

**DRAFT: DO NOT CITE**

**HIV/AIDS, CONFLICT AND WOMEN:  
A LOOK AT THE DESTABILIZING EFFECT OF PANDEMIC  
DISEASE AND HOW IT UNIQUELY AFFECTS WOMEN**

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## Introduction

HIV/AIDS<sup>1</sup> is now the world's fourth largest cause of death, after heart disease, strokes and acute lower respiratory infections (Dixon, McDonald and Roberts, 2001). Since the emergence of HIV and AIDS, over 20 million people have died; a staggering number that eclipses all deaths from war in the 20<sup>th</sup> century<sup>2</sup>. The global HIV/AIDS pandemic is intensifying in the face of expanded prevention, treatment, and care and support efforts (UNAIDS/WHO, 2004). While infections have been largely contained, and are at relatively low levels in Western Europe and North America, it has exploded in the developing world. HIV/AIDS claimed 3.1 million lives in 2005, of which over 570,000 were children. However, in absolute numbers and as a percentage of the total population, the burden of disease has massively and disproportionately fallen to sub-Saharan Africa (UNAIDS/WHO, 2004c). The most recent report by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (2005) revealed that the number of people living with HIV/AIDS reached an unprecedented high in 2005 at 40.3 million, up from 39.4 million in 2004 (UNAIDS/WHO, 2004). Of this figure, approximately 95% live in developing countries, of which 64% live in sub-Saharan Africa (Joint United Nations Programme on HIV/AIDS (UNAIDS) & World Health Organization (WHO), 2004). The literature is replete with evidence and projections of the multi-faceted (demographic, social, economic, political, cultural) and multi-levelled (household, community, state, regional, global) impacts of HIV/AIDS, particularly for developing countries. Ultimately, HIV/AIDS is expected to intersect with and exacerbate existing social, political and economic issues and inequities, and threaten or reverse gains made in development (Dixon, McDonald and Roberts, 2001). Elbe (2003) claims:

“By 2020, life expectancy in many countries could be lower than at the beginning of the twentieth century, thus undermining virtually a century of developmental gains” (54).

HIV/AIDS has already begun to demonstrate its impact on demographic and population indicators (see table below). Life expectancy estimates for sub-Saharan Africa have declined sharply and estimates suggest that by 2010, life expectancy at birth in the nine countries with the highest HIV prevalence rates will decline by an average of 17 years (Dixon, McDonald and Roberts, 2001: 411). HIV/AIDS affects mortality, predominantly for adults aged 15 to 49 years, consequently impacting dependency ratios, fertility rates, and population growth and composition. However, because the epidemic is only 20 years old, much of the impact, demographic and otherwise, is yet to unfold. Not surprisingly, there are considerable gaps in research and understanding the multi-leveled and layered impacts of HIV/AIDS.

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<sup>1</sup> Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS)

<sup>2</sup> Speech by former U.S. Vice President Al Gore to the United Nations Security Council meeting on AIDS in Africa, January 2000, [www.unint/usa/00\\_003.htm](http://www.unint/usa/00_003.htm)

**Figure 1.**  
**Projected Life Expectancy By 2010 With and Without HIV/AIDS<sup>3</sup>**

Country	With AIDS	Without AIDS
Botswana	38	66
Burkina Faso	46	61
Burundi	45	61
Cameroon	50	63
Cote d'Ivoire	47	62
Dem. Republic of Congo	52	60
Ethiopia	39	55
Kenya	44	69
Lesotho	45	66
Malawi	35	57
Namibia	39	70
Nigeria	46	65
Rwanda	38	59
South Africa	48	68
Swaziland	37	63
Tanzania	46	61
Uganda	48	60
Zambia	38	60
Zimbabwe	39	70

Though humanity has endured devastating disease epidemics before<sup>4</sup> the HIV/AIDS epidemic, particularly in sub-Saharan Africa, is inherently different due to its transmission methods, its resistance to and cost of treatment, and the social stigma that accompanies infection. This disease, which Garrett (2005) terms “death in slow motion” is unlike other diseases, because it largely affects the healthiest and most reproductive and productive populations (individuals between the ages of 15 and 49). Thus, the implications for children, families, agriculture, education, government, the private sector, and the health sector can be acute and extensive.

Likewise, the attendant social instability and disruption resulting from HIV/AIDS carries the potential to create and/or exacerbate conditions for intra-state or inter-state conflict. Viewing HIV/AIDS or epidemic disease in general, as a security threat is relatively new to security studies. Typically, security studies have been dominated by the realist school of thought, focusing on military aspects of security, and virtually ignoring other potential sources of conflict. This perspective is largely a reflection of traditional notions of security whereby the security of a state hinged on its ability to thwart territorial occupation by another army or pre-emptively act as the aggressor. However, in an increasingly interconnected world, the concept of security has expanded beyond its traditional preoccupation with militaristic threats to national security. Study of non-conventional threats (NCTs) to security and stability has organically emerged to fill the gaps left by the realist school, encompassing issues like the environment, health (including pandemic disease), access to natural resources (i.e. water), terrorism,

<sup>3</sup> P.W. Singer, p. 6, 2002

<sup>4</sup> International health diplomacy, including new regulations and mechanisms for controlling disease spread, emerged in the 19<sup>th</sup> century as a result of widespread disease epidemics such as cholera and the plague.

urbanization, demographic shifts, failures in governance, and issues respecting human rights<sup>5</sup>. It is clear that HIV/AIDS belongs on this list as a legitimate NCT. With this understanding, this paper seeks to ask under what conditions could HIV/AIDS-induced conflict emerge, and how gender factors in to how individuals are affected by the disease particularly when conflict is present, as it is well understood that women are disproportionately affected by conflict. In reference to the latter, research has begun exploring the linkages between the potential catalyzing effects of high incidences of HIV/AIDS infection and conflict, while conflict simultaneously serving as a catalyst for the spread of infection. Several scholars have begun exploring these linkages, including Randy Cheek (2001), P.W. Singer (2002), and Robert Ostergard (2002). This paper will build on these ideas by firstly, arguing that HIV/AIDS disproportionately and uniquely affects women, and secondly, that HIV/AIDS-induced conflict is an emerging non-traditional threat to security and stability in sub-Saharan Africa, acting as both an *accelerant* and a *byproduct* to conflict. Thirdly, analytical and practical approaches for managing HIV/AIDS and the linkages between individual and state security will be proposed.

