The art of medicine
HIV/AIDS and the challenges of security and conflict

The UN Security Council marked the turn of the millennium with a bold gesture: for the first time ever its members discussed a disease as a threat to international peace and security. The session was held on Jan 10, 2000, a timing that was carefully staged. Some of the more conventionally minded members, such as Russia and China, were (and remain) unhappy at the broadening of the Council’s concern from traditional areas of interstate security to a human security issue, which smacked of intrusion into the domestic policies of sovereign states. In fact, the debate’s timing was contrived to outflank the traditionalists. Many ambassadors had been home for the extended break over Christmas, the New Year, and Eid (which fell in early January), and in their absence the then US Permanent Representative, Richard Holbrooke (who chaired the Council that month) together with the Executive Director of UNAIDS, Peter Piot, made ready to present them with a fait accompli. 6 months later the Council passed Resolution 1308, which deals only with the specific issue of HIV/AIDS and peacekeeping operations.

Over the decade that has followed, the issue of HIV/AIDS and security enjoyed a dramatic intellectual profile, which shaped the global response to the pandemic. The precursor to the Security Council debate was a US National Intelligence assessment of the security threat posed by infectious diseases, which singled out HIV/AIDS as the gravest such peril. The National Intelligence Council report sounded the alarm: “the persistent infectious disease burden is likely to aggravate and in some cases, may even provoke economic decay, social fragmentation and political destabilisation of the hardest hit countries in the developing world”. The analysis was innovative and its forecasts were frightening. It had the desired impacts. Today, the incorporation of human security issues, such as hunger, disease, or climate change, into the international security agenda is part of commonplace discussion in foreign ministries and UN agencies.

Two reports over the past year show how the agenda of HIV/AIDS and security has come of age. In the last weeks of the Bush administration, the National Intelligence Council published Strategic Implications of Global Health, which did not focus on the security threat posed by disease but rather emphasised its economic costs and identified “medical diplomacy” as an opportunity for US leadership. This report can also be read as a plea to the incoming Obama administration to take good care of the President’s Emergency Plan for AIDS Relief (PEPFAR), which was established after the earlier National Intelligence Council report. Last September, the AIDS, Security and Conflict Initiative (ASCI) published its final report Security and Conflict: New Realities, New Responses. ASCI was a collaborative enterprise of researchers across five continents, and its findings show how the questions have become diverse, less dramatic, and responsive to good policy and improved practice. The focus has now shifted to a host of intermediate and tractable issues.

Among ASCI’s recommendations are issues that chart new agendas for research and policy. One is the policy gap for HIV/AIDS during postconflict transitions. For some years, the conventional wisdom was that armed conflict exacerbated HIV/AIDS, a claim that has not stood up well under empirical analysis. Concern is now focused on what happens at the end of conflict, when refugees return home, soldiers demobilise, isolated populations return to commercial networks, and contractors, peacekeepers, and aid workers pour in to provide aid for recovery. A postconflict transition can be simultaneously a period of heightened risk for HIV transmission and of programmatic weakness because of discontinuities between emergency assistance and reconstruction and development efforts. This is a gap to be filled.

Another critical issue is the need to create better dialogue between military and civilian HIV/AIDS policy makers, especially with regard to testing and accountability for HIV prevention. From the early days of the epidemic, the civilian and military sectors mounted sharply divergent responses. Faced with governmental denials and social stigma, the 1980s AIDS activists created a new model for health governance that focused on individual rights and civic mobilisation. This approach was successful in promoting a global movement around HIV/AIDS, which simultaneously transformed traditional control-based approaches to public health. At the centre of this approach is the individual’s right to privacy about her or his HIV status, alongside personal responsibility for good epidemiological citizenship.

