Compromising Human Security:

The Securitization of HIV/AIDS Response and Indonesia's Transition from Vertical to Horizontal Approach

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Abstract

In the collective effort to tackle and securitize HIV/AIDS epidemic, outright securitization was effective in terms of directing financial and political support to the cause, which in turn triggered substantial donor funding for HIV/AIDS response. Over time, outright securitization is losing its luster due to fiscal crunch and human security concerns, kindling the growing worldwide momentum to shift HIV/AIDS response from disease-specific ("vertical") approach to health systems-based ("horizontal") approach parallel to the drive for Universal Health Coverage (UHC) as the preferred approach to securitize the epidemic. This paper is not meant to argue the pros and cons of those approaches, and instead—using the case of Indonesia as an example—attempts to illustrate how transitioning from one approach to another might compromise the human security of PLWHA (People Living With HIV/AIDS).

Keywords:

Human Security, HIV/AIDS, Securitization, Universal Health

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INTRODUCTION

This article analyzes the securitization discourse vis-à-vis HIV/AIDS response, by asking the central question of *why had attempts to securitize HIV/AIDS inadvertently jeopardize human security?* To expound its arguments, this article will be divided into several sections. The first section will touch upon the many forms of linkage between health and security, which shapes the conceptual basis for securitizing health issues such as HIV/AIDS. The second section examines the genealogy of securitizing HIV/AIDS, acknowledging that while securitization had initially been vital in ensuring that HIV/AIDS response could attain the needed political and financial support, in the process it had also resulted in threat-defense mentality, which in turn propagates stigma and other exclusionary behavior, which directly goes against the very principle of human security.[1] The third section briefly examines the horizontal integration of HIV/AIDS response into public health systems and later on Universal Health Coverage (UHC) as the latest vogue among the long line of the attempts to rein in and curb HIV/AIDS epidemic, as well as how doing so may inadvertently jeopardizes human security. The second and third chapter will cover examples from Indonesia's HIV/AIDS response, drawn from the author's interviews with key informants. Overall, this article argues that while efforts to securitize HIV/AIDS have initially produced positive results in terms of directing financial and political supports to the cause, it had also done a fair share of harm towards the human security of People Living With HIV/AIDS (PLWHA). Ironically, in the process of transitioning from one approach to securitize HIV/AIDS from another to better tackle the challenges of contemporary HIV/AIDS response, human security—especially for PLWHA and at-risk marginalized groups—may be compromised.

1) As noted by *Human Security Now* bulletin, the vulnerability of populations is not limited to the poorest of the poor. There are also people "on the borderline," and "have jobs and yet cannot afford essential prescription medicines, safe living conditions, uniforms, lunches, or transport costs to send their children to school" (UN/CHS, 2003).

Health and Security Linkage

The link between health and security is not new, nor is the framing of health hazards as a security issue. Humans have long been exposed to the unseen hazard: bacteria, viruses and other microbes that may jeopardize our health. In fact, "infectious disease morbidity and mortality far exceeds war-related death and disability in human history" (Fidler, 2003, p. 807). In the post-Cold War era, fewer conflicts were fought between states; conflicts are increasingly fought within state borders, and between non-state actors. In these so-called 'new wars', security of citizens can no longer be ensured only through military protection of national borders (Chen & Narasimhan, 2003, p. 182).[2] As noted by Mack (2004, p. 366), 'while state remains the fundamental purveyor of security...it often fails to fulfill its security obligations—and at times has even become a source of threat to its own people'. Plus, there are limits to putting state security at the center of health issues, and as noted by DeLaet (2014, p. 341), in contrast to the primarily indirect linkages between health and state security, health issues poses a direct threat to individual human beings.[3] Against this backdrop, the United Nations Development Programme (UNDP) published its annual Human Development Report in 1994, titled *New Dimensions of Human Security* (UNDP, 1994). As noted by Chen, Leaning & Narasimhan (2003), the 1994 UNDP Report triggered many scholarly efforts to link health concerns to human security. Another monumental document is the Commission on Human Security report published in 2003, titled *Human Security Now: Protecting and Empowering People*. The commission, which was co-chaired by Sadako Ogata and Amartya Sen, identified in the report that health security is a vital component of human security (Rushton, 2011, p. 786). It differs, in principle, from previous approaches to health security by linking health with poverty and inequality issues, bringing health security closer to the everyday health concerns of ordinary individuals and communities (Elbe, 2005).

Consequently, health issues has gradually been drawn into human se-

2） See Kaldor (1999) for a more thorough explanation on 'new wars'.

