multiple times, most imports and exports occurring between the year 1985 and 2000 which coincide with the transition period (that is discussed below). Most viral imports came from Zambia, followed by Botswana, Malawi and Zimbabwe, where the bases of the oppositional African National Congress (ANC) in exile were located (Wilkinson et al., 2016, p. 203; Clark and Worger, 2013, p. 103).

The first two cases of AIDS in South Africa were found in white male homosexuals in 1982 (Fourie, 2006, p. 1). However, the government did not come up with a systemic national response to HIV epidemic until 1986-87 (Fourie, 2006, p. 52). This was caused by the false presumption that the disease affected only homosexuals and as the Chief Medical Health Officer of Cape Town, Reg Coogan, said himself, "there were not many of those kind of people" (Grundlingh, 1999, p. 63). Predictably, the spread of AIDS among the African population was neglected by the regime as well, and thus the collection of epidemiologic data on the disease among Natives and the development of a preliminary AIDS prevention approach did not start until the early 1990s, when it stopped being perceived solely as a health problem and the disease was redefined as a human rights and development issue (Susser, 2009, p. 72-73; Fourie, 2006, p. 100). Unfortunately, the early recommendations for prevention were heavily based on western experience promoting the practice of monogamy, avoidance of high-risk sexual behaviour and the use of condoms, which the risk population could not identify with (Fourie, 2006, p. 72). On top on that, since homosexuals faced searing discrimination and any "commercial sex was criminalised under the NP administrations […], there were no apparent avenues open to government agencies which might wish to implement HIV and AIDS programmes" for afflicted individuals, who, furthermore, were very much

reluctant to seek health or legal authorities, driving the underground spread of the epidemic (Fourie, 2006, p. 55; Susser, 2009, p. 71).

By this time the system of apartheid was already crumbling. Police brutality, violent protests and government repressions escalated, South Africa was facing more and more sanctions fuelled by international antiapartheid sentiments and disinvestment campaigns. State President P. W. Botha had no other choice but to loosen the apartheid restrictions and consent to initiate talks with the opposition represented by the ANC (Cottrell, 2005, p. 109). F. W. de Klerk who replaced Botha as the head of the country in 1989 realised the dire need for reform. Opposition parties were legalized, Nelson Mandela released from prison and a new democratic constitution was being drafted (Sonneborn, 2010, p. 85-86). The first democratic national election took place in late April 1994 and was marked by the sweeping victory of the ANC. Nelson Mandela became president (Cottrell, 2005, p. 114). Some of the ANC representatives were familiar with the impact of HIV/AIDS from their years in exile in Angola and Mozambique, where the rates of infection were high. Dr Nkosazana Dlamini-Zuma, the women's health advocate and HIV/AIDS activist who had been trying to draw attention to this problem for many years, was appointed the Minister of Health, which allowed her to take steps she deemed necessary to fight the infection (Susser, 2009, p. 86). The new HIV policy-making was supposed to "be inclusive, conciliatory, stable and consensual, focusing on bottom-up, populist measure mechanisms to ensure that all the appropriate policy stakeholders take ownership of the policies" (Fourie, 2006, p. 110).

The same year the ANC assumed the leadership of the country the National AIDS Plan (NAP), drafted two years prior by the National AIDS Convention of South Africa (NACOSA), was adopted by the new government with a main goal to lower HIV prevalence and the number of AIDS-related deaths. The plan itself warned about the possible outcome if the rising epidemic would be left unaddressed. It predicted that by the year 2000 there would be 4-7 million HIV+ cases with about 60% of total AIDS-related deaths (African National Congress, 1994). Pieter Fourie (2006, p. 109) in his book *The Political Management of HIV and AIDS in South Africa* described the NAP to be the most "politically correct and seemingly socially appropriate policy" one could image because "[t]he contents of the Plan contained all the elements required by HIV and AIDS and policy stakeholders including the World Health Organization's (WHO) Global Programme on AIDS (GPA) officials, members of South African civil society, business, political parties, AIDS activists and trade unions". The NAP's main objectives were to (Fourie, 2006, p. 111):

- prevent the transmission of HIV;
- provide care for people infected with and affected by AIDS;
- alleviate the impact of AIDS on communities;
- support people not infected by HIV in their efforts to retain that status;
- provide a forum for all South Africans to become involved in efforts to combat the spread of HIV and AIDS;
- identify resources that could be deployed in the fight against AIDS, and
- ensure that communities were fully involved in all stages of the development, planning and implementation of the Plan.

However, the NPA overestimated the availability of the economic resources and turned out to be totally ineffective. According to UNAIDS, out of 36.8 million South Africans was only 78,000 living with HIV (which is roughly 0.2%) in 1990. In 1994, the year of NAP became effective, 690,000 people out of 40.5 million was infected (1.7%). However, the subsequent decade witnessed the number of cases skyrocketing. In 2004, 4.7 million inhabitants of South Africa out of 47.3 million were HIV+ (almost 10%) (UNAIDS, 2019c; The World Bank, 2019). From 13,000 AIDS-related deaths per year in 1994 South Africa went to 200,000 in only ten years (UNAIDS, 2019c). Between 1998 and 2005, life expectancy at birth fell from 68.2 to 54 (Fourie, 2006, p. 1; Stats SA, 2018, p. 6; see Appendix no. 9). This number was expected to fall even lower down to 41 years in 2010 (Fassin, 2002, p. 64). According to Nicoli Nattrass (2004, p. 41), the AIDS policy at the time was "a sorry tale of missed opportunities, inadequate analysis, bureaucratic failure and political mismanagement". The HIV/AIDS issue was overshadowed by other urgent policy imperatives due to ANC's "overwhelming urge to improve all of South Africa" (Fourie, 2006, p. 114) and any efforts to deal with the issue were complicated by the inexperience of the new government, difficulties in coordinating responsibilities in the political system in transformation, and the inadequacy of infrastructure and communication with the affected community (Schneider, 1998, p. 7-8). Krista Johnson (2004, p. 110-111) attributes the ineptitude of the ANC's government to respond to HIV/AIDS epidemic to several factors: "(1) the adoption of neoliberal macroeconomic strategies to conform to the dictates of capitalist globalization, (2) administrative/bureaucratic restructuring that accompanied the transition to democracy, (3) the retention of apartheid-era civil servants, and the quasi-federal system that places social-service provision in the hands of provincial authorities, and (4) the non-participatory and secretive leadership style of the ANC, a legacy of militant opposition while in exile."

Furthermore, the relationship between the government and the AIDS community was further damaged by number of scandals and affairs like the so-called *Sarafina II* or the *Virodene* controversy. *Sarafina* was an anti-apartheid play by the South African playwright Mbongeni Ngema which told a story of a young African girl and the struggle for political freedom. In 1995, the National Department of Health came up with an idea to produce a musical informing young South Africans about the dangers of HIV/AIDS. The development of the *Sarafina* sequel with the involvement of Ngema consumed large portion of the budget dedicated to AIDS, which together with the failure of communicating the problematic AIDS message and the neglect of involvement of the South African AIDS civil society into the process generated some heavy criticism and doomed the project (Schneider, 2002, p. 147). Nelson Mandela even declared the scandal as one of the most significant mistakes of his administration (Nattrass, 2004, p. 45). In 1997, the government announced the development of a new retroviral drug *Vironede* (Schneider, 2002, p. 147). The research was conducted by a small team of scientists attached to the University of Pretoria and allegedly funded by the ANC (Fourie, 2006, p. 125). The Deputy President Thabo Mbeki himself pushed the Medical Control Council (MCC) to expedite the approval of the 'miracle cure'. However the MCC found out that the drug was a derivative of an industrial solvent (dimethylformamide) that had previously been tested as treatment for cancer but abandoned for being toxic and unfit for consumption (Nattrass, 2004, p. 45). Mbeki and Dlamini-Zuma accused the *Virodine* opposition of racism and the MCC of obstructing the development of life saving therapies (Schneider, p. 147). As Johnson (2004, p. 122) writes, the affair "further solidified the patterns of criticism of the Department of Health by the media, opposition parties, and some civil-society groups, and increasing defensiveness and hostility in response by the government".

On top of that, it was known that the ANC government was generally unable to reasonably spend its budget, and yet in late 1998 HIV+ pregnant women were denied provision of AZT (azidothymidine, an antiretroviral drug) by the government advocating this decision by asserting that the purchase of this drug would not be cost-effective and that the state could not afford to implement a mother-to-child-transmission (MTCT) programme (Fourie, 2006, p. 127-128). This led to the establishment of the Treatment Action Campaign (TAC), a voluntary association of individuals and organizations connecting all the South African risk groups and fighting for the access to ART for all people with HIV/AIDS and prevention of new infections (Johnson, 2004, p. 125). However, the TAC activity contributed

to further deepening of the government versus civil society relationship (Fourie, 2006, p. 130).

When Thabo Mbeki replaced Nelson Mandela in the presidential office in June 1999, South Africa lied amidst an AIDS furore (Nattrass, 2004, p. 46). The years of neglect of the HIV/AIDS issue by the NP government were substituted by the years of contradictory rhetoric and misguided efforts to effectively confront the disease (Susser, 2009, p. 96).

4.3. The Negative Impacts of HIV/AIDS on the State

It is a widely excepted fact that HIV/AIDS can have devastating effects on the economic development, politics and social sphere of countries with high prevalence rate (Elbe, 2002, p. 159). Especially in southern Africa where most of the victims of AIDS-related deaths are between 15 and 49 years of age, which is the most important group for proper functioning of the state (P. Williams, 2007, p. 1030-1031).

Even though it is increasingly difficult to distinguish the effect of HIV/AIDS on the economy from other factors like climate change, food insecurity, or inflation, there are identified several ways in which the disease can undermine economic security of a country (Whiteside, 2010, p. 417). First, it reduces the productivity of 'breadwinners' and therefore brings down the economic security of household as a whole. Second, it further pressures the household to divert its already scarce resources towards medical expenses and also increases the states expenditures on the public health system. Third, slower economic growth caused by the lower income and consumption undermines the development of the state. Fourth, the state economy has to provide for orphaned children of AIDS victims. In South Africa, HIV/AIDS is devastating especially at household level. According to Nattrass (2004, p. 33), AIDS creates a vicious circle of poverty leading to higher vulnerability to the infection which lowers economic growth and thus generating more households on the brink of poverty.

