Gender, HIV/AIDS and Security

A WISCOMP Forum

Chennai, India
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The Forum Report

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The HIV/AIDS pandemic is a multi-dimensional global crisis. It was first read as a public health crisis, after which its developmental aspects began to be recognized. Its gender dimensions are now well-documented across the world. Security analysts have recently begun to map the multiple levels of the insecurity crisis caused by the spread of HIV/AIDS. The objective of the WISCOMP Forum was to define the security crisis caused by HIV/AIDS in India, highlighting the experience of women as part of that definition.

ABOUT THE WISCOMP FORUM SERIES

Non-traditional formulations of and approaches to security have formed a central part of WISCOMP’s research agenda. The twin exercises of redefining ‘security’ and delimiting the scope of security discourse and policy entail searching beyond familiar and the self-evident subjects.

The WISCOMP Forum Series was designed as a series of structured conversations on specific issues, intended as an exploratory exercise for WISCOMP’s non-traditional security research agenda. The Forum Series raised new issues and new perspectives in this work.

A select and small group of practitioners and scholars were invited to submit in advance, extremely brief, 2-4 page essays highlighting issues, challenges, perspectives/ programs and sharing their experiences. These were compiled and circulated among the entire list of invited participants to enable the sessions to move forward. Those invited to submit essays led the discussion in their own sessions with very succinct ideas that created a framework for the discussion.

Since its inception, Chaitanya – The Policy Consultancy in Chennai has organized the series for WISCOMP. The first Forum was on Disasters and Security, held in September 2006.
FORUM IN PERSPECTIVE

In the last two decades, in the field of security studies, definitional debates have accommodated concerns and issues not traditional within its purview, adding new lenses such as gender to the analytical toolbox. There is a gender dimension to HIV/AIDS and a gender dimension to security; what is the interface between the two in the Indian context?

There is a growing body of literature, primarily commissioned reports like the one jointly commissioned by NACO, NCAER and UNDP, on Gender and HIV/AIDS in India. A few UN statements and a handful of Western studies have forged a connection between the HIV/AIDS epidemic and security, whether national or human security. Moreover, as there is a gender dimension to HIV/AIDS, the forefront of WISCOMP’s efforts has been to en-gender security. The pivotal question around which the WISCOMP Forum on Gender, HIV/AIDS and Security was organized was: Where do gender, HIV/AIDS and security intersect in the Indian context?

It is probably most efficient to first clarify what the WISCOMP Forum was not about. The Forum did not seek to map the advance of the HIV/AIDS epidemic in India, or to assess the effectiveness of the response by state or civil society in India. Our interest was in stepping back a little from both those exercises, undertaken ably by others, to look at HIV/AIDS through the two lenses of gender and security.

HIV/AIDS in India

The first case of HIV was detected in Chennai in 1986 (PFI 2003:12). Two decades later, it was estimated by the National AIDS Control Organization that 36% of India’s population, which translates into a far more significant-sounding 2 to 3.1 million people, are living with HIV (UNAIDS Press Release July 7, 2007).

According to NACO, of the reported AIDS cases in India, HIV spread most through sexual contact (85.3%) as of 2003. Mother-to-child transmission, blood transfusions and needle-sharing drug use follow distantly at around 2.5% each. (PFI 2003:16). Six states have been identified as hardest hit: Tamil Nadu, Maharashtra, Andhra Pradesh, Karnataka, Manipur and Nagaland, in that order (PFI 2003:17). Ignorance remains the greatest facilitator of the disease, being higher among women across states and urban-rural populations.

It is believed that there is a difference between the way HIV has spread in Sub-Saharan Africa, which forms the basis of most studies and reports on this subject, and the way it spreads in India. It is recommended that HIV prevention efforts in India centre on high-risk population groups –
sex workers, men who have sex with men, migrant workers, truckers, people with other sexually transmitted diseases and needle-sharing drug-users (George Institute India 2007).

While HIV/AIDS is essentially a public health issue, the WISCOMP Forum highlighted the potential security concerns related to the epidemic, paying particular attention to its impact on women.