3） This is not to say that state security should be abandoned when considering the linkage between health and security, or that states should be absolved from their role as the principal provider of health care. States remains the precursor to individual health—differences of health metrics across borders are a testament to this.

curity and development discourses, not only by influential reports such as the *New Dimensions of Human Security* and *Human Security Now*, but also through multilateral dialogues such as the G8 Summit in 2000 and the Trilateral Commission (Lisk, Sehovic & Sekalala, 2015, p. 27).[4] As noted by Takemi et al. (2008, p.5), health issues offers a useful entry point for implementing human security. Regardless, terms such as 'health security', 'health and security', 'individual health security' and 'global health security' are used almost interchangeably, signifying a divergence of views and understandings among authors (Paris, 2001).[5] The problem boils down to a series of questions: Security for whom? Security from what threats? Security under which values? Security by what means? (Baldwin, 1997; Rushton, 2011). In some circles, the idea of bringing back the traditional notions of security, such as border protection and military interests back into health issues are becoming more prominent, a process that Fidler (2003) attributed to the idea of 'violence paradigm' and perception of threat as an exogenous violence against the state, its military power and its citizens. The questions above were put into action during events such as the 1995 Tokyo Sarin Attack and 2001 Anthrax Attack and the post-9/11 War on Terror, which perpetuated the fear of biological warfare and bioterrorism.[6] States responded with forums such as the Global Health Security Initiative (GHSI) and pressures to strengthen pre-existing conventions such as the 1972 Biological Weapons Convention, which in principle invokes the logic of national security.

Recent outbreaks of SARS in Eastern Asia and Ebola in Western Africa emphasized what Aldis refers to as 'threat protection mentality' (2008, p. 371). During such outbreaks, states are more likely to become pre-occupied with the question of how to contain and isolate infectious diseases and prevent them from spreading from their origin rather than dealing with altruistic humanitarian concerns (Jacobs, 2016). Several scholars

4) The Trilateral Commission is a non-governmental policy discussion group originally established by The Rockefeller Foundation in 1973 to promote dialogue and closer political and economic cooperation between Japan, United States, Canada and Western European states. In recent years it has also included members from China, India, Mexico and newer member states of the European Union. See http://trilateral.org/page/3/about-trilateral

5) Also refer to Davies (2010) and Lakoff (2010) for approaches to classify the diverging views on the link between health and security.

6) Biological warfare is defined by Koblentz (2014) as the "use of micro-organisms, toxins derived from living organisms or bio-regulators to deliberately cause death or illness". For more insight into bio-terrorism, refer to Greenberg (2002) and Aginam (2005).

thusly contend that the linkage between health and security is somewhat moving away from the norms of human security in its original UNDP formulation and instead dominated by the *statist* strain of health security, as stated eloquently by Caballero-Anthony & Amul (2014, p. 36):[7)]

> *[Health] may be securitized, but it is a narrow, state-centric version of health security, preoccupied with acute, trans-boundary public health emergencies rather than with problems of chronic diseases or social determinants of health.*

Regardless, health security discourse is not solely the domain of statists, who typically employs conventional notion of state-as-provider-of-security, focusing on how to prevent health threats from potentially harming the socio-economic, political and military dimensions of a state through means such as border control (Caballero-Anthony & Amul, 2014, p. 36). In fact, statist proponents of faces challenges from *globalist* strain of health security which, as noted by Davies (2010), focuses on the well-being of individuals rather than states, focusing how individuals are positively or negatively affected by the actions of the many actors in global health.[8)] This signifies that although seemingly divergent at first sight, there is indeed an overlap of interests between human security and health security—even if it is limited to the globalist strain. The focus on individuals is also shared by critical security scholars—often referred to as the Welsh school—who contends that security has real meanings and implications towards individuals and societies rather than an abstract concept fought over by states through the processes of high politics (Brown & Stoeva, 2014, p. 309).[9)] These scholars argue that security is an emancipatory exercise in improving human well-being, empowerment of individuals and mitigation of inequalities and marginalization—concepts that should prove familiar to proponents of human security. In other words, there is a convergence of ideas from various school of thoughts which connects health with security—namely human security, globalist health security

7） See also: Peterson (2002), Davies (2010), Weir & Mykhalovskiy (2010) and Rushton (2011).
8） Also refer to O'Manique & Fourie (2010) for a more thorough analysis on the tensions between the statist and globalist strains of health security.
9） See also: Booth (2007), Krause & Williams (1997), Peoples & Vaughan-Williams (2010) for comprehensive explanations of critical security.

and critical security—signifying a considerable push to depart from the state-centered bent of traditional security and instead centered on individuals as referent, emancipatory and empowering in nature, but also one that gets lost in the process—which is apparent in the securitization of HIV/AIDS covered in the next section.

SECURITIZATION DEBATE AND HIV/AIDS

The powerful wave of understanding HIV/AIDS as a threat towards state and global security began in the early days of 21st century. The efforts was spearheaded by then-United States Ambassador to the United Nations Richard Holbrooke and then-Vice President of the United States Al Gore to push HIV/AIDS further up the international security agenda, which culminated in UN Security Council taking up the issue of HIV/AIDS in January 2000, via Resolution 1308.[10] As noted by Campbell (2008, p. 5), the tone and content of this wave largely mirrored the discourse on wars and traditional security. Gore called the disease "a global aggressor that must be defeated", noting that "the United Nations was created to stop wars" and that the international community must "wage and win a great and peaceful war of our time—the war against AIDS". While political and financial support for HIV/AIDS was initially a tough sell for politicians and policymakers—even the late Nelson Mandela conceded that supporting a cause as divisive as HIV/AIDS is a difficult proposition in terms of balancing it with public support—the hope was that linking HIV/AIDS with security discourse brought a greater sense of threat and urgency into the epidemic, which puts it on the political agenda of the state and in turn brings into play national and international bureaucracies involved in diplomacy, intelligence and military affairs (Prins, 2004, p. 940).[11] Constructing the image of HIV/AIDS as a collective worry by employing strong words to describe the epidemic, such as "enemy" or "aggressor" to be "defeated" was vital is appealing to *states'* security and therefore