HIV/AIDS also causes an erosion of social and family structures of affected countries. Due to higher mortality of people in their productive age there are consequently more orphaned children which can no longer be cared for by the extended families. Children are often withdrawn from school so they could care for their infected family members. Single-parent households, 'skipped generation' households (headed by grandparents) or even households headed by a child are on the rise. These households have very limited income and therefore vulnerable. Many of such affected children turn to crime and/or prostitution in order

to survive (Heineken, 2001a, p. 123.). This phenomenon could be a significant contributor to the country's high criminality rates (see Sicetsha, 2018). The situation in South Africa is further complicated by the prevailing discrimination against HIV+ people that still draws from misconceptions of their race, gender, sexuality or their socio-economic status. (Frohlich, 2010, p. 374-376)

Stefan Elbe (2002) puts forward arguments on how the disease influences armed conflicts in sub-Saharan Africa. Many African armed forces have noted a decrease of their operational efficiency due to the epidemic. Rates of STDs are usually higher than average among military personnel as a result of a variety of factors: soldiers are usually of a reproductive age; they have more opportunities to engage in risky sexual behaviour; they tend to be separated from their families for longer periods of time; and they might seek stress relief through sexual activity (Elbe, 2002, p. 163). In 2000, South Africa estimated that 15-20% of its army is HIV+ (Heinecken, 2001b, p. 11), although some reports have suggested that this number was much higher (Le May, 2002). AIDS also lowers down the number of potential new recruits. High HIV prevalence rate could also lead to a loss of not easily replaceable personnel like high-ranking officers or specially trained staff. Last but not least, "HIV/AIDS can hinder the ability of soldiers to carry out their duties" (Elbe, 2002, p. 165). By these measures, HIV/AIDS impacts the security sector of the most affected countries. In addition, because these countries often contribute troops to international peacekeeping operations they unintentionally further spread the infection.[8] However, intentional spread of the disease might also function as a weapon of war, as documented in some conflicts in Africa where rape was systematically used against civilian population (Elbe, 2002, p. 166).

On the other hand, further research showed that while in some long conflicts the HIV prevalence increased, there were other conflicts in which prevalence rates actually declined (McInnes and Rushton, 2010, p. 238).

[8] For example United Nations Transition Authority in Cambodia (UNTAC) is quite often blamed for the country's high prevalence rates (Elbe, 2002, p. 166).

5. Securitization of HIV/AIDS: The Case of South Africa

5.1. Securitizing HIV/AIDS

According to Gwyn Prins (2004), there were three forms of engagement with the disease that dominated the 1990s and three possible (new at the time) approaches to interpret the HIV/AIDS pandemic in the new millennium. The first of these 'new' approaches considers geopolitical implications of the pandemic based on the recent biochemistry findings. Human immune system is dependent on micro-nutrients within general nutrition to successfully combat diseases, selenium in particular. It has been found that the rise of illnesses correlates with selenium deficiency in soil. The second approach perceives HIV/AIDS as a public health issue through the lens of renovated political economy. The last one interprets the pandemic as a security issue. (Prins, 2004, p. 935-393)

The previous chapter explored the nature of HIV/AIDS and followed progression from the first interspecies transmissions to a full-blown pandemic. This part of the thesis discusses the problematic of the HIV/AIDS pandemic becoming accepted as a security issue. Many scholars have welcomed the notion of securitizing the disease whilst others have pointed out dangers of such action (Rushton, 2007, p. 1; see Elbe, 2006; Ingram, 2005).

It was recognized quite early on that the disease requires a global response. Chapter 3.2. outlined the establishment of initiatives such as the Global Program on AIDS in 1987 or the Joint United Nations Programme on HIV/AIDS in 1995. Jansson (2017, p. 72-73) argues that the HIV/AIDS-security nexus entered both national and international discussion in mid-1990s, when the security framing of the disease started to be promoted by sub-Saharan national governments as well as powerful international organizations like the WHO, the World bank and UNAIDS. However, apart from a small number of security think tanks and a few US Central Intelligence Agency (CIA) analysts, this issue and other health issues did not attracted much attention of scholars working in the field of Security Studies until the beginning of the new millennium (Elbe, 2006, p. 121). Now many scholars perceive and treat the pandemic as a threat to peace and security of the most affected regions (Heinecken, 2001a; Elbe, 2002; Vieira, 2007; Sjöstedt, 2008).

In the early 2000s, securitization became a very popular framework among scholars. After the implementation of the Resolution 1308, the academia mostly accepted the issue of HIV/AIDS as securitized (McInnes and Rushton, 2011, p. 122-123), even though some argued it was too soon to proclaim the securitization process complete (Rushton, 2007, p. 1). Arguably, this trend may correlate with broadening of the security agenda even outside

academia (see Rushton, 2007). Stephan Elbe (2006, p. 126), when applying the Copenhagen School's approach on the case of HIV/AIDS, observed a shift of arguments:

> [In recent years,] arguments have shifted from humanitarian and public health ones to officials in international organizations, government, and non-governmental organizations (*securitizing actors*) increasingly arguing that beyond these humanitarian considerations, the survival of communities, states and militaries (*referent objects*) is now being undermined (*existentially threatened*), unless drastic measures (*emergency measures*) are undertaken by national and international actors to better address the global pandemic.

Feldbaum, Lee and Patel (2006, p. 0755) argue that in the security community's analysis there are three ways to examine the pandemic from the perspective of the HIV/AIDS -national security nexus: (1) impact of the disease on individuals is critical to international security (soldiers and peacekeepers) and to the maintenance of the state in general, (2) the instability and failure of the most affected states in sub-Saharan Africa, and (3) "the security effect of the worsening pandemic on the large, strategically important states of Russia, India and China".

Even though many recognize the existence of the HIV/AIDS-security nexus, it does not necessarily mean the issue has been securitized. Securitization of HIV/AIDS is hindered by many aspects. One of them is the nature of the epidemic itself. HIV/AIDS epidemic is a long-wave event and should be treated as such (Barnett and Prins, 2006, p. 361). Long-wave events exceed the span of a generation. They usually emerge inconspicuously, but by the time they become evident it is hardly possible to halt their progress. Its long-term ramifications require long-term solutions, however, "[m]ost political and administrative capacities are not established to deal with such events" (Barnett and Prins, 2006, p. 361).

Some scholars (Barnett and Prins, 2006; Elbe, 2006), apart from the feasibility of such action, also discuss ethical implications of securitizing health issues, HIV/AIDS in particular. First, securitization often leads to hasty responses. However, long-wave events such as the HIV/AIDS epidemic treated as 'emergencies' by taking short-term solutions are much more prone to get worse in the long run (Barnett and Prins, 2006, p. 361). Second, the 'extraordinary measures' might require shifting responsibilities away from civil society and towards other institutions (e.g. military) that possess the power to override basic human

rights, especially of the affected individuals. Third, Elbe (2006, p. 120) addresses the language of security:

> [T]he language of security also brings a "threat-defense" logic to bear on HIV/AIDS, which may ultimately prove counterproductive to international efforts to stem the pandemic because (i) this logic makes such efforts not a function of altruism but of more restrictive and narrow national interests, (ii) because it allows states to prioritize AIDS funding for their armed forces and elites who play a crucial role in maintaining security, and (iii) because the portrayal of the illness as an overwhelming security 'threat' works against the efforts of many grassroots AIDS activists seeking to normalize social perceptions regarding persons living with HIV/AIDS.

Especially in South Africa where the perception of the disease and affected people is heavily influenced by stigma, securitization of the issue might actually do more harm than good.

5.2. HIV/AIDS Securitization by International Actors in Relation to South Africa

After conducting the research, several documents and speeches by the relevant securitizing actors were identified as securitizing moves. This chapter shows that over the years, quite a few moves securitizing the issue of HIV/AIDS were conducted. These particular moves are examined below.

Vieira (2011, p. 7) writes: "At the global level, three main *securitizing actors* were involved in the promotion of [HIV/AIDS securitization norms], namely the UNAIDS, the US Government (notably under George W. Bush's administration) and transnational networks of NGO's working with HIV/AIDS." However, this thesis identifies as relevant other securitizing actors, namely the former Secretary-General of the UN Kofi Annan and the United Nations Security Council (UNSC), the Organisation of African Unity (OAU) as well as its successor the African Union, and the US Government. Potential securitizing actor relevant for the last chapter is the Government of South Africa.

Unsurprisingly, the existential threat is in this case the HIV/AIDS pandemic. As referent objects are identified international peace, world nations, societal (or other kind of) stability, or specifically South Africa. However, they vary from one securitizing move to

another and usually do not appear together. The audience in this chapter also differs depending on the securitizing actor. However, all of the securitizing moves could be related to South Africa. The way in which the securitizing actors and audiences changed aligns with McInnes and Rushton's theory of multi-level securitization. They observed that in the case of the HIV/AIDS pandemic, "the original audience effectively became securitizing actor at the second level" (McInnes and Rushton, 2011, p. 126).

On 10 January 2000, Kofi Annan (2000) addressed the Security Council by saying that "the fight against AIDS in Africa is an immediate priority, which must be part and parcel of our work for peace and security in that continent" because in (especially southern and eastern) Africa, AIDS has "become a threat to economic, social and political stability" to an extent incomparable with any other region of the world. Annan, as the head of the UN secretariat at the time and therefore "in position of authority" (Buzan et al., 1998, p. 33), figured as very plausible securitizing actor. In his speech, Annan identified AIDS as the existential threat to referent object, which in this context was the stability of countries with high prevalence rate with an accent on countries of southern and eastern Africa. Arguably, his audience – the UNSC – had been persuaded to accept the issue as a security threat because few months later the UNSC adopted the Resolution 1308 (which is in more detail addressed below). This way the audience prioritized the HIV/AIDS issue and became a securitizing actor themselves. Therefore, Kofi Anna's securitization move was successful.

However, it took more than the effort of the Secretary-General to persuade the members of the UNSC, with three out of the five permanent members (Russia, China and France) initially opposed the idea (McInnes and Rushton, 2010, p. 230). AIDS as a security issue was firstly placed at the forefront of the UNSC agenda by the US Ambassador to the UN Richard Holbrooke after his trip to southern Africa a month prior (Shadyab, Hale and Shaffer, 2017, p. 78). Holbrooke managed to persuade Annan, who was very much against the notion at first,[9] to hold a UNSC meeting on AIDS. Al Gore (United Nations Security Council, 2000a; Prins, 2004, p. 941), the Vice President of the US between the years 1993-2001 who presided over the 10 January meeting, reminded the UNSC that (1) "the heart of the heart of the security agenda was protecting lives", (2) "AIDS was not someone else's problem, but

[9] According to the US Senator Russ Feingold, Kofi Annan's initial reaction on Holbrooke's idea of the UNSC meeting on AIDS was: „We can't do that. AIDS isn't a security issue." (STERNBERG, Steve, 2003. Former Diplomat Holbrooke Takes on Global AIDS. *USA Today*. McLean, Virginia: Gannett, June 10, quoted in Prins, 2004)

everyone's problem", and that (3) "[w]hen a single disease threatens everything from economic strength to peacekeeping, we clearly face a security threat of the greatest magnitude". The key words clearly figure in these utterances by Al Gore. Gore had the same audience as Kofi Annan at the 10 January meeting and therefore it could be argued that he also contributed to persuading the UNSC to accept HIV/AIDS as a security threat. Peter Piot, an actor with undeniable 'social capital', also contributed to the discussion of the dangers of the pandemic on a global scale in favour of securitization (McInnes and Rushton, 2011, p. 122).