**HIV/AIDS and Security**

In 2000, the United Nations Security Council recognized HIV/AIDS as a potential global security threat if unchecked (UNSC Resolution 1308). The resolution refers to “social instability and emergency situations”, while recognizing that violence and instability exacerbate the spread of the disease. Writing about HIV/AIDS as a human security issue, Ulf Kristofferson wrote of two dimensions to this relationship: “One is the threat to socio-economic development and the other is the threat to human survival... The HIV epidemic has a great capacity to magnify all the social problems of the environment in which it occurs.” (2000:2-3)

In a 2003 study for Population Action International, Cincotta, Engelman and Anastacion argued that the positive correlation between demographic transition stages and the presence of civil conflict justified the inclusion of demographic analysis into security assessments. History has shown that while societies that stabilize the birth and death rate at low levels experience stability and some prosperity, high birth and death rates place societies at risk for civil conflict. In our time, this study identifies four stress factors that precipitate such a situation, and states that sub-Saharan Africa, the Middle East and South Asia are most vulnerable.

What are these stress factors? The first stress factor is found when 15-29 year olds constitute more than a third of the population. This happens usually when high fertility coincides with declining infant mortality. The higher the percentage the greater the onus on society to provide health care, education and jobs for them; failure to provide this creates a generation of underemployed, and frustrated citizens. Where the status of women is low, a preponderance of young males worsens the problem. Rapid urbanization that arises from growing shortages of arable land and fresh water, are the third and fourth factor respectively. The last stress factor is important, however, purely for its demographic impact: HIV/AIDS.

Cincotta, Engelman and Anastacion (2003:69) point to sub-Saharan Africa’s experience where in one decade large numbers of skilled technical and professional workers have contracted and died of HIV/AIDS. This places a tremendous strain on society, which has to take care of (and bear expenses for) the sick, as well as train replacements for the dying and dead. This incapacitates both private and public sectors. The dependency ratio of societies (those too young and old to work) affected by large numbers of AIDS deaths can further destabilize society. The tragic reality of swelling numbers of AIDS
orphans is identified as a ‘source of future urban discontent, criminal activity, and recruits for insurgencies or police states.’

In 2005, the US think-tank, Council on Foreign Relations commissioned a study on HIV and National Security, which is the most systematic and comprehensive study so far of the impact of HIV on the security of states. The author begins by comparing the HIV/AIDS pandemic to the Black Death, the plague that swept through Europe in the fourteenth century, in terms of its devastating long-term societal impact. In the contemporary context, Garrett’s primary interest is in the security sector of the state, narrowly construed as the armed forces and decision-making elite.

Writing about how armed forces around the world have been affected, Garrett draws four conclusions (2005:29):

1. In states hardest hit by the pandemic, the armed forces will be at least as affected as the population at large;
2. It becomes difficult to replace infected and dying soldiers with healthy ones as the infection spreads in society;
3. Disparities in access to lifesaving medications that favour the upper ranks of the military could create resentment and spark rebellion;
4. Deployment needs might interrupt treatment of infected soldiers.

Soldiers posted close to home show infection rates similar to those of their society, but when posted far away, the infection rates are much higher. UN Peacekeepers, especially when posted to hard-hit areas, are thus especially vulnerable; moreover, sexual misconduct or carelessness on their part can spread the infection beyond where they are posted. This has in turn the consequence of lowering the capacity and credibility of the UN presence in conflict zones (2005:31-33).

Conflict per se, Garrett writes, does not increase transmission; it is the use of rape as a weapon of war, and in the moment of transition from conflict to peace, when people regain their mobility and move across conflict zones to resume normal living, that HIV spreads (Garrett 2005: 9-10). Garrett also points to accusations levelled by Libya that Bulgarian agents infected children in a Libyan hospital with HIV, and flags a new instrument both of terror and diplomacy. While Garrett’s first emphasis is on the armed forces, she says that it is political and social instability that is most feared, leading states to act not against the virus but by those it infects (2005:40).