10) See also: Prins (2004). Regardless, as pointed out by McInnes & Rushton (2010, p. 226), this master narrative aimed to polemicize and securitize has been around for a long time, potentially as far back as 1987, during which a US Special National Intelligence Estimate laid out the potential security implication of HIV/AIDS epidemic.

11) As noted by Elbe (2006, p. 122), "many of those drawing the links between HIV/AIDS and security do so instrumentally in the hope that this will accrue important humanitarian benefits by bolstering international efforts to combat the spread of the disease".

eliciting a number of effects which elevated HIV/AIDS issue from a topic of taboo into the realm of high politics.[12] This in turn triggered policy responses from the highest echelons of governments—such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)—and firmly entrenching HIV/AIDS within the mainstream global policy agenda.

However, securitizing the disease is not without its shortcomings—it is essentially a subjective act, one whereby political actors actively choose a particular issue to be elevated as security agenda, and in the process, they identify securitizing agents, referent objects, the threats and measures to counter the threats (Buzan et al., 1998, p. 24). This is not to say that HIV/AIDS does not create security problems; rather, the problems are much more nuanced and complex than simply saying that it is a matter of state security. As eloquently laid out by Elbe (2006, p. 137), there is a major difference between arguing that People Living With HIV/AIDS (PLWHA) are security threats and arguing that HIV/AIDS epidemic is a security threat. Lost among the security discourse and the frantic search for an explanation for the high rates of HIV/AIDS prevalence, morbidity and mortality, as well as how to curb the epidemic, is the social aspects of the epidemic and the epidemiological cofactors in disease transmission (such as malnutrition, migration, gender relations, poverty and the lack of public health care). In other words, securitization could very well be employed by certain political actors as an act for, deliberately or inadvertently, self-preservation by demonizing others. As noted by Fourie (2014, p. 115), while securitization is a powerful tool not only for HIV/AIDS epidemic but also for health interventions in general, it comes with a set of normative and ideological baggage. For one, securitization propagates what experts refer to as 'HIV exceptionalism'. Indeed, the 15-year span of the Millennium Development Goals (MDG) was largely considered as the era of HIV/AIDS exceptionalism, during which the epidemic was understood as a uniquely pressing matter, drawing unprecedented levels of political and financial support (Poku, 2018, p. 769).[13] Yet at the same time the same exceptionalism led to a narrow, vertical, single-disease approach, which diverts resources away from health systems-based solutions intended to

12） Refer to Fourie & Foller (2013) for a more in-depth explanation of the said "effects".

13） Poku (2018, p. 769) also noted that the result of HIV/AIDS responses during this period are impressive—long ways to go notwithstanding—with 38% reduction in new HIV infections, along with 15 million people on anti-retroviral treatment (ART).

tackle poverty-related health challenges (DeLaet, 2014, p. 347).

To be sure, securitization of HIV/AIDS has saved countless lives by channeling resources into HIV prevention as well as better access to antiretroviral treatment (ART) for AIDS patients. However, looking at securitization through the lens of human security made it apparent that state responses towards the epidemic have often been characterized by a lack of consideration towards PLWHA, as noted by Elbe (2006, p. 128): "Calls for quarantining such people, subjecting them to various forms of violence, attempting to bar them from serving in state institutions, and refusing to issue visas to HIV-positive foreigners are only a few of the examples in which persons living with HIV/ AIDS have been ostracized and even persecuted by some states for their illness". This sort of threat-defense logic invites a dichotomous us-versus-them situation in which PLWHA are ostracized and stigmatized upon as the threat to the broader society—exactly the sort of "people with HIV/AIDS are security threats" argument Elbe warned about. In other words, securitization of HIV/AIDS amounts to nothing more than a containment strategy, one whereby powerful states—or perhaps the non-PLWHA majority—are the referent object to security, thus heightens the sense of unease about whose security health securitization really serves (Rushton, 2011; DeLaet, 2014).

The marginalization of PLWHA is further perpetuated by the securitization bent towards preventing new HIV infections. This is attributable not only to the internal struggle within HIV/AIDS response, one that is fought between prevention and treatment, but also the ignorance recognition of AIDS as a chronic disease—one that permeates even major targets such as SDG 3.3 and global bodies involved with HIV/AIDS, as noted by Ashley & Brown (2018). Ashley & Brown specifically called out UNAIDS and their Fast-Track strategy, which mirrors SDG 3.3 target; they argue that the language used, such as "we can end the AIDS epidemic by 2030" and "ending AIDS as a public health threat" are dangerous because it essentially puts the spotlight on reducing or eradicating new HIV infections and therefore diverts the attention away from the long-term needs of PLWHA. While it is important to stop more people from contracting the virus, there were roughly 8 million PLWHA in 1990 and 36 million in 2016. Even if we are able to put a complete halt to new infections, those 36 million lives will not simply go away—their burden will last for their entire lifetime.