The *UN Security Council Resolution 1308* adopted on 17 July 2000 has been perceived by many as being "*the* decisive moment in the securitization of the disease" (Rushton, 2007, p. 3; see McInnes and Rushton, 2011; Jansson 2017). Peter Piot (UNSC, 2005, p. 5), the Executive Director of UNAIDS at the time, evaluated the resolution:

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

However, the resolution explicitly deals with the issue as with a threat to *international* security (UNSC, 2000b). In this case, the disease is perceived as an existential threat to "the social and economic stability of those states with high prevalence levels and has a detrimental impact upon the effectiveness of military and security services which play the key roles in maintaining order" (Rushton, 2007, p. 5).

The UN Security Council is a favourable securitizing agent. However sub-Saharan Africa, the worst affected region of the world, was at the time represented only by Mali and Namibia (UNSCR, 2019). By "[r]ecognizing that the spread of HIV/AIDS can have a uniquely devastating impact on all sectors and levels of society" and by presenting the pandemic as "a risk to stability and security" (if unchecked) that requires "coordinated effort of all relevant United Nations organizations" the UNSC was making a clear securitizing move (UNSC, 2000b). The text expressed urgency of the issue and also warned about the 'point of no return', even though the main focus of the resolution was on the UN peacekeeping forces.

Referent objects of 1308 were the UN peacekeeping forces as well as the UN member states (including South Africa). As emergency action, the resolution recommended specialized training for peacekeeping personnel regarding HIV/AIDS prevention awareness skills, encouraged member states to develop and implement national programs on HIV/AIDS in cooperation with UNAIDS and also 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, 2000b). McInnes and Rushton (2011, p. 122) argue that all the facilitating conditions of a successful securitization defined by the Copenhagen School were fulfilled.

On the other hand, it can be argued that this securitization move was timid and mild. Rushton (2007, p. 11-13) blames the relatively limited scope and form of the text and pointed at the evasive and tentative linguistics used by the Council. Instead of imperative language typical for binding resolutions by which the Council *'decides'* or *'demands'*, in 1308 the Council merely *'requests'*, *'encourages'* or *'expresses concern'* (UNSC, 2000b). As for the limitations in scope, the resolution was mostly concerned with the well-being of peacekeeping personnel and had very little requirements of the member states.

Nevertheless, the Resolution 1308 resonated with the audience. As a result, HIV/AIDS was suddenly being implemented in many new policy initiatives and agendas in the early 2000s. The United Nations General Assembly adopted the *Millennium Development Goals* that resolved to "have, by [2015], halted, and begun to reverse, the spread of HIV/AIDS", to "provide special assistance to children orphaned by HIV/AIDS" and to "help Africa build up its capacity to tackle the spread of the HIV/AIDS pandemic and other infectious diseases" (UN General Assembly, 2000). In 2001, the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases gathered by the Organisation of African Unity (OAU) adopted the Abuja Declaration of 27 April 2001 (P. Williams, 2007, p. 1031). The *Declaration of Commitment on HIV/AIDS* was adopted by UN member states later the same year (Vieira, 2007, p. 151). In 2002, the *Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria* was established by the G8. Year after that, the US launched one of the most ambitious national initiatives to fight the global effects of the disease, the *President's Emergency Plan for AIDS Relief* (PEPFAR) (McInnes and Rushton, 2010, p. 229). These actions and this amount of attention HIV/AIDS received were unprecedented for a health issue. It also shows the signs of successful securitization, at least in case of some parts of the global audience.

The Abuja Declaration is important because the securitizing move was endorsed by all fifty three member states of OAU, including South Africa (Vieira, 2007, p. 150). Therefore OAU acts from a clear position of authority. The declaration followed the *Lomé Declaration on HIV/AIDS in Africa* from July 2000 which expressed the need to mobilize all segments of society for combat with the disease (Organisation of African Unity, 2000). However, the Lomé Declaration still treated the epidemic as a health issue. In contrast, the declaration of 2001 specifically described the epidemic of HIV/AIDS (together with tuberculosis and other diseases) as "a major health crisis, but also an exceptional threat to Africa's development, social cohesion, political stability, food security as well as the greatest global threat to the survival and life expectancy of African peoples" (OAU, 2001a, p. 3). By proclaiming AIDS a top priority and a 'State of Emergency' the OAU follow the grammar of security defined by Buzan et al. (OAU, 2001a, p. 5). Unlike 1308, the member states of OAU use much more convincing rhetoric when they '*declare'* to prioritize the fight against the epidemic before other issues in respective national development strategies. It is evident, that the key words were present in the declaration and therefore it clearly constituted a securitizing move. As referent objects were identified the survival of people of Africa as well as stability and development of the continent. The declaration was followed by the *Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in Africa* which specified the goals and priority areas in addressing the issue, for example research, resources mobilization, access to treatment, education, protection of human rights etc. The plan enjoined the member states to mobilize all their capacities in order to "arrest and reverse the accelerating rate of HIV infection, [tuberculosis] and [other related infectious diseases]" (OAU, 2001b). This action plan represents an emergency measure that the OAU urged member states to adopt along with devoting 15% of their respective annual budgets to the health sector (OAU, 2001a, p. 5). The audience of the declaration, however, were not only the member states of OAU but also non-African donor countries and NGOs to help Africa gather financial resources essential for fulfilling set goals.

The Declaration of Commitment on HIV/AIDS adopted on 27 June 2001 at the 26th Special Session of the UN General Assembly (UNGASS) on HIV/AIDS was "a landmark in the history of the epidemic" because it "represented an official recognition by all UN member states that the epidemic was a 'global emergency' and 'one of the most formidable challenges to human life and dignity', therefore demanding global action and unrestricted commitment by member states" (Vieira, 2007, p. 150; United Nations General Assembly Special Session on HIV/AIDS, 2001). The declaration opens with Kofi Annan's warning presenting the 'point

of no return': "For there to be any hope of success in the fight against HIV/AIDS, the world must join together in a great global alliance." (UNGASS on HIV/AIDS, 2001, p. 1) The rhetoric of urgency spreads through the whole text reminding the audience that HIV/AIDS in sub-Saharan Africa "is considered a state of emergency which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden, and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action" (UNGASS on HIV/AIDS, 2001, p. 8). However, the HIV/AIDS-international security nexus was noticeably side-lined. Apparently, the General Assembly was primarily concerned with the pandemic's impact on international development and human rights far more than security (Rushton, 2010, p. 500). Even so, the declaration aligned with the previous UN documents on AIDS as yet another securitizing move.

The George W. Bush's PEPFAR was launched in January 2003 as a "part of a broader renaissance in partnerships for international development" (Vieira, 2011, p. 10; Office of the United States Global AIDS Coordinator, 2007, p. 9). Its agenda was outlined in the *United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003*. PEPFAR is a unilateral initiative working mainly "through bilateral aid programmes with target states" (Vieira, 2007, p. 157). As the 'focus countries' were chosen 12 countries in sub-Saharan Africa (South Africa included), Vietnam, Haiti and Guyana (Ingram, 2010, p. 610). The plan was initially meant to last for five years and in that time period it was supposed to prevent 7 million new infections, treat at least 2 million infected people with antiretroviral drugs and provide care for people suffering from the disease as well as for children orphaned by it (108th US Congress, 2003). An allocated budget for that purpose went over $18 billion, 55% of which was dedicated to improving the access to ART (Ingram, 2010, p. 607 and 610). Many scholars have argued that PEPFAR represented the security concerns about HIV/AIDS of the US government (McInnes and Rushton, 2010, p. 240). McInnes and Rushton (2010, p. 241) go even further and argue, that securitization "has not only bolstered overall support for PEPFAR, but also affected the way in which money is spent", as the resources were allocated to countries of strategic interest for the US (Ingram, 2010, p. 610). Furthermore, PEPFAR was supposed to strengthen "the capacity of the United States to be an effective leader of the campaign against HIV/AIDS" (108th US Congress, 2003). Since its creation, PEPFAR has been reauthorized two times and "has saved over 17 million lives through accountable, transparent, and cost-effective investments" (PEPFAR, 2018). To summarize, PEPFAR was

not a securitizing move but an *emergency measure* undertaken by the US government as a result of successful securitization.

The report of the High-level Panel on *Threats, Challenges and Change* presented at the 59th session of the UN General Assembly evaluated the international response to HIV/AIDS as "shockingly slow and shamefully ill-resourced" (United Nations General Assembly, 2004, p. 26). The report also mentioned a point of no return: "In the worst-affected States, middle-aged urban elites are heavily afflicted, eroding State capacity and decimating the economic activity of what should be a State's most productive group. The increasing number of infected women and girls is threatening food and agricultural production. If trends are not reversed, some of these States face collapse under the combined weight of poverty and HIV/AIDS." (United Nations General Assembly, 2004, p. 17-18) However, the report did not mention any extraordinary measures that should be implemented.

The issue of HIV/AIDS was occasionally brought up several times in the subsequent years, for example during the sixtieth UNGASS in 2006 or as the UNSC Resolution 1983 (2011). However, any possible connection to security was usually left out. Furthermore, some scholars argue that the UNSC approach towards the issue may be characterized as desecuritization (Jansson, 2017, p. 74).

The African Union, on the other hand, followed in its predecessor's footsteps and continued with the securitization process. In 2006, the Heads of State and Government of the African Union assembled once again in Abuja, Nigeria to come up with the *Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa* (African Union, 2006). These infectious diseases were still marked as threats to the "national and continental socioeconomic development, peace and security" and considered as a State of Emergency in all of Africa (AU, 2006). The African Heads of State and Government rededicated themselves to the emergency measures stated in the previous declaration. Seven years later in 2013, another AU meeting took place in Abuja. This time, the *Abuja Actions toward the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030* was adopted (AU, 2013). This declaration still acknowledged the link between HIV/AIDS and security as well as the need for prioritizing health as "central to Africa's development with focus on elimination of HIV/AIDS, Tuberculosis and Malaria and Other Neglected Diseases" (AU, 2013). Even though the key words such as 'security' and 'threat' were not so commonly used in the text, the declaration did not lack the overall feeling of urgency. As emergency measures, the AU called for "speeding up actions to strengthen our health systems to provide comprehensive and integrated health care services and improve

access to essential services; financing of health research; partnerships with relevant stakeholders; and a multi-sectoral and integrated approach to disease control“ (AU, 2016). The latest document of the AU concerning HIV/AIDS is the *Strategic Framework (2016-2030)* developed by the AIDS Watch Africa (AWA). AWA was created during the Abuja Summit of 2001 and since then leveraged the AU member states into action (AWA, 2016, p. 5). This document, however, does not encompass the key words in desired context and thus is not a security move.