### **Gendered Pathways of HIV Infection and Impact**

Gender “refers to the widely shared expectations and norms within a society about appropriate male and female behaviour and roles” and is not synonymous with “sex” or “women” (Gupta, 2000). The concept of gender relates to the social and cultural construction of male and female roles, norms, expectations, behaviours, and responsibilities. With regards to HIV transmission and impact, these constructs and practices shape male and female sexuality, sexual behaviour, vulnerability to HIV, and create differential impacts of HIV/AIDS for men and women. This paper maps out some of the gendered pathways of HIV/AIDS infection and impact to reveal how gender relations are playing a key role in creating and exacerbating women’s vulnerability to HIV/AIDS and the accompanying social impacts like conflict.

Globally, HIV infection rates for women continue to rise disproportionate to rates of HIV infection in men (Global Coalition on Women and HIV/AIDS, 2005). In 2005, 17.5 million women were living with HIV, an increase of over 1 million from 2003 (Global Coalition on Women and HIV/AIDS, 2005). In fact, women and girls now represent 57% of all people in sub-Saharan Africa currently living with HIV/AIDS (UNAIDS, 2005). Rates are particularly high among young women in sub-Saharan Africa; young women between 15 and 24 years old are at least three times more likely to be HIV-positive than young men (Global Coalition on Women and HIV/AIDS, 2005). In the Great Lakes Region, for example, women represent the majority of individuals living with HIV/AIDS (see Figure 2).

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<sup>5</sup> Final report, Conflict Prevention project, “Preventing the Next Wave of Conflict: Understanding Non-Traditional Threats to Global Stability”, Woodrow Wilson International Center for Scholars, 2002, p. 1

**Figure 2: HIV/AIDS in the Great Lakes Region of Africa**

	Adult HIV Prevalence Rate	Number of Adults and children living with HIV/AIDS	Number of women (15-49)	Number of HIV/AIDS Orphans <sup>6</sup>	Number of deaths in 2003 due to AIDS	Women's Share <a href="http://unstats.un.org/unsd/demographic/products/indwm/ww2005/tab3c.htm">http://unstats.un.org/unsd/demographic/products/indwm/ww2005/tab3c.htm</a>
<b>Burundi</b>	6%	250,000	130,000	200,000	25,000	59.0%
<b>DRC</b>	4.20%	1,100,000	570,000	770,000	100,000	57.0%
<b>Kenya</b>	6.70%	1,200,000	720,000	650,000	150,000	65.0%
<b>Rwanda</b>	5.10%	250,000	130,000	160,000	22,000	57.0%
<b>Tanzania</b>	8.80%	1,600,000	840,000	980,000	160,000	56.0%
<b>Uganda</b>	4.10%	530,000	270,000	940,000	78,000	60.0%

UNAIDS 2004 Update (End of 2003)

Globally, Kenya and Uganda respectively have the two highest rates of women's share of the epidemic (65% and 60%), while Angola, Burundi and Mali report rates of 59% for the women's share of the epidemic. In every African country, with the exception of the North African countries, women's share of the epidemic was over 50%.<sup>7</sup> High rates of women's share of the epidemic are symptomatic of underlying gender relations that affect women's vulnerability to HIV infection and impact. The literature on gender and HIV/AIDS describes disproportionately higher risks for women in both contracting and living with HIV/AIDS (Fleishman & Morrison, 2004; Galambos, 2004; Marton, 2004; Turmen, 2003; UNAIDS/WHO, 2004; Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), and United Nations Development Fund for Women (UNIFEM) Fund, 2004). The next section describes how gender norms and relations expose women in sub-Saharan Africa (and elsewhere) to increased risk of HIV/AIDS infection *and* impact.

One of the explanations for disproportionate infection rates among women is that women are more susceptible to HIV infection. Physiologically, women are more likely to acquire HIV through heterosexual intercourse than men. Furthermore, some sexually transmitted infections substantially increase a woman's risk of contracting HIV. For example, bacterial vaginosis can double a woman's susceptibility to HIV infection (Global Coalition on Women and HIV/AIDS, 2005). While the public health literature has contributed immensely to our knowledge about the linkages between gender and health (see Maclean & Sicchia, 2004; Turmen, 2003); studies tend to focus primarily on health *outcomes* for women and fail to explain gender as a relational construct and practice. The result is that women are often portrayed as victims, men are absent from

<sup>6</sup> HIV/AIDS Orphans are children who have lost their mother or father or both parents to AIDS and who were alive and under the age of 17 in 2003 (UNAIDS)

<sup>7</sup>Where data was available, no country in Asia, Europe or Oceania reported having a women's share rate over 50%, indeed the highest rate observed in those regions was 38% in India. Only one country in South America (Guyana) reported a rate over 50% (55%). In North and Central America, only Haiti, Honduras, and Trinidad and Tobago had rates of 50% and higher.

<http://unstats.un.org/unsd/demographic/products/indwm/ww2005/tab3c.htm>

the analysis (or depicted as perpetrators), and findings in the studies yield little towards supporting women's *strategic* needs<sup>8</sup> in public policies. In recognizing these realities and the real threat of HIV/AIDS-induced conflict, this paper seeks to bridge the gap between the 'big picture' or state-level perspective, and the individual in order to address security implications at each level in a manner that incorporates human rights and dignity, gender issues, and risk *reduction*, rather than containment.