Even among major proponents and agents of securitization, the HIV/AIDS security narrative seemingly lost its luster in the 2010s (Patterson, 2014, p. 280), pointing to the nuance that securitization was never that salient to begin with. It seems that the old way of framing HIV/AIDS epidemic as a security problem may not be as appealing as it was in the past. Experts such as Poku (2018, p. 769) suggests that a fiscal crunch is looming—cutbacks of international and bilateral funding for HIV/AIDS responses in lower-middle income countries are pervasive, signaling the waning momentum of securitization as a tool to attract political and financial support and therefore the unsustainable nature of simply securitizing HIV/AIDS. At the same time, ambitious HIV-related goals set by international organizations such as UNAIDS' 90-90-90 treatment target in addition to the SDG 3.3 mentioned above will undoubtedly require significant political and financial support if those targets are to be achieved.[14] The question moving forward then is how to strike a good balance between maintaining the political and financial mobilization initially brought by donors and proponents of securitization—while still making sure that PLWHA are not excluded or even ostracized from efforts to curb the epidemic. HIV/AIDS is a hard sell from a political standpoint, due to its long-slog nature, especially in states where stigma runs deep—policymakers preters non-controversial policy with easy-to-quantify results during their term in office, so it is unlikely that recipient states will readily fill the void left by donors. The irony is that all the donor funding vertically distributed towards recipient states inadvertently precludes recipient states from taking stock of HIV/AIDS response after the donors left.

In Indonesia, for example, aside from a handful of concerned stakeholders, HIV/AIDS epidemic are still treated with stigma and disdain by many government officials, and therefore putting HIV/AIDS on lower footing, especially on the sub-national levels, where there are an abundance of local laws and policies unconducive to HIV/AIDS response—often with punitive tones towards marginalized groups at risk of contracting the vi-

14) UNAIDS' 90-90-90 sets a target that by 2020, (1) 90% of all people living with HIV will know their HIV status, (2) 90% of all people with diagnosed HIV infection will receive sustained ART and (3) 90% of all people receiving ART will have viral suppression. SDG 3.3 target states that by 2030, *end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases*.

rus.[15] Hence it is no wonder that government officials are in no hurry to allocate budget to eventually fulfill the need once donors leave.[16] This is certainly problematic considering that donor funding usually constituted a significant portion of HIV/AIDS response budget in Indonesia—in some provinces, donor funding contributed more than 70% of the total HIV/AIDS response budget during fiscal year 2016.[17] Yet it must be noted that donors still maintain support for HIV/AIDS programs in Papua and West Papua provinces owing to the higher percentage of PLWHA among the population, although it may simply be a reflection of the threat-defense and containment mentality warned by Elbe, Rushton and DeLaet previously—or, in the words of a HIV/AIDS officer stationed in Jayapura, "the pressure to keep the disease here and not let it spread elsewhere".[18]

Of the many characteristics of HIV/AIDS epidemic which often gets lost among the securitization debate are the unique ways of how the virus gets transmitted and their social implications. Unlike pathogens which are airborne, waterborne or carried by vectors such as mosquitos or ticks, HIV is transmitted through blood, pre-ejaculation fluids, semen or vaginal fluids.[19] Those transmission methods are unfortunately linked to behaviors that are deemed to be 'deviant' and closely associated to certain groups of ostracized by the majority in many societies: The use of injected drugs, same-sex relations and promiscuity, which inadvertently perpetuates the stigmatizing behavior towards PLWHA.[20] Framing HIV/AIDS ep-

15) Interview with Inang Winarso, former Program Deputy, Indonesia National AIDS Commission. March 3rd, 2019. He spoke of how a senior government official in Aceh who dismissed any prospect of provincial funding for HIV prevention program as "a useless effort of helping heretics and sinners".

16) *Ibid.* In another interview with an official affiliated with Indonesian Ministry of Health (who refuses to be named), on March 8th, 2019, he dismissively described HIV/AIDS response as *"kerjaannya bule, bukan urusan kita"* (the foreigners' business, none of our concern).

17) *Ibid.*

18) Interview with dr. Beeri Wopari, Head Officer, Sub-division of AIDS, Tuberculosis and Malaria (ATM), Papua Health Bureau. According to him, foreign donors and national government officials singled out Papua and West Papua and kept it on their respective funding priority list due to concerns that the epidemic could spread to other provinces, using the example of the mandatory HIV/AIDS testing for students who receive scholarship to study elsewhere in Indonesia.

19) HIV transmission may also occur during pregnancy from infected mothers to her infant, during childbirth through contact with blood or vaginal fluids and also through breast milk.