It is peculiar that the AU made number of securitizing moves over a long time period. However, the Copenhagen School's approach does not specify the time frame in which the securitization must either succeed or fail as well as it does not specify the number of securitizing moves in one process of securitization. And thus both declarations (not including the Strategic Framework) might arguably be proclaimed securitizing moves.

5.3. Securitization of HIV/AIDS vs. Thabo Mbeki and Beyond

The securitizing moves discussed in the previous chapter were supposed to convince the South African government enough to start implementing the emergency measures defined by the securitizing actors. Unexpectedly, the new government of South Africa reacted by a "denial at the public scale" (Prins, 2004, p. 934).

Alan Whiteside (2008, p. 88-89) lists among possible explanations of South African denialism: (1) the issues of sexuality and masculinity – having multiple sexual partners was perceived as right and masculine but suddenly could cost a man his life; (2) the scientific discoveries revealing that HIV comes from monkeys which was often seen as stigmatizing, because for an ill-informed person this knowledge could be an implication of inter-species sexual activity; (3) stereotyping lack of control of their sexuality in African population (because HIV is sexually transmitted and sub-Saharan Africa is the worst affected region); (4) complex historical background of the South African 'Rainbow Nation' and the apartheid legacy (science and race used to be closely connected in the apartheid era); or (5) unaffordability of ART.

When Thabo Mbeki became a president after the 1999 election, the country was overwhelmed with the impact of HIV/AIDS. As soon as he assumed the office, he began to look for a non-mainstream 'African solution' to the disease. The HIV is surrounded by many conspiracy theories raging from claims that it was manufactured as a bioweapon to claims

denying causal link between HIV and AIDS (Nattrass, 2012, p. 1-2). Unfortunately, the President decided to follow one of them promoted by the so-called AIDS denialists, who were led by Peter Duesberg, researcher based in Berkley and author of articles like *Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome: Correlation but not Causation*, *HIV is not the Cause of AIDS*, and *AIDS since 1984: No evidence for a new, viral epidemic – not even in Africa.*[10] From these headlines as well as from the *Virodene* controversy it is obvious that Mbeki was inclined to question the science AIDS treatment and to deny "the established causal link between HIV and AIDS, exacerbating the anti-intellectualism that had been characteristic of the Mandela government's AIDS management" (Fourie, 2006, p. 140). Mbeki considered AIDS denialists 'dissident' scientists and compared them to the ANC revolutionaries that had fought against apartheid (Susser, 2009, p. 97). Mbeki's whole interpretation of the epidemic was heavily influenced by his years in exile and his criticism of the unequal distribution of wealth in the world.

The issue of AIDS was often racialized by the elites during Mbeki's administration, for example by attributing AIDS to poverty as a result of colonial history and global capitalism favouring Western/white countries. In Susser's (2009, p. 97) opinion, "[s]uch rhetoric allowed the South African government to adopt drastic fiscal policies, reduce support for the hundreds of thousands people with AIDS, and find Western capital the source of the problem". Mulwo et al. (2012, p. 572) even attribute the negative attitude of the South African government towards ART to the 'African genocide' discourse, which led to claims that HIV-infected foreigners "were deliberately being sent to Africa as part of global conspiracy of multidrug companies to produce African 'guinea pigs' for Western AIDS research" (Fortin, 1987).[11] Their argument might be based on Mbeki's claims that "the pharmaceutical industry was conspiring with the US government to inflict toxic drugs on Africans" (Nattrass, 2012, p. 2) and that "South Africans were being used as 'guinea pigs' and the provincial government's prescription of such dangerous medication could be compared to the biological warfare of the apartheid era" (Fourie, 2006, p. 155).

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[10] DUESBERG, Peter H., 1989. Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome: Correlation but not Causation. *Proceedings of the National Academy of Sciences of the United States of America*. **86**(3), pp. 755-764.
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[11] FORTIN, Alfred, 1987. The politics of AIDS in Kenya. *Third World Quarterly*. **9**(3), pp. 906-919. Cited in Mulwo et al., 2012, p. 572

In January 2000, the Mbeki's administration completed the *HIV and AIDS/STDs Strategic Plan for South Africa, 2000-2005* (Fourie, 2006, p. 142). The plan shows that its creators were well aware of the dangers that the epidemic posed and that it should be "both a regional and a national priority" (National Department of Health, 2000, p. 7). However, there were no implications of HIV/AIDS constituting a security threat, as the key words made only a sparse appearance. Furthermore, the plan, among other things, established the South African National AIDS Council (SANAC), a coordinating agency that was supposed to advise the government on issues regarding the HIV/AIDS problematic, recommend appropriate research, and "oversee the national response to the epidemic and the implementation of the Strategic Plan" (National Department of Health, 2000, p. 11-12). SANAC was to be made up of 17 members from various sectors of civil society and 17 governmental officials including the Deputy President who would chair the Council (Fourie, 2006, p. 145). However, after its creation SANAC, whose members were appointed by the government, consisted mainly of 'dissident' scientists and governmental dilettantes while excluding the MCC, the Medical Research Council (MRC) and other leading researchers on HIV/AIDS (Butler, 2005, p. 594).

To the first securitizing attempts of the UN Mbeki answered by a letter encouraging AIDS denialism addressed to world leaders, including the US President Bill Clinton and the UN Secretary-General Kofi Annan. From the letter it is evident that Mbeki recognized the dangers posed by AIDS, however refused to implement a Western solution to 'uniquely African catastrophe', since "a simple superimposition of Western experience on African reality would be absurd and illogical" (Mbeki, 2000). He further stated that: "I am convinced that our urgent task is to respond to the specific threat that faces us as Africans. We will not eschew this obligation in favour of the comfort of the recitation of a catechism that may very well be a correct response to the specific manifestation of AIDS in the West." (Mbeki, 2000)

In July 2000, over 5,000 scientists gathered at the 13th International AIDS Conference in Durban after they signed the Durban Declaration [12] which declared the existence of causality between HIV and AIDS to voice their disapproval of Mbeki's stand on the issue (van Rijn, 2006, p. 522). Despite this, Mbeki and his Minister for Health Manto Tshabalala-Msimang continued to question the safety and efficacy of AZT and other antiretroviral drugs and the motives of ART manufacturing pharmaceutical companies (Mulwo et al., 2012, p. 574).

[12] Later published in the prestigious science journal *Nature* (Schneider, 2002, p. 149)

In 2001, Mbeki again refused to proclaim AIDS a national emergency and even casted doubt on statistics confirming AIDS to be the main killer or South African adult population (Fourie, 2006, p. 155-156). However, organizations like TAC, the Pan-African National Congress (South African opposition political party founded in 1952) and the Congress of South African Trade Unions (COSATU) together with new Nobel Prize winners Nelson Mandela and Desmond Tutu all supported access to ART. The provincial government of KwaZulu-Natal even began to provide antenatal nevirapine as a part of TAC's civil disobedience campaign (Susser, 2009, p. 102). The ANC government subdued to the increasing public pressure (and after TAC pressed charges against the government) and in 2002 decided to provide nevirapine to all hospitalized rape victims and infected pregnant women to prevent MTCT (van Rijn, 2006, p. 534). TAC managed to embarrass Mbeki's administration on the international level by constant shaming and criticism which has "triggered some normative change in the country" (Vieira, 2011, p. 26) Even though the claims against 'toxic' antiretroviral drugs and questioning of AIDS data did not fade away from Mbeki's and Tshabalala-Msimang's discourse,[13] finally on 8 August 2003 the treatment became available even through public clinics (Fourie, 2006, p. 158; Abdool Karim and Abdool Karim, 2010, p. 586; see Appendix no. 13). The government's plan, however, had been implemented slower than initially expected and between the years 2005 and 2006 the AIDS-related deaths reached its peak (UNAIDS, 2019c). Even then, the government did not feel the urge to frame HIV/AIDS as an existential threat. The events turned for the better when the Deputy President Phumzile Mlambo-Ngcuka assumed the role of SANAC chairperson (Whiteside, 2008, p. 89). The epidemic was in all subsequent government documents like the *HIV & AIDS and STI Strategic Plan for South Africa 2007-2011*, the *National Strategic Plan for HIV, STIs and TB 2012-2016*, or the most recent *South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022* treat the disease only as a human rights and development issue.

This section of the thesis addressed the denialist approach of the South African elites to the HIV/AIDS issue and followed the evolution of AIDS-related decision-making in the country. Mbeki's discourse caused a widespread confusion that slowed down policy-making capabilities of his government. The external HIV/AIDS norms were framed by the country's

[13] The Minister of Health, for example, suggested that people with AIDS should rather boost their immune system by consuming garlic, olive oil, beetroot and African potatoes rather than taking ART (Susser, 2009, p. 101).

elites to fall in line with the existing normative order built on the resentment of Western (white) domination. As Vieira (2011, p. 25) noted: "the internationally proposed securitization of HIV/AIDS faced a domestic context permeated by strong racial divisions and a political leadership sceptical (even hostile) towards HASN entrepreneurs".

The problem with addressing HIV/AIDS in South Africa was that it was seen as a side product of poverty resulting from years of exploitation by whites. Mbeki frequently used the dissimilarities between the epidemic in the West and in Africa when disapproving of ART. In his letter, he emphasized thee points in which the African disease differed from the Western (Mbeki, 2000):

- contrary to the West, HIV-AIDS in Africa is heterosexually transmitted;
- contrary to the West, where relatively few people have died from AIDS, itself a matter of serious concern, millions are said to have died in Africa; and,
- contrary to the West, where AIDS deaths are declining, even greater numbers of Africans are destined to die.

Mbeki was right with all of these arguments, however he decided to trust marginal AIDS research and thus put hundreds of thousands of lives at stake. All of the securitizing moves by external securitizing agents therefore fell completely flat in the early 2000s South Africa. Mbeki's administration mostly disregarded them with suspicion as products of capitalist imperial powers, especially PEPFAR because of the close links between the US pharmaceutical industry and Bush's administration (Vieira, 2011, p. 25). However the distrust faded over time and South Africa began to engage in active working relationships with several NGOs such as UNAIDS, Global Fund or UNICEF. The HIV/AIDS epidemic then evolved from non-politicized to a politicized issue over the course of a few years. It remains a highly politicized issue still.