*Gendered Distribution of Sexual, Social and Economic Resources, Rights, and Rewards*<sup>9</sup>

Gender relations asymmetrically distribute sexual, social, and economic rights, resources and rewards to men and women, which ultimately can exacerbate vulnerability to HIV infection and create disproportionate impacts of HIV for women. Notions of masculinity attach importance and status to sexual conquest. Having multiple partners or using partners solely for sexual release often confirms heterosexual malehood. These high-risk norms relegate women into secondary sexual roles where they become objects of men's desire. Women's rights to demand pleasure, protection from infection, and fidelity are constrained by these notions of masculinity. Furthermore, the culture of silence surrounding sex and sexuality perpetuates gender norms and relations, putting women at a distinct disadvantage within the context of HIV/AIDS. These realities are worsened by the fact that women also tend to have inferior access to health care (Gupta, 2000), which is partly a function of gender relations which privilege men's health and undermine women's autonomy in health care decision-making.

There are also substantial differentials in the distribution of educational attainment. Although educational attainment for women has improved over time in sub-Saharan Africa, large differentials between men and women remain. In Ghana, for example, men are more educated than women at all levels (Ghana Statistical Service, 2003). Differentials in education are more pronounced at the higher levels; twice as many men as women have completed secondary or tertiary education (Ghana Statistical Service, 2003). Education, particularly secondary education is associated with lower rates of HIV infection. Garbus & Marseille (2003) cite lower educational attainment, higher unemployment, and weaker negotiating skills within relationships as primary factors that increase women's vulnerability to HIV/AIDS in Uganda, for example.

The distribution of economic rights, resources, and rewards tends to favour men, and consign women to economically inferior and/or dependent positions. Gupta (2000) argues that women have inferior access to and control over productive resources,

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<sup>8</sup> The distinction here is between *practical* gender needs (income, employment, food, shelter, and other daily subsistence and survival needs) and strategic gender. Strategic gender needs refer to cognitive and/or social opportunities or changes in gender relations, which elevate women's economic, social, and political power and bargaining positions. These include: enhanced opportunity to participate in the political process, enhanced power in social relations, including marital and/or sexual/intimate relations; opportunity to access all levels of education and training, equitable property and inheritance rights, and so forth. We are aware that this distinction is a tenuous one, in that these needs are complementary and overlap. Practical gender needs are important pre-conditions for achieving and exercising strategic gender needs.

<sup>9</sup> This section describes gender relations, which expose women to disproportionate infection and impact to HIV/AIDS in sub-Saharan Africa (SSA). This section of the paper is not attempting to essentialize gender relations in SSA and suggest that all gender relations are marked by these types of norms. It is, however, attempting to demonstrate how these gender norms and relations, where they exist, contribute to disproportionate infection and impact for women.

including income, land, credit, and education. While there are variations in gender disparities, Gupta (2000) argues that they are observable in almost every society. Economic dependence creates several critical pathways for vulnerability to HIV infection and impact. For instance, women experiencing economic hardship may trade sex for money or other favours. Women are also disproportionately employed in the informal economy, which offers no coverage for health and social insurance, and are thus less likely to be able to access or afford health treatments or interventions if they become infected with HIV. Women's economic dependence on men may mean that women are less likely to leave an abusive relationship, even if they know their partners are infected with HIV or are at high risk of acquiring infection.

Women also often have inferior economic and property rights. For example, "property grabbing" from widows is widespread in Uganda. Garbus & Marseille (2003) report from a study on property grabbing, that 29% of widows had property taken from them when their husband died, a figure four times higher than for widowers. Women in many countries in sub-Saharan Africa continue to experience inequalities in terms of inheritance, property and land tenure rights. The unequal and inequitable distribution of economic rights, resources, and rewards, renders women vulnerable to economic dependence, destitution, and oppression, which elevates their risk of HIV infection and compounds their vulnerability to the impacts of HIV/AIDS.

#### *Gendered Division of Power, Labour, and Responsibilities*

Gender relations construct and reinforce the division of power, labour, and responsibilities between men and women. These gendered divisions tend to privilege male power and authority in sexual relations, decision-making, and in the domination and control of women, which ultimately increases women's vulnerability to HIV infection and impacts. The gendered division of power is expressed in sexual relations when men make the decisions on whose pleasure is privileged, when sexual activity takes place, how it takes place, and with whom (Gupta, 2000). When men control sexual relationships, or hold the balance of power in gender and/or sexual relations, women's autonomy within that relationship is constrained. The privileging of male power exacerbates women's vulnerability to HIV by undermining women's voice and agency in sexual and social relations. Gender-based violence substantially increases women's vulnerability to poor health and HIV infection and impact. In December 2005, the World Health Organization released its first ever report on the linkages between gender violence and health<sup>10</sup>. This report acknowledged the impact of gender-based violence on physical and mental health as well as health-seeking behaviours. Furthermore, a study conducted by Maman et al (2000) revealed that the experience of gender-based violence was a strong predictor of HIV. In the study, women who tested positive for HIV at a voluntary counselling and testing centre in Tanzania were 2.6 times more likely to have experienced violence in an intimate relationship than those who were HIV negative (Maman, et al, 2000). Cultures of silence and tolerance toward gender-based violence perpetuate and *rationalize* male domination and violence towards women. In the 2003 Demographic and Health Survey in Ghana, 37% of women stated that wife beating was

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<sup>10</sup> World Health Organization, 2005. *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses*. Geneva: WHO.

justifiable under certain circumstances, including refusing to have sex with the husband, neglecting the children, burning the food, arguing, or going out without informing the husband (Ghana Statistical Service, 2003). Gender-based violence undermines women's physical, psychological and emotional autonomy, placing them at substantially increased risk of poor health.