20) See Malcolm et al. for a more thorough discussion on HIV/AIDS-related stigma.

idemic as a security threat brings the risks of fueling the stigma, which in turn perpetuates exclusionary and dehumanizing behaviors towards PLWHA in the name of protecting the state or the international community.[21] As noted by Fourie (2014, p. 107), among the many frames to make sense of and construct appropriate response to the epidemic, there have been attempts to respond through *moralization*, whereby HIV/AIDS are seen as a divine punishment of some sorts towards the objectionable—often considered "sinful"—behaviors of immoral individuals or groups, which necessitates social sanctions or punishments. As a result, PLWHA are marginalized, which could be problematic as it could very well hinder PLWHA's willingness to receive treatments or prevent those who are at risk of contracting the virus from taking the initiative to get tested.[22]

Perhaps a new way of framing the epidemic is needed to maintain the momentum and ensure that the epidemic will be halted. As mentioned above, social aspects of the epidemic and the epidemiological cofactors in HIV/AIDS transmission are somewhat lost among the securitization debate, which indirectly results in the exclusion of PLWHA from getting involved in the policymaking of HIV/AIDS response. The argument that an epidemic constitutes an emergency which requires securitization is an indication that individual health is not being seen as a referent object (Davies, 2010b, p. 21), and the irony of HIV/AIDS response is that it is, in most cases, formulated by those who are not directly affected and not involving PLWHA themselves. Without empowering PLWHA and ensuring their involvement in HIV/AIDS-related policymaking, HIV/AIDS response will fall back into the securitization trap—quickly becoming vested in self-interest and threat-defense logic, with PLWHA paying the price. For now, horizontal funding—that is, integration of HIV/AIDS response into public health system and eventually into Universal Health Coverage—seems to be the consensus within international community to solve the waning momentum of HIV/AIDS securitization and the resulting vertical funding.

21） Sontag (1988, p. 94) argued during the dawn of HIV/AIDS epidemic that security posturing the use of military-invoking metaphors such as "war against AIDS" as a communication strategy contributes to the excommunication and stigmatization towards PLWHA.

22） From a medical standpoint, the earlier the better when it comes to identifying and treating HIV/AIDS; taking ART early could prolong the dormancy stage of the virus and prevent it from manifesting into AIDS well beyond the normal lifespan of human being. Case in point: The famed basketball athlete, Magic Johnson, who was diagnosed early and hence received treatment early.

The next section will analyze this change of approach and, drawing from Indonesia's example, the potential pitfalls in doing so from a human security perspective.

FROM VERTICAL TO HORIZONTAL: A RISKY PARADIGM SHIFT?

Financing for HIV prevention and treatment has shifted from vertical, disease-specific programs into a horizontal, health systems-strengthening approach meant to integrate HIV/AIDS response into the public health system (Nattrass, Hodes & Cluver, 2016, p. 682). Experts such as Roger England posited that HIV/AIDS was not the global catastrophe claimed by early proponents of HIV/AIDS securitization such as Gore and Holbrooke. England further argued that donor aid for HIV/AIDS was disproportionate to global disease burden anyways—hence it would have made more sense to divert donor funding into more pressing health issues (England, 2006). A more cynical view on this paradigm shift suggests that it is merely another strategy aimed to *securitize* and *contain* disease to where it originated and prevents the diseases from crossing borders—echoing the threat-defense mentality typically found in disease-specific response (DeLaet, 2014). Lessons from disease outbreaks such as SARS in 2003-2004, Ebola in 2013-2016 and the prolonged spread of HIV/AIDS exposed the limits of securitization through disease-specific response, while at the same time highlighting the deficiencies of public health systems during critical moments. Skeptics argued that the recent global appetite for horizontal funding was something of a knee-jerk reaction stemming from the lessons learned from the outbreaks above; after all, the massive effort and expenditure that transitioning from vertical to horizontal response would necessitate was rationalized only when disease-specific response have reached its ceiling.[23] The decrease of HIV/AIDS donor funding and the subsequent push to shift from vertical HIV/AIDS response to a horizontal model coincides with the global attention for Universal Health Coverage (UHC) as an aspirational goal to strengthen public health systems. In other words, we are collectively heading towards the integration of HIV/AIDS response into UHC (Ooms & Kruja, 2019)—a trend which, while seemingly sensible

23) Stuckler et al. (2010) for example contends that the demands for UHC is reminiscent to past backlash against 'vertical', disease-specific programming, which triggered reaction for 'horizontal' approach such as Sector-Wide Approaches (SWAPs).

on paper, brings its own set of human security concerns.