In conclusion, the securitization of HIV/AIDS in South Africa by international actor was unsuccessful. The government did not accept the security discourse of the securitizing actors and did not become securitizing actor itself. The issue of AIDS is one of the government's priorities but arguably not as a result of external securitization efforts but because of the raw statistical fact that the state of the epidemic in South Africa has been one of the worst in the world for many years. Furthermore, the issue was always overshadowed by other pressing matters, such as poverty during Mbeki's administration or unemployment during Zuma's (South African Government, 2019). Most of the securitizing moves promoted

access to ARV as an emergency measure to tackle the disease. This chapter illustrated the position of Mbeki's government towards the antiretroviral drugs. Eventually, the government yielded to the public pressure and allowed everyone in need to access the treatment but not as a result of securitization by external actors.

Conclusion

Health issues are receiving great attention, mostly because the increasing globalization which clears the way for the spread of diseases. Many scholars try to employ the concept of securitization to explore the possible links of the diseases to (particularly national) security. There certainly are dangers to securitizing infectious diseases, as some scholars presume. However, whatever ethical (and other) implications such securitization might have, at least creating the disease-security nexus contributes to raising awareness. This leads to a wider recognition of the negative impacts of the issue and galvanizes the mobilization of resources to combat the disease.

Since 1981, when the first cases of AIDS were publically reported, the world has observed in great distress what danger had been lurking around unnoticed. The epidemic has risen and swelled and soon spread around the Globe. The need for joint action against it was recognized by powerful international actors who began to take initiative. However, it took twenty years and millions of lives until the link between HIV/AIDS had been created.

The main aim of this Master's Thesis was to apply the Copenhagen School's theoretical framework on the case of HIV/AIDS and evaluate the possibility of explaining the international reaction to the pandemic through securitization. After answering this first research question, the thesis then proceeded to explain whether the securitization was successful and what factors influenced the outcome.

The thesis discussed how the securitizing actors, namely the United Nations Security Council, the Organisation of African Unity as well as its successor the African Union, and the Government of the United States, handled the issue of HIV/AIDS by creating the link with security to advocate extraordinary measures. This was demonstrated by dissecting the documents and speeches that somehow related to the disease to see whether they contained the beforehand defined key words ('threat', 'security', 'priority', 'emergency' and 'point of no return') in relation to HIV/AIDS as an existential treat to the defined referent objects (international peace, worlds nations, societal stability or directly to South Africa). The results showed that many of these documents and speeches in fact constituted a securitizing move. However, these actors eventually relaxed their interpretation of the pandemic and the issue is now mostly regarded as a public health issue.

Even though the securitizing process worked in some African countries (for example in Botswana), it did not in the case of South Africa, which was found out by evaluating the response of the government based on set criteria. The securitization of HIV/AIDS in South

Africa by external actors was unsuccessful for various reasons. First, despite being in the position of authority, the securitizing actors did not manage to convince the audience about the *nature* of the threat and benefits of its securitization. The AIDS was an undisputable problem but its cause was attributed to the wrong agent – poverty. Mbeki's government also did not realize that if they allowed the issue to become securitized, the World Trade Organization's (WTO) legislation would allow South Africa as a developing country to import antiretroviral drugs protected by the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) for significantly lower prices (Elbe, 2006, p. 133). Second, the South African policy-making was strongly influenced by the persona of Thabo Mbeki who had spent great portion of his life in exile fighting against apartheid and was accustomed to distrust anyone outside his closest circle of advisors. Third, the government's relationship with the AIDS civil society was distant, conflictive, and damaged by the numerous scandals and mishaps. Fourth, Mbeki disregarded all of the securitizing moves as products of Western imperialism and ART as an experimental treatment which was meant to be tested on African 'guinea pigs'.

The application of the Copenhagen School's securitization framework has uncovered the limits of the framework. It has particularly accentuated the Balzacq's argument that the role of audience and its characteristics is seriously under-developed by the authors. This case of South Africa and Thabo Mbeki demonstrated that the background, socio-political context and general attitude of key audience players might actually be more important than other condition of successful securitization. The Copenhagen School also do not operate with motives of securitizing actors to securitize in the first place. This would contribute to deepening the understanding of the relationship between securitizing actor and the audience and maybe also figure as one of the facilitating conditions of successful securitization.

The issue of HIV/AIDS and securitization is so broad and fascinating that it opens many doors for further study. After having conducted this research, I propose to deepen it by applying a synthesis of McInnes and Rushton's and Floyd's revised securitization to explore the moral dimension of securitizing HIV/AIDS. Another valuable addition to the existing research would be the examination of the role of non-governmental actors in association with the disease.

Summary

The main aim of this thesis was to explore the theory of securitization by applying the framework on the reaction to HIV/AIDS in the United Nations Security Council, the Organisation of African Unity and subsequently the African Union, identify possible securitizing moves by these actors, and then analyse the response of the Government of South Africa to these securitizing moves.

The first chapter defined key research methods and evaluative criteria based on the Copenhagen School's securitization theory. According to the researcher, a securitizing act must encompass or at least imply following key words in relation to HIV/AIDS. Criteria for successful securitization were defined as follows: (1) the audience must adopt the securitizing actor's discourse concerning the issue and eventually become a securitizing actor themselves, (2) the audience must prioritize the issue over other issues as a result of the securitizing move, and (3) the audience must accept the emergency measures proposed by the securitizing actor.

In the second chapter, the thesis discussed the conceptualization of security and provided insight to the theory of speech acts which is essential for understanding the Copenhagen School's securitization. Then it explained the main aspects of the theory of securitization as well as the critique of this approach.

The next chapter focused on the HIV/AIDS. First, it was explained what is HIV, what subtypes does it have, and why does it matter. Second, it was demonstrated how the HIV works, what cells does it affect and how it progresses into AIDS. Third, the chapter proceeded by describing how is HIV transmitted and how the transmission can be prevented as well as how to treat the disease. Then the chapter followed the discovery of HIV/AIDS, its origins and spread.

The thesis continues with the examination of the situation in South Africa. It was explained how the policy of segregation and apartheid influenced the spread of HIV/AIDS and how the issue was handled after transition to New South Africa. Then the impact on economy, society and security was briefly delineated.

The last chapter revolved around interpretation of the research using the methods described in the first chapter. Several documents and speeches were presented and analysed to see whether they constituted a securitizing move. Then the situation in South Africa was examined in relation to HIV/AIDS and securitization. It was explain why and how the Thabo Mbeki's administration chose to handle the issue and why the securitization was found unsuccessful.

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Institut politologických studií
Projekt diplomové práce

Zdůvodnění výběru práce

HIV/AIDS patří v Africe k nejčastějším příčinám úmrtí. Toto onemocnění zároveň snižuje průměrnou délku života obyvatel zemí především v Jižní Africe a výrazně oslabuje ekonomiku nejvíce postižených států.

Ve své práci se budu věnovat problematice sekuritizace HIV/AIDS. Co se týče časového vymezení, budu se soustředit na období mezi lety 2000 a 2018, tedy od doby vzniku rezoluce 1308 Rady bezpečnosti OSN, která je označována za zlomový bod v sekuritizaci epidemie, až po současnost.

Téma HIV/AIDS je relevantní nejen v regionálním, ale především v globálním měřítku, neboť ovlivňuje ekonomiku a celkovou stabilitu regionu, což má při provázanosti moderního mezinárodního systému dopad celosvětově. Aspekt sekuritizace této problematiky není dle mého názoru v literatuře dostatečně zpracován, přestože se v případě AIDS/HIV jedná o první prohlášení nemoci bezpečnostní hrozbou.

Předpokládaný cíl

Hlavním cílem této diplomové práce je zmapování procesu sekuritizace HIV/AIDS a jaký vliv měl tento krok na boj s nemocí v Jihoafrické republice. V první části práce se tedy budu věnovat aplikaci teorie sekuritizace na konkrétní případ epidemie HIV/AIDS a zodpovědět tak výzkumnou otázku, zdali byla tato epidemie úspěšně sekuritizována. Ve druhé části bych chtěla odpovědět na otázky týkající se epidemie v Jižní Africe, a to jaký efekt měla sekuritizace HIV/AIDS na stav epidemie v Jihoafrické republice, jakou sekuritizace vyvolala v těchto státech odezvu a jakou roli zde hraje kultura daných států.

Metodologie

Jako metodologický rámec své práce jsem zvolila instrumentální případovou studii. Teoretickým rámcem bude teorie sekuritizace Kodaňské školy. Hlavní metodou práce bude aplikace teoretického rámce na konkrétní případ, tedy onemocnění HIV/AIDS. Nejprve tedy představím samotnou teorii sekuritizace, následně zhodnotím, zdali v případu HIV/AIDS v Jižní Africe došlo k úspěšné sekuritizaci onemocnění a jak to ovlivnilo situaci v regionu.

Využiji tak poznatky z teoretické části v části empirické, kdy budu zkoumat vývoj a dopady onemocnění a samotné jeho sekuritizace na Jihoafrickou republiku.

Základní charakteristika tématu

Onemocnění HIV/AIDS postihlo celý svět, nikde ve světě však nepáchá tolik škod jako v Africe, kde přebývají dvě třetiny z celkového počtu nakažených. Nejhůře postižené jsou právě země Jižní Afriky, a obzvlášť Jihoafrické republiky, kde nemoci spojené s AIDS stále patří k nejčastějším příčinám úmrtí mužů a žen v produktivním věku (15-49 let). Dne 17. července 2000 byla Radou bezpečnosti OSN jednohlasně přijata rezoluce 1308, která si poprvé všímala i bezpečnostních rizik, které s sebou epidemie může přinášet. Od té doby celkový počet obětí tohoto onemocnění klesl o 29%. Jakou roli v tomto poklesu hrála sekuritizace, je třeba empiricky prokázat.