Stuart Watson (2006) delineates four aspects of the HIV/AIDS security challenge in a presentation to an UNAIDS workshop. The defence dimension for him, is in the impact of the HIV/AIDS epidemic on armed forces: the loss of skilled personnel, fewer healthy peacekeepers, difficulty of recruiting healthy
candidates and finally, the discontinuity in the military command when officers die. He does not consider the part played by armies, in peacekeeping and other operations, in the spread of the disease. The second dimension Watson lists is the social, wherein he includes ruptures in schooling due either to fewer teachers being available or children being removed from school; a strained health care system, with overstretched budgets and staff losses; and finally, orphaned children and families whose care burdens increase. Disruptions in the political process, loss of technocrats and institutional knowledge and ultimately, an erosion of political legitimacy constitute the political dimension, according to Watson. Reductions in investment, labour force depletion, high turnover and overall productivity at the level of the economy and the illness of family breadwinners are the economic dimension.

Whether we define security narrowly in terms of conflict and armies or broadly as human security, HIV/AIDS poses a challenge to society, and not just within the confines of state borders. For the WISCOMP Forum, two questions emerged:

1. How do we define the gender dimension of the security challenge that is posed by HIV/AIDS?
2. How does the above description of HIV/AIDS as insecurity apply to the Indian context?

The Gender Dimensions of HIV/AIDS and Women

Globally, the numbers of men and women living with HIV are almost equal; in Africa, the Middle East and the Caribbean, they are beginning to outnumber men (WHO 2003:1).

Existing gender inequalities reinforce HIV vulnerability. Women make up the majority of the world’s poor and illiterate. They receive less pay for the same work as men. Their access to proper health care remains a function of poverty, malnutrition and patriarchal attitudes that limit women’s learning and ability to make decisions for themselves. If these structural factors exacerbate women’s vulnerability to HIV and limit their agency in avoiding infection, HIV in turn reinforces the unequal status of women in most societies, developed or developing.

Women start off at a physical disadvantage when it comes to contracting HIV/AIDS as it is easier for a woman to be infected as a result of sexual contact than it is for a man (WHO 2003:2). Moreover, complications related to pregnancy necessitating blood transfusions can expose women to the infection. Breastfeeding is not possible for women living with HIV/AIDS, and using formula might also expose them to stigma as it marks them as positive women. This section highlights ways, beyond the point of departure limitations placed by biology, in which this downward spiral can manifest.
From inequity to HIV/AIDS

• The continuing ignorance of girls and women about safe sex, sexual relationships and HIV/AIDS leaves them unable to protect themselves against infection (Sy 2001:2).

• In patriarchal societies, men sometimes learn to measure their worth in terms of their virility. In such settings, the need to keep up appearances may preclude their getting the right information about safe sex and condom use, exposing an ever-growing circle to infection.
  o Early marriage of girls to older men, which is the norm in traditional societies, can also pose the threat of infection.
  o “For many women, being vulnerable to HIV can simply mean being married.” (WHO 2003:2) While men’s sexual promiscuity is acceptable, women are not even able to negotiate safe sex practices, it does not matter that the women are not promiscuous.

• “Sex-for-survival”, whether in the context of poverty, conflict or displacement, constrains a woman’s ability to choose when sex takes places and to choose safe sex.

• Violence against women is more common than most people believe, and the threat of violence discourages women from asking for condom use or negotiating any other aspect of their interaction. Sy identifies the following groups as especially vulnerable: women known or suspected to be HIV positive, young women and girls, sex workers, trafficked women, street children and AIDS orphans (2001:6).

• In conflict zones, systems of social security break down.
  o Children, both boys and girls, are in danger of being recruited as child soldiers, used also for sexual services and therefore exposed to HIV infection.
  o Rape, systematically used in some conflicts as a weapon of war, spreads HIV/AIDS through acts of violence on girls and women who may survive to live with the disease. In Rwanda, Sy says around 5000 women have borne and abandoned children after being raped during the genocide (2001:5).
  o Women and girls bartering sex for food or medicines from occupying or peacekeeping forces could infect or be infected.