Some hope has been invested in the idea that UHC could serve as a silver bullet which could ensure sustainable delivery of health care by coaxing governments to increase domestic spending for health system strengthening and increase states' self-resilience in dealing with disease outbreaks and epidemics (Poku, 2018, p. 766). Many governments, experts and development agencies now openly advocate UHC, contending that it will provide an impetus for states to address health resource shortages, strengthen its public health system and thus preparing it for health-related eventualities—therefore signaling UHC's credentials as a health securitization tool in lieu of disease-specific approach (Kutzin & Sparkes, 2016).[24] At the same time, UHC is also widely appropriated by proponents of human security as an example of human security operationalization, with Japan spearheading the movement.[25] However, in its implementation, UHC does not automatically guarantee that the principles of human security are upheld. In Indonesia, for example, while it could be argued that the political demand for UHC is a synergy between a top-down political interest and bottom-up advocacy (Pisani et al., 2017, p. 272), the implementation is decidedly top-down, with minimal consultation process with beneficiaries and implementers (Budipramono, 2018), let alone bottom-up empowerment.

In reality, there are no widely accepted definition and what constitutes as 'universal' health coverage; the particular details are lacking, and there are no standard performance or outcome measures for an adequately functioning UHC system, nor are there an authoritative list of states with operational UHC systems (Poku, 2018, p. 768). In other words, UHC

24） Even donor agencies such as the Global Fund, which had traditionally adopted disease-specific program, explored an increasingly integrated approach reminiscent to UHC, as noted by Mookherji, et al. (2015).

25） For more analysis on Japan's spearheading role in calling for support towards UHC, see Yamey (2015). Japan have reiterated—in multiple occasions and through multiple forums—its take on the vital role of UHC as a pre-requisite to ensuring human security. In the fifth Tokyo International Conference on African Development (TICAD), for example, Japan announced a plan to contribute to the progress of universal health coverage, pledging to provide approximately $500 million for human resource development in Africa's health sector (Government of Japan, 2016). Japan also hosted the 2017 Universal Health Coverage Forum, which resulted in the Tokyo Declaration on Universal Health Coverage, which reiterates that "...health is a human right and that UHC is essential to health for all and to human security" (WHO, 2017). For other instances in which Japan connects UHC to human security, see also MOFA (2015); Korc & Hubbard (2015); Kitaoka (2019).

shares the very problems which has long plagued human security; both are idealistic, all-encompassing and have amorphous definitions—which, although arguably the reasons why both are so popular—is also what makes them so tricky to implement and operationalize (Stuckler, 2010, p. 8).[26] The implementation of UHC systems—especially in the low-to-middle income states which had implemented UHC only recently—are still riddled with difficulties: The tricky balancing act between coverage and financing schemes and the challenges of implementing UHC to health systems which are often mismanaged and lacking in manpower, infrastructure as well as monitoring mechanism (Chan, 2015).[27] This brings us back to the health system strengthening argument, creating a chicken-and-egg conundrum: Is UHC conducive to the strengthening of health systems, or is a strong health system a pre-requisite for a proper implementation of UHC?

UHC often goes hand-in-hand with politicization through the 'health care for everyone' or 'free healthcare' narratives, and how adopting UHC program as a campaign tool helped politicians in swinging electoral results in their favor.[28] While this politicization of UHC—as with politicization of prior hot topics in global health such as AIDS or SARS—could very well lead to a heightened sense of awareness, ownership and invariably an influx of financial and political support, it remains a risky proposition. The use of "free healthcare" narrative as a political tool could inadvertently put a spotlight on *curative* medicine by creating a sense that UHC is all about enabling individuals to go to a health care service provider and receive medical intervention free of charge, despite the inclusion of promotive and preventive health services in WHO's definition of UHC. Indeed, most UHC-related allocation of efforts and resources to date have focused mostly on the delivery of individual, curative services (Verecchia et al., 2018). Chapman (2016, p. 4-5) further suggests that in states lacking strong health system, the blind pursuit of simply expanding UHC partici-

26) See also Bump (2015).

27) Data compiled by Stuckler et al. (2010, p. 15-17) concludes that out of the 44 countries analyzed with UHC program which covers more than 90% of the population with point-of-entry health services, about one-half would today classify as high-income countries, one-quarter as upper middle-income countries, and the final quarter as lower middle-income countries at the time of implementation, suggesting that moderate level of economic development is potentially needed for implementation of UHC.

28) See Aspinall (2014) for his example on Indonesia.

pation—in order words, enlisting as much members as possible—often trumps the consideration towards the marginalized, poor and/or vulnerable, leaving the small, privileged groups living in urban areas to utilize most of the benefits provided by UHC systems, while vulnerable groups such as migrants and refugees are not provided for.[29] This conundrum seemingly defeats the very purpose of UHC itself—how "universal" is UHC when it is not able to provide health services for the vulnerable and marginalized, and when health care is seemingly divided into caste? How effective is UHC at tackling HIV/AIDS epidemic, when it is skewed heavily towards *curative* medicine? And more importantly, if the impetus to integrate HIV/AIDS response into UHC was to mitigate the loss of donor funding, how should the massive resource needed to achieve UHC in the first place be accounted for? As noted by Ooms & Kruja (2019), the logic behind the transition from vertical to horizontal approach was predicated on the idea that states should pick up the slack and mitigate the decrease of donor funding. The question of (1) whether those states are capable of picking up the slack and (2) whether the transition is being handled properly, however, remains underexplored—which may put PLWHA at a human security risk, as well will see in the case of Indonesia.