Osnova práce

1. Úvod
2. Metodologie
3. Aplikace teorie sekuritizace na případ HIV/AIDS
   3.1. Teorie sekuritizace
   3.2. Epidemie HIV/AIDS
   3.3. Proces sekuritizace HIV/AIDS
4. HIV/AIDS v Jižní Africe
   4.1. Vývoj epidemie 2000-2018
   4.2. Reakce Jihoafrické republiky na sekuritizaci epidemie
5. Závěr

Seznam literatury (10 nejdůležitějších titulů)

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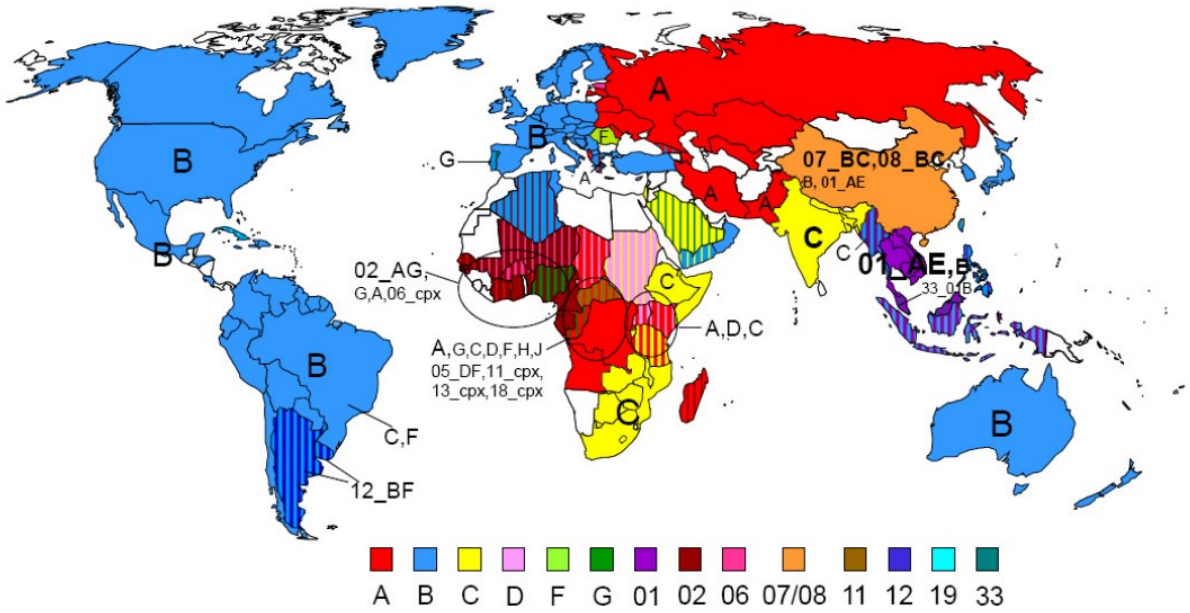
VIEIRA, Marco Antonio. Southern Africa's response(s) to international HIV/AIDS norms: the politics of assimilation. Review of International Studies. 2011, 37(1), 3-28.

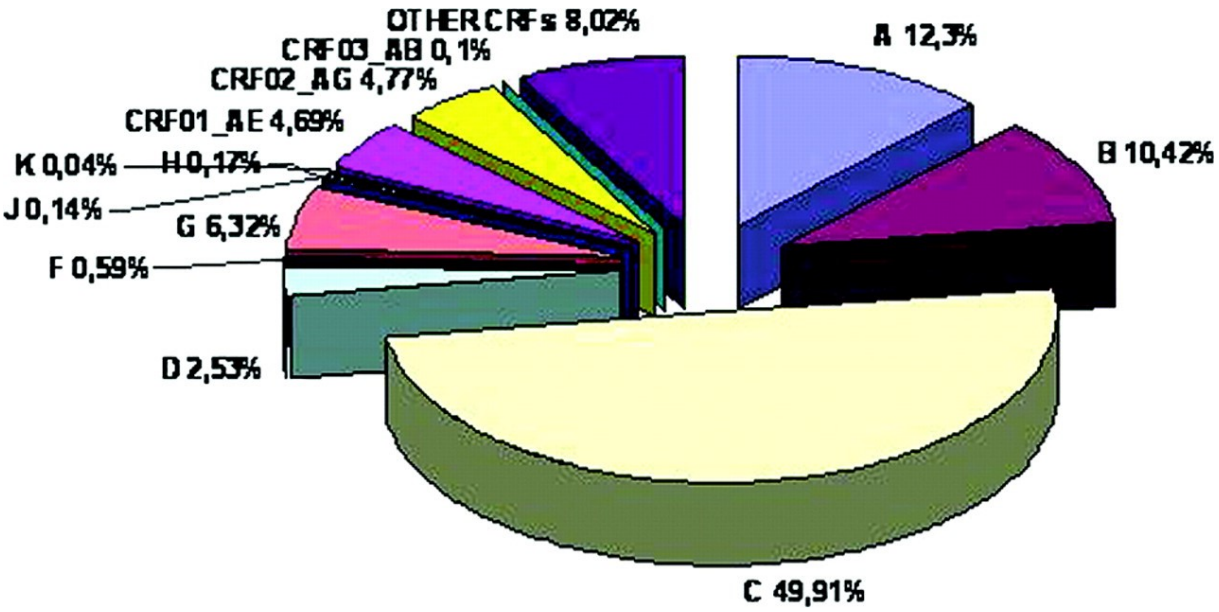
List of Appendices

Appendix no. 1: Geographical distribution of HIV-1 subtypes (map)



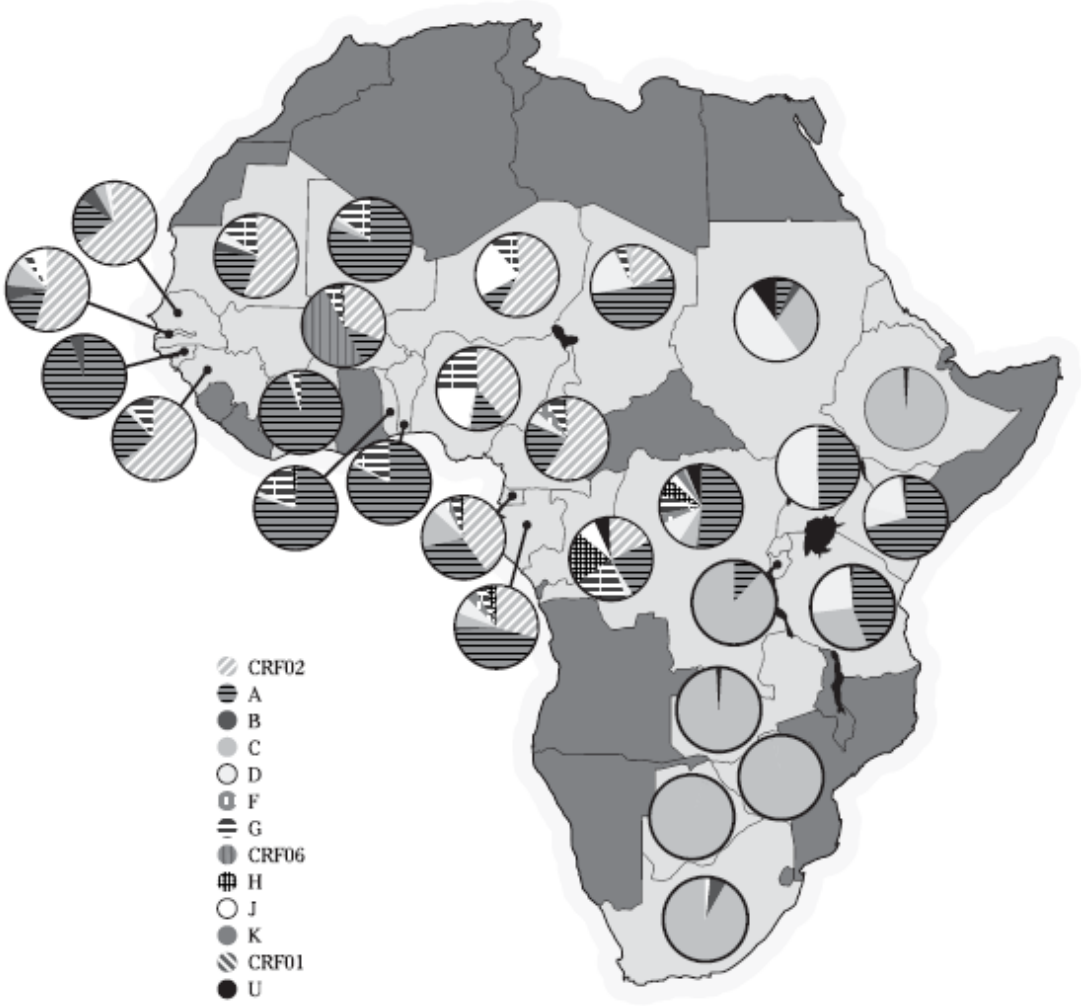
Source: KIPTOO, Michael, 2011. The Changing Trends of HIV Subtypes and Its Implication on Mother-to-Child Transmission. In: YI-WEI, Tang, ed., 2011. *Recent Translational Research in HIV/AIDS*. IntechOpen, p. 72. (Adapted from WHO-UNAIDS HIV Vaccine Initiative)

Appendix no. 2: Global prevalence of HIV-1 genetic forms (graph)



Source: BUONAGURO, L., M. L. TORNESELLO and F. M. BUONAGURO, 2007. Human Immunodeficiency Virus Type 1 Subtype Distribution in the Worldwide Epidemic: Pathogenetic and Therapeutic Implications. *Journal of Virology* [online]. **81**(19), pp. 10209-10219 [Accessed 2019-07-30]. Available at: http://jvi.asm.org/cgi/doi/10.1128/JVI.00872-07

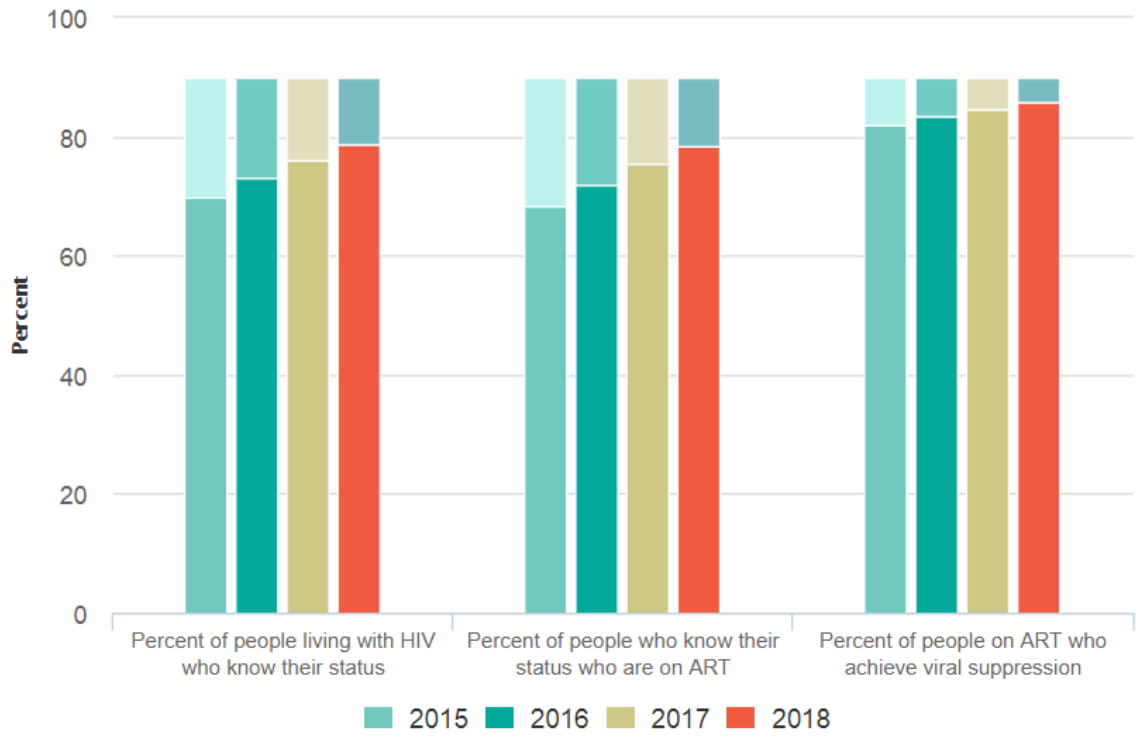
Appendix no. 3: Genetic diversity of HIV-1 in sub-Saharan Africa (map)