From HIV/AIDS to further inequity

• Individuals and families where the breadwinner is infected are pushed into poverty when they are unable to work and have to spend money on medicines and lose the support of their community.
• Gendered impact on families:
  o When women fall ill, the family’s food security is affected.
  o As women are the primary caregivers in most families, it is likely that the schooling of girls is interrupted to assist with the woman’s extra burden.

• Women’s access to treatment and care are both likely to be limited. They may hesitate to get tested without the consent of their partners or even disclose that they are HIV positive.

• Grandparents, especially grandmothers, resume a parenting role when both parents are lost to HIV/AIDS. Lacking resources, physical strength and family support, this poses an enormous challenge to them. Here, it has been seen in India, that where grandparents choose, they choose HIV-negative grandsons over grand-daughters (Pradhan and Sundar 2006:116).

• Stigma and discrimination stemming from HIV/AIDS infections is more likely to affect women because social norms regarding women’s behaviour are usually more conservative and women tend to be economically weaker. An important Indian study underscores this in the context of HIV-positive widows, who are driven to sex work in the absence of other income-generating options (Pradhan and Sundar 2006:115-16).

From the point of view of the WISCOMP Forum, the challenge was to filter these observations, derived mostly from African cases, to see:

1. How many of these observations obtain in India as well and in what way?
2. Which of these gender-related issues may also be defined as security concerns relating to the HIV/AIDS epidemic?

**The Forum Problematic**

HIV/AIDS devastates societies over a period of time; so do famine and disaster. Where in the spread and containment of the epidemic do we draw the line and say, this impinges on societal, state or individual security? In particular, while acknowledging that HIV reinforces existing insecurities, we must ensure that our understanding of that includes the insecurities experienced by women.

While the term gender is used to suggest that there are ramifications for men and women, the focus of this Forum was largely on women. Existing case studies and reports show how structural context shapes the vulnerability of women to HIV/AIDS and also how the infection in turn aggravates their situation. We asked which of these factors and consequences may be defined as a source of security or insecurity, for women and for society at large. The answer would help us define the gender dimension of the security challenge that is posed by the HIV/AIDS epidemic.
Those who would redefine the scope of the term ‘security’ sometimes take it to mean ‘freedom from want’ and ‘freedom from fear’.1 In keeping with this, we structured the discussion at the Forum around two pivots:

1. The nature of the latent human security problem in the gender-HIV/AIDS interface in India;
2. The ways in which violence, conflict and security makes worse the HIV/AIDS epidemic, increasing the vulnerability of women and girls.

Structured conversations, the WISCOMP Forum Series hallmark, were scheduled across five related areas of the problematic:

1. The development, security and HIV/AIDS interface
2. HIV/AIDS and food and livelihood security
3. The HIV/AIDS Public Health Crisis, gender and security
4. Violence against women
5. Conflict, HIV/AIDS and gender

**GENDER, HIV/AIDS AND SECURITY: THE INTERFACE IN INDIA**

**1. The development, security and HIV/AIDS interface**

One of the lessons learnt in the last two decades is that the spread of HIV/AIDS is definitely facilitated by structural factors such as poverty, patriarchy and conflict. Development strategies and programs seek to create structural change in a society. Where they have failed to a great measure, the spread of HIV/AIDS has been greater; where the spread of HIV/AIDS has been greatest, there has been a reversal of development gains.

Gillespie, Kadiyala and Greener (2007) found in a recent study that in the early stages of the epidemic, the well-to-do, educated classes who have greater personal freedom are more likely to be vulnerable to HIV. However, as the epidemic advances, this class learns to stay safe, and it is the poorer sections of society that remain most vulnerable. Economic necessity, they feel, drives risky behaviour. Their study identifies three mediating factors: gender inequalities, mobility and the societal environment (they call it “socio-ecology”) in which HIV spreads. All three are altered by successful development initiatives.