Indonesia's Transition

The case of Indonesia might be salient in order to understand how integration of HIV/AIDS response into a public health system—which simultaneously undergoes transformation into a UHC-based system—inadvertently jeopardize the human security of PLWHA and at-risk marginalized groups. Initially, like any other states adhering to the vertical HIV/AIDS response model, the National AIDS Commission (NAC) as well as a number of local AIDS Commissions was established to coordinate efforts to curb the epidemic, while existing government stakeholders act as program implementers (Mboi & Smith, 2006). Over time, the commissions became more and more prominent, taking on the responsibilities for program implementation and essentially acting as receptacles for donor funding from various organizations such as British Government's Indonesia Partnership

29） A growing body of evidence suggests that UHC is more difficult to achieve in societies divided along ethnic, religious and linguistic fault lines and/or significant income inequalities; See Stuckler et al. (2010).

Fund (IPF) and The Global Fund (Arnquist & Weintraub, 2011). While this is partly due to the ineffectiveness of local government stakeholders in a number of provinces, the commissions had also developed working partnerships with local communities and civil society—and hence deemed more effective in conducting outreach and prevention programs.[30)]

However, Presidential Decree (PD) 124/2016 effectively dissolved the NAC at the end of 2017. The decision to dissolve the NAC caught PLWHA communities and civil society organizations off guard and was fraught with backstage politics.[31)] NAC's growing role and influence ruffled feathers within several circles among government stakeholders who thought that NAC had long overstepped the boundaries relating to its standing as coordinator of HIV/AIDS response.[32)] The dissolution of NAC was also precipitated by President Jokowi's intention to clean house and dissolve ineffective government apparatus—interestingly, a 2015 assessment on non-structural government apparatus conducted by the Ministry of Administrative and Bureaucratic Reform of the Republic of Indonesia concluded that the NAC was vital and hence should be maintained, although NAC was not without its transgressions.[33)] The dissolution of NAC attracted controversy as well as far-reaching chain of consequences, chief among which was the suspension of donor funding for the entire fiscal year 2017.[34)] As a result, NGOs and CSOs that were reliant on donor funding to for day-to-day operation and implement HIV/AIDS related programs,

30) Interview with Inang Winarso, former Program Deputy, Indonesia National AIDS Commission, March 3rd, 2019. Local government apparatus was often constrained by a lack of domestic funding, unresponsive leaders and/or discriminative laws—both of which negatively impacted HIV/AIDS response.

31) Interview with dr. Dewi Inong Irana, a consultant to many NGOs and CSOs involved in HIV/AIDS response, February 18th, 2019. She asserted that non-government stakeholders were never involved in the decision to dissolve NAC.

32) Interview with Rachmat Sentika, former Deputy, Coordinating Ministry for Human Development and Cultural Affairs, February 20th, 2019. He asserted that MoH officials were especially dismissive of the NAC; this assertion was echoed by Inang Winarso, another respondent interviewed at a later date.

33) *"Penanggulangan AIDS: Perpres Nomor 124 tahun 2016, Blunder Pemerintah?"* Kumparan, March 2nd, 2017. At the same time, two of the respondents, namely Inang Winarso and Rachmat Sentika, spoke of NAC's many transgressions, including the yet-to-be-traced vanished donor funding from NAC's bank account, which is reported via an internal whistleblower letter to the President.

34) The NAC was the intended recipient for 150 trillion Rupiah worth of fundings from major donors such as the Global Fund and USAID—the funding had nowhere to go due to the dissolution of NAC.

which effectively paralyzed a significant portion of HIV/AIDS response in the country: Staff wages were left unpaid, preventive programs frozen, and distribution of ART supplies to PLWHA who sourced their dose from donor trickle-downs were stifled.[35] Those NGOs and CSOs are often indispensable in fulfilling public outreach, advocacy, legal protection and awareness-related roles not undertaken by the government—especially towards PLWHA and key populations (Ooms & Kruja, 2019, p. 15). PD 124/2016 was also problematic since it overrides the previous landmark HIV/AIDS law, the PD 75/2006, which became the basis of many regional law pertaining HIV/AIDS and the formation of local AIDS commissions. Although PD 124/2016 was intended to dissolve NAC and not local commissions, there were confusion among local governments regarding whether they should maintain their local AIDS commission or not; several regions dissolved their local AIDS commission, while some others did not (Kumparan, March 2nd, 2017).

The consensus among interviewed respondents is that the government erred by enacting PD 124/2016. While regulations such as Ministry of Home Affairs (MoHA) Regulation 18/2016 and MoH Regulation 43/2016 technically oblige sub-national governments to be responsible for HIV/AIDS prevention and treatment, it was barely implemented when PD 124/2016 took effect. The central government did enact several damage control measures to prevent sub-national authorities to dissolve local AIDS commission, such as the Ministry of Home Affairs' circulars 440/3064/SJ for governors and 440/3065/SJ for regents and mayors, although they are deemed too little, too late; many local AIDS commission were either dissolved or rendered non-functional. In any case, functions, responsibilities and funding previously held by the NAC are later transferred to the Ministry of Health's (MoH) HIV/AIDS and STI Control Sub-Directorate.[36] The MoH is largely pre-occupied by the *Jaminan Kesehatan Nasional* (JKN—National Health Insurance)—Indonesia's rendition of UHC—since its implementation in 2014, and therefore stretched thin in

35） Trickle-down from donor made up roughly 30% of the ART distributed in Indonesia. dr. Dewi Inong Irana stated that she started receiving calls from PLWHAs who scrambled to secure ART supplies after the dissolution of NAC.