Note: The circles show the distribution of HIV-1 subtypes in various counrties (U strands for unknown)

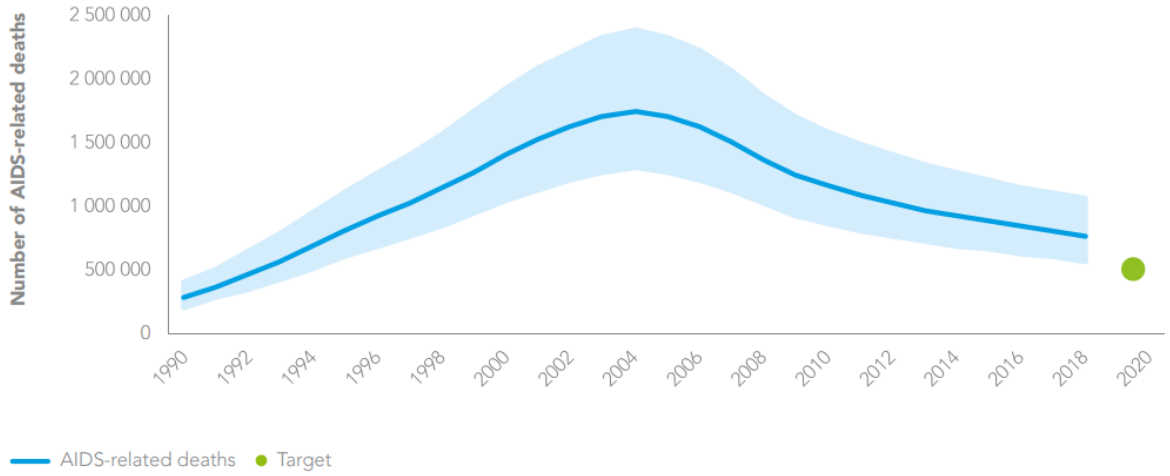
Source: PEPIN, Jacques, 2011. *The Origins of AIDS*. New York: Cambridge University Press, p. 15. (Adapted from PEETERS, Martine, Coumba TOURE-KANE and John N. NKENGASONG, 2003. Genetic diversity of HIV in Africa: impact on diagnosis, treatment, vaccine development and trials. *AIDS* [online]. **17**(18), pp. 2547-2560. [Accessed 2019-07-19]. Available at: https://journals.lww.com/aidsonline/Fulltext/2003/12050/Genetic_diversity_of_HIV_in_Africa___impact_on.2.aspx)

Appendix no. 4: Progress towards 90-90-90 target (graph)



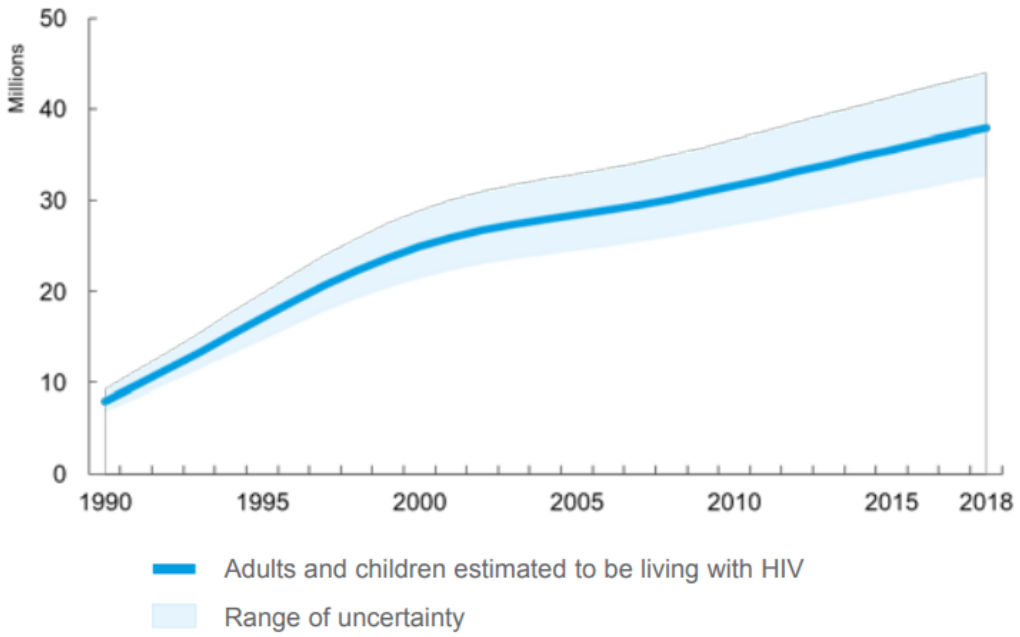
Source: UNAIDS, 2019a. AIDSinfo. In: *UNAIDS* [online]. Geneva, Switzerland: UNAIDS [Accessed 2019-07-16]. Available at: https://aidsinfo.unaids.org/

Appendix no. 5: Number of AIDS-related deaths, global, 1990–2018 and 2020 target (graph)



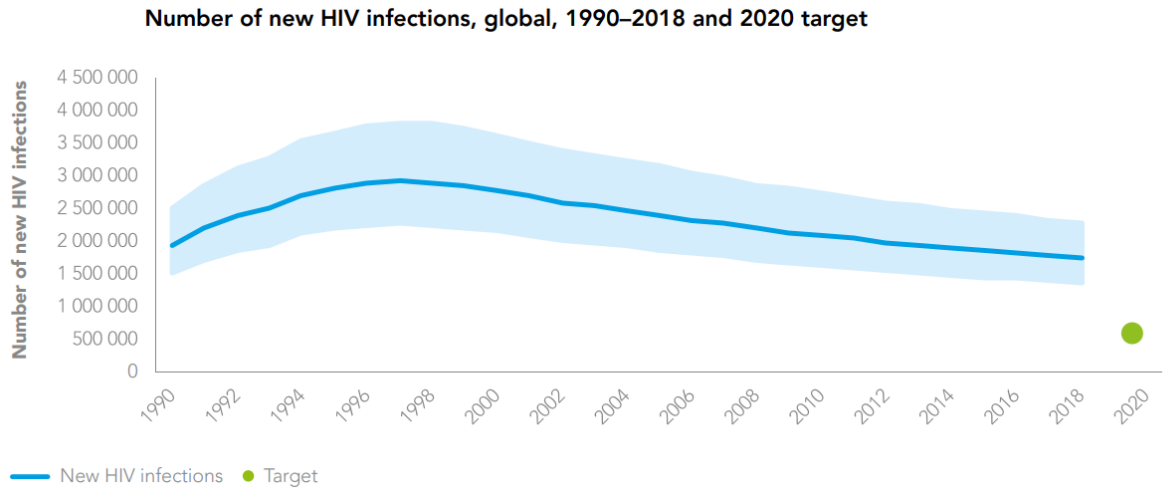
Source: UNAIDS, 2019d. *UNAIDS Data 2019* [online]. Geneva, Switzerland: UNAIDS [Accessed 2019-07-11], p. 6. Available at: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

Appendix no. 6: Adults and children estimated to be living with HIV, 1990-2018 (graph)



Source: UNAIDS, 2019d. *UNAIDS Data 2019* [online]. Geneva, Switzerland: UNAIDS [Accessed 2019-07-11], p. 18. Available at: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

Appendix no. 7: Number of new HIV infections, global, 1990–2018 and 2020 target (graph)

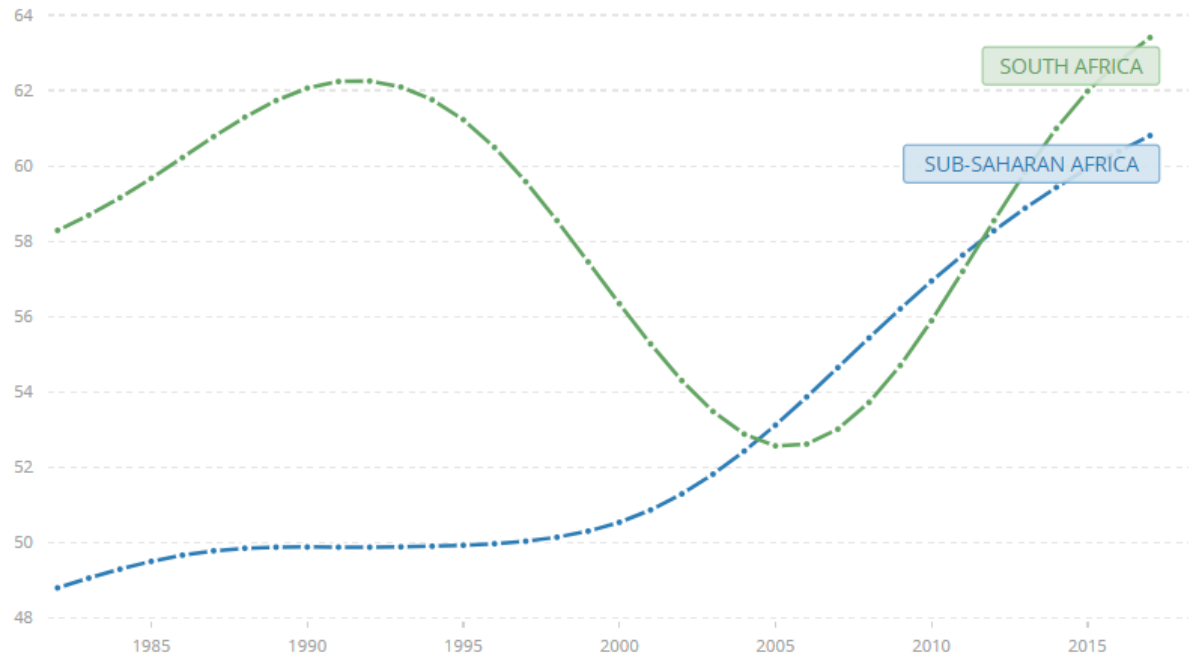


Source: UNAIDS, 2019d. *UNAIDS Data 2019* [online]. Geneva, Switzerland: UNAIDS [Accessed 2019-07-11], p. 7. Available at: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

Appendix no. 8: Map of South Africa (map)