In many countries—from the USA to South Africa and Ethiopia—military sectors responded more rapidly than national governments, and in a more traditional way. They saw HIV primarily as a threat to their operational capabilities, and had no qualms about control approaches that involved mandatory testing, exclusion of those who test positive, and (in some cases) making unit commanders responsible for keeping HIV rates down among their troops. A well-run programme of testing and exclusion will, of necessity, keep down HIV prevalence in the army, by shifting the burden of the epidemic to the civilian sector. But the best military AIDS policies have achieved more than that. In Ethiopia, for example, a “command-centred approach” to HIV prevention integrates incentives and disincentives for HIV outcomes into the mainstream functioning of the army as an institution. Units that remain free from HIV will be rewarded with promotions, more desirable missions,
and bonuses. Because comprehensive health assessments are integral to the command’s core activities, the medical services gain greater status. Such models of HIV prevention, based on membership of collectivities and institutional priorities, provide interesting alternatives to the dominant approach that emphasises individual responsibility.

Within a command-centred approach, testing becomes a tool towards a broader goal, not the sole mechanism for controlling HIV. Habitually secretive, armies have a poor record in publicly articulating the rationale for their approach to HIV/AIDS. In a notable court case in 2008, the South African National Defence Force (SANDF) failed to put forward principled arguments for employment discrimination on the basis of HIV status, and lost a case brought by Sergeant Sipho Mthethwa, an army musician. Mthethwa was tested for HIV before deployment on the UN-African Union Mission in Darfur and dismissed after he had a positive HIV test. The SANDF could have argued that every army functions on the basis that each recruit forfeits the right to control his or her body, that international humanitarian law recognises the principle of military necessity, and that the army must take into account the wider context of the integrity of the unit and the demands of the institution under existing and potential scenarios of national emergency. Even armed with the arguments above, the army’s lawyers would have struggled. The command-centred approach is a problem-solving method rather than a hard-and-fast principle of exclusion. Context is important. The plaintiff was a musician not a front-line soldier, and the SANDF had slimmer reason to object to his deployment and no reason to dismiss him. The SANDF duly complied with the court ruling and Sgt Mthethwa was deployed in Darfur in October, 2009.

The debate on testing and exclusion has become a dialogue of the deaf, yet the two sides should make a greater effort to understand one another’s concerns. This is particularly salient in the case of UN peacekeeping missions, which have become impaled on the contradiction between the UN’s normative stand and the operational requirement of the UN Department of Peacekeeping Operations, which needs to find countries willing to provide troops for peace missions. At present, the UN upholds the human rights standard but also respects the national policies of countries that contribute troops (which mostly include mandatory testing and exclusion). This double standard is tolerable but far from ideal.

Many of the same considerations apply for HIV/AIDS and law-enforcement agencies. Compared to military sectors, police services have been laggards in confronting the challenge of HIV within their ranks. Customs and immigration, prison warders, and the like lag even further behind. But of even greater concern is the role of law-enforcement practices, especially in relation to stigmatised and criminalised activities and groups, and how they influence the trajectory of national and regional epidemics. Insofar as HIV epidemics in many countries are concentrated among injecting drug users, sex workers, and other groups whose major interface with the authorities is with the police, it follows that law-enforcement practices are a principal determinant of how these epidemics unfold.

A global programme of collaborative learning on law enforcement and HIV/AIDS is sorely needed. Some of this is implementing what has long been known, but politically difficult to acknowledge; some of the learning will involve new research. An example of this is turning around the conventional epidemiological wisdom that sex workers constitute a “core group” or reservoir of HIV infection, which they transmit on to clients. In many countries, for example in southeast Asia, sex workers are a transient category. It is those who control the sex trade, including pimps, long-term clients, and (in many cases) law-enforcement officers, who constitute a more important core group, insofar as it is they who transmit the virus to newly recruited sex workers. Identifying a sex-worker-based epidemic requires an analysis of who controls the business, and how they do so.

Some time in the next 12 months, HIV/AIDS will return to the UN Security Council’s agenda. This will be a less historic occasion than the first debate of the 21st century, but it could be a more practical opportunity. HIV/AIDS remains a threat to armies, police services, peacekeepers, and the civilians with whom they interact, and policies are needed that tackle the issues during and especially after conflict.


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Further reading