36） According to Rachmat Sentika, Coordinating Ministry for Human Development and Cultural Affairs was initially slated to take over NAC's coordinating roles; however, Puan Hamarani—the Minister—was not eager and instead motioned for the MoH to do so instead.

fulfilling its HIV/AIDS-related responsibilities.[37] Although medical intervention and medication for symptoms common to AIDS patients such as tuberculosis and pneumonia are technically covered by JKN in participating health facilities, it is often stigma-ridden and not PLWHA-friendly; stories of public health facilities refusing to treat PLWHA are still common—reflecting the prevalent societal attitude in Indonesia (Ooms & Kruja, p. 15). ART, while provided for free, are not distributed within JKN and therefore only available at designated hospitals—many of which frequently ran out of ART.[38] To this end, the MoH has endeavored—with limited success—to expand access to HIV treatment to primary care (Januraga et al., 2018), although the mechanism to synchronize HIV treatment with JKN is unclear. In fact, there is an ongoing debate whether HIV/AIDS-specific services will be included in JKN coverage; integration is predicted to bring its own set of complications.[39] Besides, even if the hope behind horizontal funding was to mitigate donor loss and enable HIV/AIDS response to synergize with and tap into the public health system, implementing UHC is a resource-intensive undertaking—JKN continues to rack up deficit annually, affecting even MoH budget—where in the public health system could the resource for HIV/AIDS response comes from? In Indonesia's case, it is unclear if the horizontal integration of HIV/AIDS will not backfire—let alone bring the results predicted by its proponents.

Conclusion

Although there is a clear interest for human-centered approach to health security, health issues such as the HIV/AIDS epidemic shows that in practice, human-centered approach takes a backseat to a more pragmatic securitization approach. While initially successful in gathering political and financial support during the earlier days of HIV/AIDS epidemic, securitizing approach and the vertical response it spawned had seemingly reached their limits due to human security concerns and waning donor

37) Respondents interview in Ooms & Kruja (2019, p. 16) noted that MoH-led coordination meeting involving stakeholders are few and far between.

38) All interviewed respondents professed that occasional absence of ART stock is a recurring problem in Indonesia.

39) As noted by Ooms & Kruja (2019, p. 13), to enroll in JKN a family must present 'family card'. However, key HIV/AIDS populations often live away from their families or, in more extreme cases, disowned—which may preclude key populations to enroll in JKN.

funding, which generated the discourse on transitioning to a horizontal approach to HIV/AIDS response. However, discussions above illustrated how transitioning into horizontal integration of HIV/AIDS response in a resource-limited setting might work to the detriment of the cause—and subsequently, the human security of PLWHA—especially when carried out in a hasty and non-inclusive manner. It could be argued that in Indonesia, the circle is not yet complete—by enacting PD 124/2016, it had taken the steps to move away from vertical HIV/AIDS response, although it was done as part of a sweeping bureaucratic reform rather than to mitigate the limitations of vertical response. At the same time, Indonesian government had not taken significant inroads to truly integrate HIV/AIDS into the public health system, with lamentable consequences. With an estimated 622.000 PLWHA at the end of 2016, Indonesia is one of few states with an increasing number of new HIV infections. It is estimated that only 44% of PLWHA in Indonesia know their status—nowhere near the 90-90-90 target—the percentage of PLWHA who receives ART as well as those who are virally suppressed are bound to be even lower. For HIV/AIDS, where consistency and continuum of care correlates directly to mortality, morbidity and escalation of the epidemic, blunders such as the PD 124/2016 is perilous, especially since it is not accompanied by a clear and timely agenda on what to do next.[40] The Indonesian case is not a conclusive indication that horizontal integration is a bad idea—although it does point out to the risk of careless transition, as have been warned by experts such as Burrows et al. (2016) and Poku (2018): HIV/AIDS and pursuance of UHC health system are both resource-intensive endeavors—integrating HIV/AIDS to the public health system while simultaneously pursuing UHC might risk putting HIV/AIDS on lower footing, owing to the gap in political palatability. Besides, there are no guarantee that the resources within UHC systems will find its way to HIV/AIDS response. All in all, transitioning from vertical to horizontal HIV/AIDS response—or any other attempts to securitize and curb the epidemic—must be conducted with a modicum of prudence, so as to not jeopardize the PLWHA, their human security and risk further aggravation of the epidemic.

40） Continuum of care includes diagnosis, linkage to and retention in HIV care, prescription of ART, and viral suppression (Poudel & Jimba, 2019).

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