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1 Elhadj Sy: “Human security presumes freedom from want and from fear, as well as access to and control of resources and opportunities. The basic elements of human security include survival, safety, opportunity, dignity, agency and autonomy. These preconditions for human security are essential in reducing vulnerability to HIV infection and its impact... Those most deprived of these needs are themselves most highly vulnerable to HIV infection and most disadvantaged in coping with its impact.” (2001:1)
What is clear is that as HIV takes its toll over a decade or so, developmental change is slowed, halted and reversed. A UN Fact Sheet summarizes:

“By killing so many people in the prime of their lives, AIDS poses a serious threat to development. By reducing growth, weakening governance, destroying human capital, discouraging investment and eroding productivity, AIDS undermines countries’ efforts to reduce poverty and improve living standards.” (HIV/AIDS and Development 2001)

The African experience substantiates this observation. HIV prevalence ranges from 10-30% in many states, slowing economic progress significantly as most of those who die are in their productive years. Those who are already poor are further impoverished by the cost of treatment (and funerals), the loss of jobs, the need to provide home-care and the shrinking of the macro-economic pie, and those who are in the middle class are pushed into poverty. The UN Fact Sheet quotes estimates that the percentage of people living in poverty has increased by over 5%. Growing poverty is likely to push people to migration, make them vulnerable to trafficking and to commercial sex work; in such circumstances, they are open to exploitation and also to infection.

HIV/AIDS affects all sections and sectors equally; societies that are hard hit watch the decimation of their skilled, professional and technical labour. There is a high bill for health care benefits to be provided and with growing numbers of AIDS orphans, that of child-care as well. Illness-related absenteeism and health care costs affect public and private sectors equally. The result is less money available for investments in education, agriculture, irrigation, infrastructure and industry. The reduced investment in agriculture deepens the public health crisis by worsening malnutrition.

HIV/AIDS thus has the impact of pushing a society quickly to a downward spiral where the hard-won gains of development efforts are eroded and developmental failures magnified to catastrophic levels.

For the WISCOMP Forum, the salient questions were:

- What have been the important markers of the development-HIV/AIDS relationship in India?
- What are the security consequences of this relationship?
- In future, which consequences in India will prove critical enough to merit treatment today on par with traditional security imperatives?

2. HIV/AIDS and Food & Livelihood Security

Several factors relating to the HIV/AIDS pandemic create a food and livelihood security crisis in hard hit societies. First, households are impoverished by the illness and death of breadwinners, the pulling out of the labour force to provide care and the shrinking of household income. Second, high health care costs shrink expenditures under other heads in the social and economic sectors.
Rural communities can be particularly hard hit on two counts. First, ignorance about HIV/AIDS is greater in rural communities. In a 2001 survey reported by the PFI Chartbook on HIV/AIDS in India (2003), 89.4% of those interviewed in urban areas had heard of the disease as opposed to 72.3% in rural areas. Among women, this difference is even more dramatic, illustrated most starkly in Bihar: while 62.8% of urban women surveyed had heard of HIV/AIDS only 21.5% of rural women had. Secondly, migrant workers, who are at risk anyway, are prone to return home when the disease affects them. The burden of care increases disproportionately, as well as the risk of the infection spreading to new precincts.

Loss of labour due to HIV/AIDS in the agricultural sector goes beyond cultivators to those who work in auxiliary areas, like irrigation, research, credit, warehousing and distribution (HIV/AIDS, Food Security and Rural Development 2001). The sale and slaughter of livestock and other productive assets to meet expenses diminishes the food and livelihood security of families that must meet the care and nutrition needs of more members as relatives fall ill and children are orphaned.

The livelihood security crisis is magnified by the discrimination faced by HIV-positive persons. HIV screening, barriers to professional growth and exclusion from social benefits are some forms of discrimination, as are breaches of confidentiality. At another end, as families and networks of care grow, the very young and the very old are pulled back into the workforce out of necessity (HIV/AIDS and the World of Work 2001). Desperation leaves them open to working in conditions that do not conform to safety or human rights standards.