The gendered division of labour often assigns women as the primary caregivers in households, and thus women experience disproportionate impacts from HIV/AIDS because the burden of care generally falls to women (Doyal, 2002). Women often take on the majority of the responsibility for the care of children and family members. When a family member becomes infected with HIV, women are typically charged with their care. Furthermore, girl children often take on child-rearing and household management responsibilities when the mother in family dies. The gendered division of responsibilities often assigns males as primary decision-makers at the household level and beyond. Thus, even if women are provided with health care, including voluntary counselling and testing, they may be constrained within their household to access these services. For example, in Ghana, 34.9% of married women report that their husbands are the sole decision makers concerning their health care, while the figure is 37.6% in Uganda and 42.9% in Kenya. Clearly, gender relations may restrict women's abilities to access health-seeking interventions, as well other decision-making at the household level.

Gender relations continue to privilege male decision-making authority inside and outside the household. Men continue to occupy the majority of decision-making positions in government in sub-Saharan Africa. On the gender empowerment measure (GEM)<sup>11</sup>, sub-Saharan African countries rate very poorly. Low rates of women's political participation are often symptomatic of gender relations that relegate women to secondary and apolitical roles in society. Women are not seen as decision-makers; their perceived functions are largely reproductive, and secondarily, productive. The gendered distribution of sexual, social and economic rights, resources and rewards coupled with the gendered division of labour, power, and responsibilities creates conditions in which women are not necessarily able to access HIV prevention strategies. All of these factors contribute to a disadvantaged position in relation to HIV/AIDS, and the conflict it could incite.

### **A Catalyst for Conflict - HIV/AIDS and Security**

Robert Ostergard (2002) views non-traditional threats to security as concurrent threats to the individual, the state and the system whose impact on each level "varies temporally in intensity and scope."<sup>12</sup> This paper adopts Ostergard's position with the distinction that threats to the individual in the context of HIV/AIDS vary by gender. In other words, underlying vulnerabilities to infection and the social impacts (i.e. caring for orphaned children) often experienced by women in sub-Saharan Africa render them particularly vulnerable to the compounded effects of HIV/AIDS-induced conflict. Some of the manifestations of this include rape as a weapon of war, increased social and

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<sup>11</sup> The gender empowerment measure rates countries on the basis of three dimensions of empowerment- economic participation and decision-making, political participation and decision-making, and power over economic resources. [www.undp.org/hdr2003/indicator/indic\\_207\\_1\\_1.html](http://www.undp.org/hdr2003/indicator/indic_207_1_1.html)

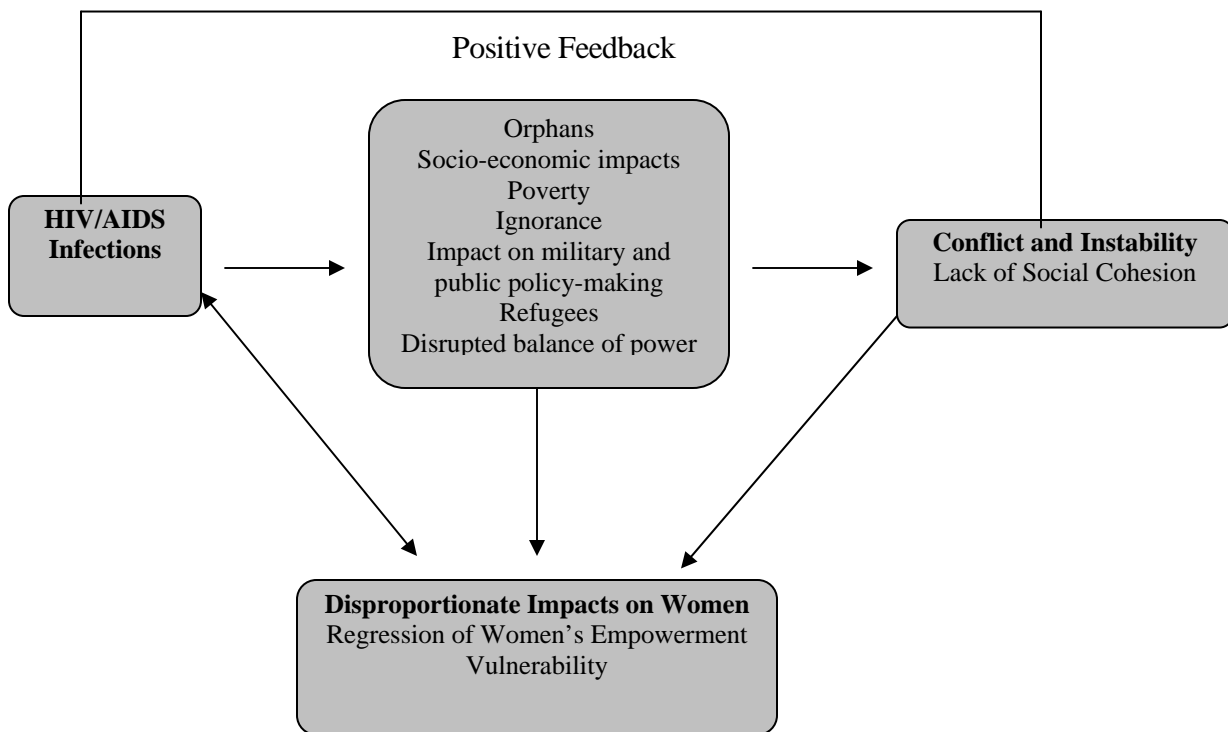
<sup>12</sup> Robert Ostergard, "Politics in the Hot Zone", Third World Quarterly, p. 338, 2002



economic vulnerabilities, displacement, and increased exposure to infection as a function of conflict. As P.W. Singer<sup>13</sup> (2002) explains, studies have proven that in times of war in Africa, infection rates amongst military personnel are as much as 50 times higher than in peacetime. If we are to accept the notion that women are more vulnerable to HIV/AIDS and its impacts, the real threat of conflict to the health and empowerment of women, are present and pronounced.

The diagram below demonstrates how the presence of HIV/AIDS infection disproportionately affects women, especially when conflict results from social and intra-state tensions. It also shows the compounding effect of conflict on women's empowerment exhibited in a cyclic fashion in that HIV/AIDS acts as both an accelerant and a by-product of conflict. Essentially, HIV/AIDS can both *create* and *contribute* to the spread of disease and conflict in that HIV/AIDS-induced conflict can in turn create conditions for further deepening and broadening of the epidemic, to the ultimate and disproportionate detriment of women. These linkages were also observed by Cheek (2001).