Source: Grade 5 - Term 4: A Heritage trail through the provinces of South Africa. *South African History Online*[online]. Cape Town, South Africa: South African History Online, 2019 [Accessed 2019-07-30]. Available at: https://www.sahistory.org.za/topic/heritage-trail-through-provinces-south-africa

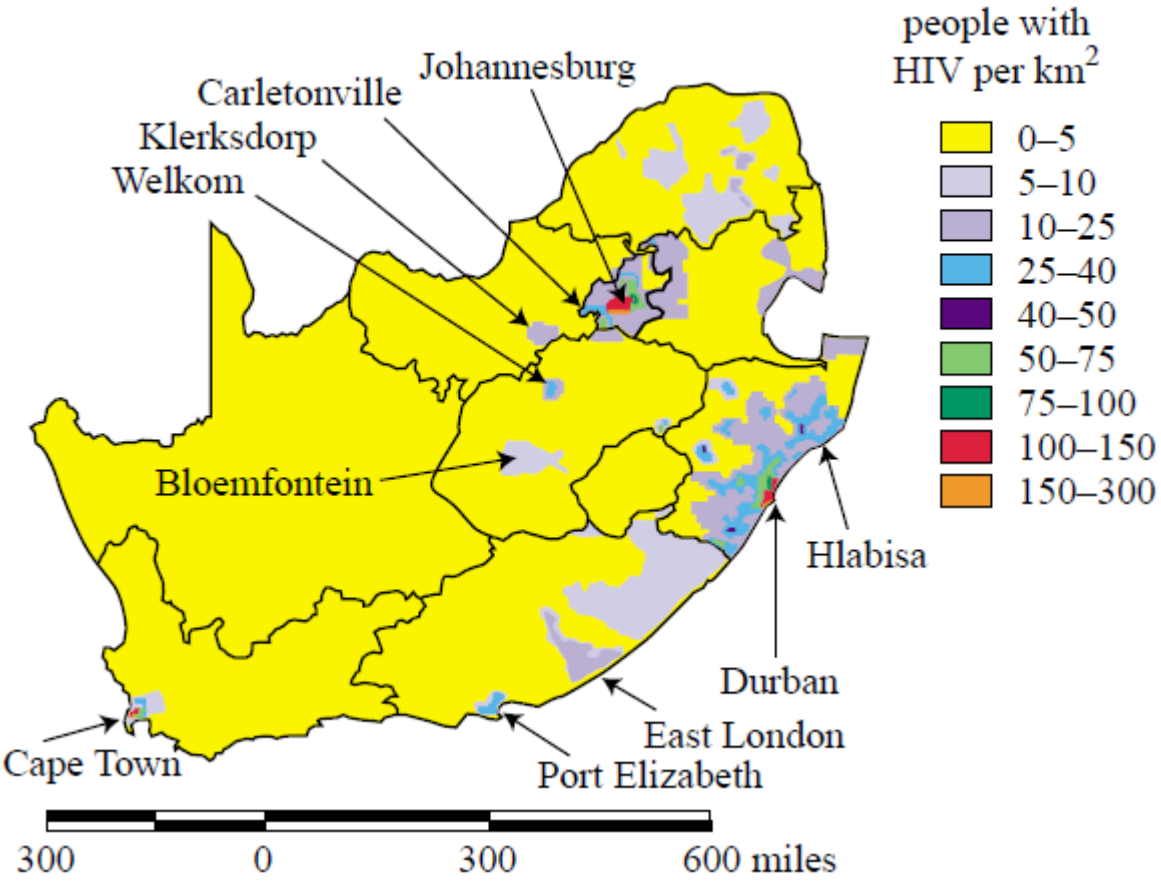
Appendix no. 9: Life expectancy at birth, total (years), 1982-2017 (graph)



Note: Life expectancy at birth indicates the number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life.

Source: Life expectancy at birth, total (years), 2019. In: *The World Bank Data* [online]. Washington, DC: The World Bank Group [Accessed 2019-07-30]. Available at: https://data.worldbank.org/indicator/SP.DYN.LE00.IN?contextual=default&end=2017&fbclid=IwAR30MA31j-TuO22X8oDVH6qFFgXNAvhsUJiv8EUOgbsLCcq6VwP5lQqFlNk&locations=ZG-ZA&start=1982&view=chart

Appendix no. 10: The number of people living with HIV infection per km2 in South Africa (map)

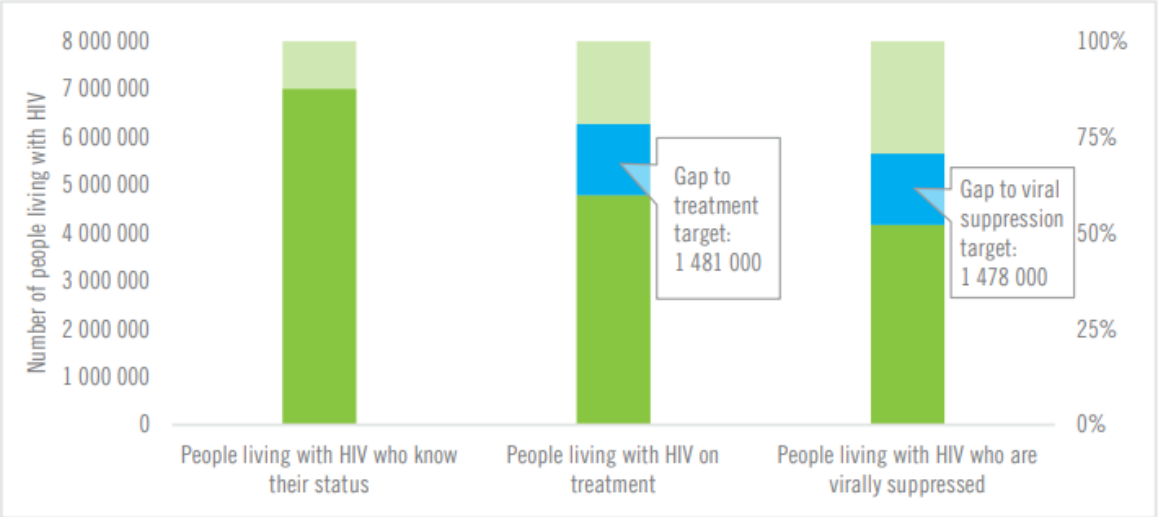


Source: WILLIAMS, Brian G. and Eleanor GOUWS, 2001. The epidemiology of human immunodeficiency virus in South Africa. *Philosophical Transactions of the Royal Society B*. **356**(1411), p. 1079.

Appendix no. 11: Epidemic transition metrics, South Africa, 2000-2018 (graph)

Source: UNAIDS, 2019d. *UNAIDS Data 2019* [online]. Geneva, Switzerland: UNAIDS [Accessed 2019-07-11], p. 63. Available at: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

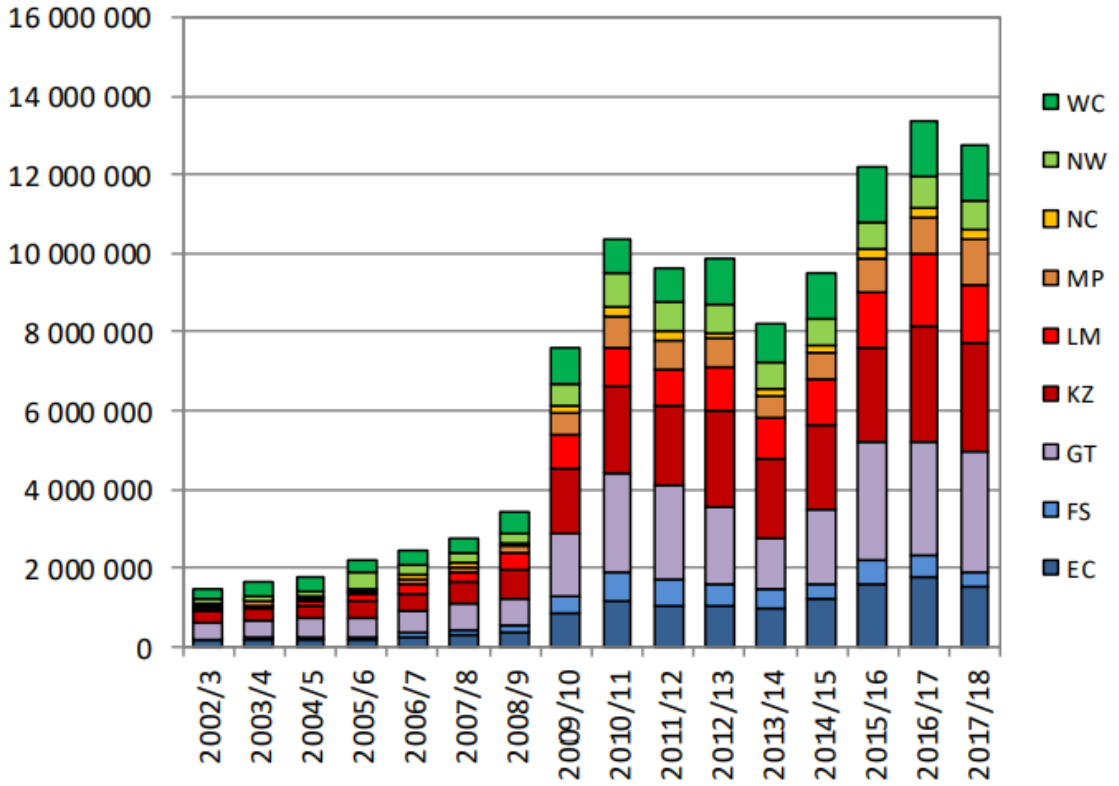
Appendix no. 12: South African progress toward 90-90-90 target status, 2018 (graph)



All ages	90% [83– >95%]	62% [57–66%] 4 788 000	54% [49–58%]
Children (0–14)	76% [59– >95%]	63% [49–87%] 163 000	46% [36–64%]
Women (15+)	93% [86– >95%]	65% [60–70%] 3 057 000	58% [54–62%]
Men (15+)	88% [79– >95%]	56% [50–60%] 1 568 000	47% [42–51%]

Source: UNAIDS, 2019d. *UNAIDS Data 2019* [online]. Geneva, Switzerland: UNAIDS [Accessed 2019-07-11], p. 63. Available at: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

Appendix no. 13: Numbers of HIV tests performed in each province, 2002-2017 (graph)



Source: JOHNSON, Leigh F. and Rob E. DORRINGTON, 2019. *Modelling the impact of HIV in South Africa's provinces: 2019 update* [online]. Version 4.2, working paper. Cape Town, South Africa: Centre for Infectious Disease Epidemiology and Research [Accessed 2019-07-30], p. 29. Available at: file:///C:/Users/Jusquea/Downloads/ProvincialModel2019.pdf