The conversation at the WISCOMP Forum on the question of food and livelihood security in the shadow of HIV/AIDS centred on the following questions:

• What are the dimensions, present and potential, of the food and livelihood crises in India?
• What is the degree and nature of mutual engagement between those working in the areas of food and livelihood security on the one hand and HIV/AIDS policy on the other?
• What might be the threshold at which the food and livelihood crises may be classified as security crises?

3. The HIV/AIDS Public Health Crisis, Gender and Security

Laurie Garrett describes HIV/AIDS as “death in slow motion” (2005). She graphs the progress of the epidemic in waves: a first wave of “infection, followed years later by waves of acute disease, and years after that by waves of death and family disruption.” The waves do not occur in quick succession so the trauma to society never really ends, and this new scourge adds to the burden in societies that have not yet dealt with health challenges stemming from poverty, malnutrition, lack of sanitation and clean water and an absence of basic health care.
There are various dimensions of the HIV/AIDS public health crisis.

- A decline in life expectancy and increase in infant mortality that reverse the hard-won gains of several decades of development work that has taken improvements in health care to different sections of society.

- An increase in the incidence of secondary infections like tuberculosis. Scarce resources are then further stretched.

- The circumstances that make women vulnerable to HIV/AIDS regardless of their situation also draw our attention to pregnancy and mother-to-child transmission. All too often, this means that HIV tests, prophylactics and care are administered through clinics dealing with women’s reproductive health.

- The cost of anti-retroviral therapy (ART) is a key factor in pushing families towards poverty, as also where they are provided through the public health system. It also means that lack of family resources limit access to medicines and in the hierarchy of the patriarchal family, women do not get enough care to make a difference.

- Increasing levels of poverty and malnutrition also contribute to poor health across classes.

- In places like India, where the public health system is inadequate for the magnitude of society’s needs, the burden of care falls squarely on the shoulders of the community, families in particular. 90% of the care is given at home by women, it is estimated (NACO 2006: 33) that a large percentage of caregivers are HIV-positive.

Two questions animated the conversation on these issues at the WISCOMP Forum:

- What are the most pressing issues, from a security perspective, to the public health crisis posed by HIV/AIDS?

- What is the difference, if any, between this public health crisis’ security implications and that of others like SARS or plague?

4. Violence Against Women

The World Health Organization classifies violence against women as a public health problem (WHO 2005). One in four women experiences violence at the hands of an intimate partner or family member; beyond the so-called safe confines of home and close relationships, women also face violence from strangers in public spaces, in workplaces and in conflict situations. Studies have shown that women who experience violence are more likely to be infected than others (IDS Health and Development Team). Ignorance about sex and about differentiating between consensual sex and violence and the inability to negotiate condom use are some factors contributing to this situation.
Sometimes being diagnosed with HIV/AIDS becomes the reason why women experience violence. This acts as a deterrent to their seeking testing or treatment, from participating in pre-natal treatment programs and from following doctor’s instructions correctly.

The inability to support themselves acts a reason for women to stay in or return to violent, abusive relationships. The same reason also leads them to other situations where they cannot negotiate their own safety. Trafficking is one of them. When people move, they are moved out of their original community support systems. Trafficking is coerced mobility that reflects an unequal power relationship between the person so helpless as to be bought/sold and the purchaser or abductor. Both trafficking and HIV victims are stigmatised and when the trafficked woman or girl contracts HIV, the stigma multiplies (Youandaids.org, Trafficking 2007).

The session on violence against women and HIV at the WISCOMP Forum raised questions relating to domestic violence, rape and trafficking, asking:

- Are there particular and peculiar ways in which these forms of gender-based violence and the spread of HIV/AIDS intersect in India?
- How do we presently view the intersect between security and violence against women in the Indian context, and how does the overlay of the HIV/AIDS epidemic alter the picture?
- Does the VAW-HIV connection reinforce the case for including VAW in the purview of ‘security’?