**Figure 3.**  
**The Cyclic and Destabilizing Effects of HIV/AIDS on Security and Women**



One of the primary consequences of high prevalence of HIV/AIDS in sub-Saharan Africa is the distinct possibility of eroding social cohesion, which is tenuous, at best, in many countries. In these conditions, a disease pandemic will exacerbate high birth rates, crime, illiteracy, unemployment and poverty. These conditions decrease confidence in the country, limit economic prosperity and ultimately, undermine the

<sup>13</sup> P.W. Singer, 2002, p. 8

state's capacity to govern. Tensions between those not infected and those infected, and accompanying class issues can become amplified by HIV/AIDS and lead to social instability, and possibly armed conflict.

The idea that pandemic disease, especially HIV/AIDS can proliferate in situations of conflict is another compounding issue that makes women more vulnerable. Martin Schonteich (2002) writes, “..war is an instrument for the spread of infectious disease”<sup>14</sup>. Furthermore, Cheek notes that HIV/AIDS can be considered an “accelerant to conflict” between nation-states particularly when one group perceives the other as weak and looks to make territorial gains. The fact that the military and government officials have been and are infected makes this possibility an inevitability that could upset regional and/or continental balances of power. For instance, in Malawi, an estimated 50 percent of the general staff is thought to be infected (Singer, 2002).<sup>15</sup> Furthermore, Ostergard reports that during the conflict in the Democratic Republic of Congo, 50-80% of the seven participating armies were infected (2002). The displacement of people as a result of conflict is also a concern that could upset equilibrium between and within states, as refugee camps are a prime transmission point for HIV/AIDS. The presence of refugees in neighbouring nation-states may enlist hostility toward those seeking asylum, resulting in violence toward an already weakened and possibly, militarily engaged opponent.

HIV/AIDS will challenge the mere viability of the state and its institutions. Given the level of attrition in many of Africa's military and police forces, HIV/AIDS may undermine the state's monopoly on violence (deWaal, 2003). deWaal (2003) considers projected impacts of the HIV/AIDS epidemic on governance in African countries. He suggests that while most states in have maintained core technocratic competencies, notably in macroeconomic management and defence, the human resource loss and capacity strains associated with the HIV/AIDS pandemic will constrain many African countries capacity to govern. Already overwhelmed with governance challenges, including regime transition, poor levels of institutionalization, provision of adequate health and social services, the multi-dimensional impacts of HIV/AIDS will compound these pre-existing problems. Consequently, these strains may exacerbate social tensions, and create opportunities for intra or inter-state conflict. All of these issues are real threats to the stability of nation-states in sub-Saharan Africa who are experiencing high incidences of HIV/AIDS.

### **Triple Threat: HIV/AIDS, Gender, and Conflict/Social Instability**

As previously discussed, women are disproportionately vulnerable to HIV infection and are therefore disproportionately negatively impacted even in the absence of conflict. In times of war or displacement, the disproportional impact becomes magnified through the use of rape as a weapon, inadequate or no access to health care and prevention programs, increased participation of poor women in the sex trade, and the vulnerability and marginalization of refugees who are usually women and children. Women in refugee camps, Schonteich (2002) reports, are six times more likely to

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<sup>14</sup> Martin Schonteich, “The Impact of Communicable Disease on Violent Conflict and International Security”, 2002, p. 4

<sup>15</sup> P.W. Singer, “AIDS and International Security”, *Survival*, 2002

contract HIV/AIDS in a refugee camp than the general population<sup>16</sup>. Clearly, there are important linkages between individual and state security *mediated by pandemic disease* that the realist and human security schools have inadequately explained. Previous sections of the paper have demonstrated how HIV/AIDS acts as both an accelerant and by-product to conflict and national insecurity. The next section examines how HIV/AIDS undermines national and individual security by examining one of the most salient issues arising from the pandemic: the creation of a large and growing generation of HIV/AIDS orphans.

### *12 Million And Counting...the Effects of 12 Million Orphans*

By 2000, more than 12 million children have lost one or both parents to HIV/AIDS, and are quite often infected themselves<sup>17</sup>. Not only is this a massive human tragedy for families and children, but also this is an issue for wider concern given the demographic, social and economic realities surrounding AIDS orphans. In addition to the emotional impacts for HIV/AIDS orphans, Whiteside and Sunter (2000) argue that generations of undersocialized HIV/AIDS orphans could undermine social stability. Furthermore, women and girl-children will arguably be disproportionately affected, as gender norms charge women with the bulk of caregiving responsibilities. The presence of a remarkable number of AIDS orphans in sub-Saharan Africa serves as an important lens of how the HIV/AIDS epidemic impacts both national and individual security and well-being; it squeezes women into increasingly vulnerable positions, and creates social and economic pressures and challenges for states.

This issue is particularly critical for women because they are often the primary or sole caregivers of children. Women and girl-children may find themselves in situations of caring for orphaned family or community members, and consequently take on additional caregiving responsibilities, thus incurring a 'triple-day'<sup>18</sup> *and/or* being unable to pursue their own goals through education, community involvement, and politics; exposing women to greater risks of exploitation and poverty. In some situations, there is no adult caregiver for orphaned children, resulting in child-headed households. Randy Cheek (2001) writes "...children orphaned by HIV are already beginning to overwhelm traditional coping mechanisms, as evidenced by the proliferation of child-headed households." Neither of these situations welcomes conditions for furthering women's empowerment or breaking the cycles of poverty, exploitation or infection. For women and children, the lack of a meaningful response to HIV/AIDS from governments has put them in a precarious position.

For orphans the lack of family stability, experience with abuse and exploitation, and lack of education means that they might engage in illicit or high risk activities, including crime, sex work, etc. Child labour is also another pressing issue in sub-Saharan Africa. In fact, a recent International Labour Organization (ILO) report found that sub-Saharan Africa has the highest proportion of children engaged in the workforce. The ILO

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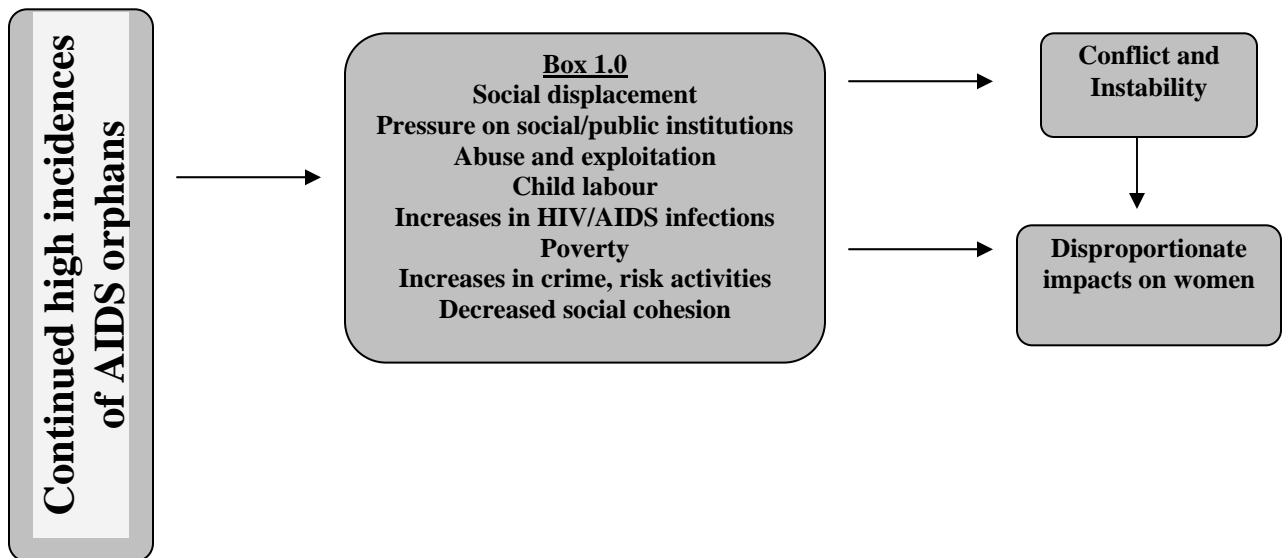
<sup>16</sup> Martin Schonteich, 2002, p.5

<sup>17</sup> See Robert Ostergard, 2002

<sup>18</sup> The triple day refers to a day that consists of multiple productive and reproductive roles: 1) caregiving of immediate family, 2) serving in the formal or informal economy, and 3) caregiving for extended family and community members (including orphans).

reported that 26% of children aged 5-17; an astonishing 50 million children are involved in economic activity<sup>19</sup>. Figure 4 demonstrates the relationship between the large and growing generation of orphans and the potential impacts on children, women, communities, and the state. The potential consequences outlined in Box 1.0 carry significant consequences for human and state insecurity, and ultimately disproportionately impact women and girl-children who are especially vulnerable to the impacts of HIV/AIDS, social instability, poverty, and conflict.

**Figure 4.**  
**The Effect of Millions of AIDS Orphans**



### Potential Outcomes – Setting the Stage for Regression of Women’s Empowerment

The thrust of this paper is to argue that HIV/AIDS should be considered not only a threat to security and stability for nation-states in Africa, but also should be considered a specific threat to women’s security *and* well-being. Using the example of the absorption of orphans into the family and the strain that places on women who are already struggling (and may be ill as well) is remarkable and an especially unique aspect of both the disease pandemic and the addition of conflict in combination. It is difficult to fully appreciate this in combination with other threats like sexual exploitation, illness, and abuse that women and AIDS orphans face.

The seriousness of the emergence of a generation of AIDS orphans should be considered within the context of increasing the likelihood of conflict and the likelihood of affecting the gains made in the socio-economic status and empowerment of women. While women in sub-Saharan Africa<sup>20</sup> have made gains in education and literacy rates,

<sup>19</sup> International Labour Organization report, “The End of Child Labour: Within Reach”, 2006, [www.ilo.org](http://www.ilo.org)

<sup>20</sup> This is based on 20 countries in sub-Saharan Africa where indicators demonstrate positive trends in indicators such as primary and secondary school enrollment, literacy rates, age at first marriage, median age at first birth, percentage of women with an unmet need for family planning,

and have demonstrated declining fertility rates, age of first marriage, and age at first birth<sup>21</sup> over the last ten years, HIV/AIDS threatens to stall or reverse these gains. While it is difficult to predict how states and societies will cope with a growing generation of AIDS orphans, it is reasonable to argue that women and girl-children will bear the largest burden in daily caregiving responsibilities, which may negatively affect their security and well-being, and thus in turn, affect community and national security.

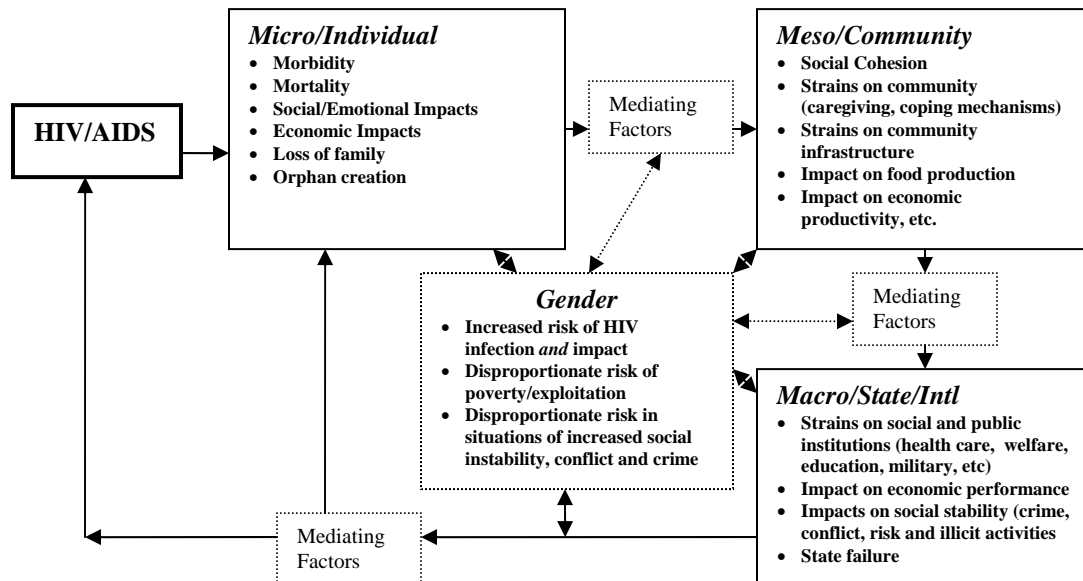
### *The Demographic Imbalance*

The demographic imbalance that already exists between the young and the old is already an apparent concern. For example, in 15 African countries 10% of the population aged 15-49 is infected with HIV/AIDS. This imbalance will invariably be worsened by imbalances in gender due to the high proportion of women infected and affected by HIV/AIDS (refer to Figure 2). In a matter of years, the loss of these women will have extensive impacts; one being the loss of caregivers in households and in the healthcare system. It will also heighten the pressures placed on women to carry an unequal share of the burden when social and health systems are stressed even further. Singer (2002) also notes that a population with a cohort heavily favouring young males is at an increased risk of violent outbreaks. Singer writes “AIDS will likely cause this in several states that are already close to this dangerous threshold.” The creation of a generation of AIDS orphans and its attendant impacts on both the individual (notably, and disproportionately, women and girl-children) and the state, demonstrates how disease, such as HIV/AIDS, operates at multiple levels to create widespread insecurity. Furthermore, insecurity operates as a feedback loop, in that the compromised security and well-being of individuals creates broader social instability, unrest, and conflict. In turn, instability, conflict, and governance issues create heightened insecurity for individuals and ultimately drive the transmission of HIV/AIDS (see Figure 5). Thus, clearly there are important linkages between individual and state security, which are mediated by pandemic disease. While other studies<sup>22</sup> have established linkages between scarcity and/or competition in material needs (including food, water, employment/income, etc.) and inter and intra-state conflict, there are considerable gaps in our knowledge surrounding the impact of pandemic disease on human and state security. This paper has demonstrated how HIV/AIDS potentially undermines individual and state security, and furthermore has argued that these linkages operate as a feedback loop, ultimately compounding and exacerbating insecurity and instability. Ultimately, this paper argues that women will suffer disproportionately in these contexts and bear the brunt of HIV/AIDS epidemics in sub-Saharan Africa and its attendant social instability.

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<sup>21</sup> An ongoing research program related to this project is compiling and analyzing multi-year data on these and other socio-economic indicators employing Demographic and Health Survey (DHS) data, and UNDP Human Development and Gender Empowerment data from 20 sub-Saharan African countries.

<sup>22</sup> See Collier & Hoeffler (1998); De Soysa, & Gleditsch (1999); Drèze, & Sen (1989) & Homer-Dixon (1999) for a cross-section of studies on human security issues and their relation to intra and inter-state conflict.

**Figure 5: HIV/AIDS: Pathways between Individual and State Security**

### **‘Securitizing’ AIDS: Some Considerations on the International Normative Order on Health**

The international normative order on health has faced on onslaught of various discourses, including health as a human right (WHO and the International Covenant on Economic, Social and Cultural Rights), health as a global public good (UNDP), health as a *means* of development (International Monetary Fund Commission on Macroeconomics and Health), and the securitization of health (UN Security Council). This paper has focused on the security implications, particularly HIV/AIDS, and its disproportionate impacts on women. The ‘securitization’ approach has emerged as both an analytical and practical tool for assessing and projecting the impacts of HIV/AIDS on states and the international community. The National Intelligence Council (U.S.) suggests that collective action around HIV/AIDS may “aid international security—another public good—by avoiding a future source of state failure” (National Intelligence Council, 2000). This realist orientation towards the international normative order on health has significant analytical and practical implications. For example, disease eradication (particularly for diseases that have the potential to affect powerful states) may retain priority, however, diseases and conditions in the developing world that are largely confined there, will receive considerably less attention if they do not pose a conceivable security threat. And diseases, like HIV/AIDS, that have demonstrable implications for national and regional security and stability are likely to garner strategies that emphasize ‘risk containment’ rather than health protection, promotion, and treatment for vulnerable and affected populations. For women, who constitute up to 65% of the people living with HIV/AIDS, ‘risk containment’ strategies may depict them as ‘vectors’ of disease, rather than generating questions regarding the gendered pathways of disease transmission and impact that are crucial to investigating and addressing practical and strategic gender needs

surrounding HIV/AIDS, for both men and women. State responses that are based upon a realist-oriented securitization approach to HIV/AIDS are likely to reflect traditional (national) security preoccupations with security threats against the sovereign state, and will thus focus on protection *from* rather than protection *for* affected and vulnerable populations. It is unlikely that a strictly realist-oriented securitization approach to health will produce the sorts of collective responses that have, at their heart, a commitment to protecting and promoting the health of affected populations, because this would not fall within the rational self-interest of the more powerful (or donor) states. This discussion of the conceptualization of health is critical to global health cooperation; because health is conceptualized will bear profound implications for the types of responses that are employed.

### *Human Security and HIV/AIDS*

The human security school has been developed, to some fanfare in the community. In many ways, the human security school fills the gaps between what other threats (NCTs) exist on the international stage and what the realist school has addressed, but there are weaknesses in this approach. The human security doctrine has been criticized by those who point to the rather weak and/or contested theoretical and conceptual foundations which underlie the approach. Hampson and Hay define human security as “the absence of threats to various core human values, including the most basic human value, the physical safety of the individual.”<sup>23</sup> Other definitions offer a more positive conceptualization of human security, including the advancement of economic and social well-being, respect for dignity and worth of human beings, and respect for human rights and fundamental freedoms, rather than viewing human security as merely the *absence of threat* (ICISS, 2001). Accordingly, at its minimum, human security implies the provision of basic material needs, including food, shelter, education, and health care (Thomas, 2001). Another serious criticism of this approach emanate from the often sweeping conceptualization of human security, in that there is a consequential lack of prioritization of threats. Paris (2001) questions the efficacy of this approach, particularly with respect to the UN’s notions of human security. He notes that considering threats as “equally valid” may in effect damage the call to action respecting HIV/AIDS. If threats of all types are all considered important, how does one prioritize urgency?<sup>24</sup>

This paper has, in some senses, bridged a realist interpretation of the security aspect of the HIV/AIDS pandemic with a human security perspective. It has argued that HIV/AIDS epidemics, particularly in sub-Saharan Africa, reveal linkages between individual, community, and state security, and that these linkages operate as a feedback loop which drive HIV/AIDS epidemics and undermine human and state security. This paper demonstrates that AIDS cannot be ignored as a state/international security issue, despite the criticisms with the securitization approach.<sup>25</sup> Furthermore, it cannot be ignored as a humanitarian and human security issue. This paper responds to the question

<sup>23</sup> Hampson, Fen Osler, and Hay, John, *Human Security: A Review if the Scholarly Literature*

<sup>24</sup> Roland Paris, “Human Security: Paradigm Shift or Hot Air?”, 2001, p. 89, 92

<sup>25</sup> See O’Manique (2004), for an interesting discussion and critique of the securitization approach to HIV/AIDS.

posed by O'Manique (2004) of 'whose security are we talking about?' This paper argues that we cannot analytically or practically disentangle state from human *or* human from state security. In the context of HIV/AIDS epidemics in sub-Saharan Africa, women's security (or insecurity) creates impacts for state security that feedback and drive the epidemic. Conversely, state insecurity, conflict, and diminished governance capacity inevitably creates significant and disproportionate impacts for women. With HIV/AIDS, everyone's security is compromised: the individual, the community, and the state. Thus, a strictly securitization approach to HIV/AIDS fails to recognize the power and social relations which structure state behaviour and impacts. Further, while a human security analysis focuses on the more micro and meso level dynamics of HIV/AIDS, it fails to adequately incorporate the macro level dynamics which feedback into micro and meso level impacts and dynamics. Figure 5 (page 17) refers to 'mediating factors' in the feedback loop between individual, community, and state security. These mediating factors offer an important starting point for future research on the linkages between individual and state security. For example, what are the factors that will support risk reduction for the individual, and particularly women? What types of policy and program interventions will mitigate against individual, community and state impacts of HIV/AIDS? For example, what types of interventions help to reduce women's risk of infection and impact from HIV/AIDS? What interventions exist to address the needs of orphans, women, and girl-children? What are the resource needs of individuals, communities, and states to support and sustain social and public institutions? How have states responded to women's disproportionate risks of HIV/AIDS infection and impact? How can international and state responses reflect and respond to the gendered nature of HIV/AIDS transmission and impact? These and other questions which connect individual to state security and vice versa offer a starting point for developing public policy and other interventions to address the multi-levelled nature and impacts of HIV/AIDS, with significantly increased attention afforded to the gendered nature and expression of the pandemic.

## Conclusions

Social science theories on gender often fail to include sex and sexuality in their analyses. Gupta (2000) notes that the public health discourse has made more progress in terms of including sex and sexuality. Political science has been slow to respond to the HIV/AIDS pandemic. Boone & Batsell (2001) suggest that political scientists may perceive HIV/AIDS as "too private, too biological, too micro level and sociological, too behavioural and too cultural" (4). This paper demonstrates that HIV/AIDS is political, both in terms of its roots and impacts. Furthermore, political science theories, including social constructivism, critical theories, feminist theories, and post-modernist theories have the potential to yield important insights into the complex relations of gender, power sexuality and health. This paper has shown how the securitization approach draws our attention to the state and international level impacts of the HIV/AIDS pandemic, while the human security approach focuses its attention on the human and material needs of people living with or affected by HIV/AIDS. It has also revealed that there are shortcomings in both approaches to the HIV/AIDS pandemic; one ignores the human dimension of disease and is ontologically insensitive to the individual/community, while



the other, in its attempt to expand the definition of 'security' has tended to ignore how macro (particularly, non-domestic or external) level relations interplay with micro and meso level dynamics. Thus, further theoretical and empirical work on the interplay between local, regional, national, and global dynamics needs to be explored. This paper has restricted its analysis to the impact of HIV/AIDS on the state, particularly intra-state social stability and conflict. However, there are obvious implications for regional and global security and stability that could be explored in future research. Particularly important is the need to connect these processes to human security and well-being.

Initially treated as residing solely as a health issue, researchers and decision makers now perceive and project the extensive social, political and economic implications of HIV/AIDS, including its ability to generate conflict. Social science research must continue to investigate the social, economic and political roots and expressions of HIV/AIDS in developing countries with a view to revealing social, political and economic changes that support impact mitigation and eventual eradication of this devastating pandemic. Two specific areas requiring urgent attention by the community are the cyclic effect of HIV/AIDS induced conflict and its impacts on women. In short, if we do not understand how women are inherently disproportionately affected by HIV/AIDS and by conflict, we will fail to recognize and address the vulnerabilities of women when both present simultaneously. This has obvious implications for public policy, programming and international collective action. Though the issues raised in this paper are complex, the fundamental need to maintain human dignity in the face of this pandemic is crucial. Ignoring the gendered nature of this disease, and its potential to create conflict and social instability will inevitably contribute to more human suffering and accelerate the destructive impacts of HIV/AIDS.

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