5. Conflict, HIV/AIDS and Gender

Save the Children characterized the coincidence of HIV and conflict as a “double emergency”. The sub-heading of their 2002 field report on this double emergency was: “Without war, we could fight AIDS.” All the consequences of violent conflict facilitate the spread of and worsen the impact of the HIV/AIDS pandemic:

- Displacement;
- The breakdown of administration, law and order, and family and community systems;
- The use of gender-based violence as an instrument of war;
- Abduction and rape;
- Recruitment into rebel armies;
- Trafficking; and
- The inter-continental spread of the disease through peacekeepers posted away from their homes.
Transitional administrations at times of post-conflict changes are often unable to guarantee safety to women and girls who find themselves insecure in a moment they expect to be safe.

The use of rape as a weapon of war has received attention for its part in hurting thousands of women in conflict settings like Rwanda and Bosnia. The militarising effect of conflict and the helplessness of emergency situations all increase the propensity to violent behaviour. In addition, to those displaced by war or living in an area where common arrangements have broken down, there is no access to prophylactics or to treatment. By recognizing rape as an instrument of war, society now allows investigation and prosecution into such cases in post-conflict transition periods. However, where both the culprit and the victim are infected, any judgment meted out by a transitional court or a truth commission is empty; neither may be well enough for it to be meaningful.

The WISCOMP Forum explored the conflict-HIV interplay in the Indian context, in three settings: Indian troops serving as UN peacekeepers; conflict zones in Kashmir and north-eastern India; and finally, in the areas where the Maoists are active.

- What do we know about HIV prevalence in the Indian armed forces and police?
- What are the education and health care programs in place to prevent them from going the way of so many African forces?
- What do we know about the conflict-HIV correlation in India’s conflict zones?
ISSUES RAISED BY THE FORUM

There were three central questions that formed the point of departure for the forum. These were:

• What is the impact of HIV on security?
• What is the impact of security on HIV?
• How do these mirror who we are?

However the questions were addressed only tangentially. This section offers an interpretive and analytical summary of the issues that were raised by Forum participants.

Welfare, Development, Security

The Forum discussions highlighted the close relationship between social welfare and the ability to minimize citizens’ risks of poverty, violence and therefore, disease.

• Our social welfare priorities are directly related to the spread of HIV/AIDS. Poverty, unsupportive social structures and patriarchy create a situation for women and girls from where they are vulnerable to trafficking. This is the most appropriate point of intervention in dealing with HIV/AIDS.

• Poverty and hunger place girls and women at risk in many ways, but once they are infected with HIV/AIDS, the challenge increases manifold. In addition to providing access to anti-retroviral therapies, access to good nutrition remains the other big test. This is because it is even harder to find a job and earn a livelihood with a positive status than it is when uninfected. In other words, access to nutrition and livelihood, which may be difficult to provide, becomes far more difficult to assure with the onset of the disease. From the point of view of both individual and society, food and livelihood security are vital components at both the preventive and the coping stages of the HIV/AIDS epidemic.

Patriarchy

Participants returned time and again to the workings of patriarchy in creating and reinforcing vulnerabilities, for women and men.

• Patriarchy pervades the legal structures and instruments of a state, for example, property law.
• As one participant put it, “Protection is also a form of patriarchy”. A policy paradigm that places at its centre protection of women rather than giving them information, skills and support, is also a form of patriarchy.

• Discussions of gender become discussions about women. Two issues were raised: that of expanding the discussion to include men; and that of bringing more men to the table when discussing women and gender.

**Public Health**

The forum discussions brought to light broader public health dilemmas as well as specific technical concerns.

• The strategy of targeted intervention to make treatment available to specific high-risk groups was critiqued. “Targeted intervention” invokes the politics of inclusion and exclusion and bears examination on those grounds.

• As the health sector is increasingly privatised, the impact of market forces on access to information, prevention and treatment remain to be studied. The issue was raised but not discussed at the forum.

• The sources of stigma and the impact of stigma on the ability to rebuild life after being diagnosed as HIV+, to seek testing or treatment and to be able to meet day-to-day needs were discussed across sessions. Like that of targeted intervention, the question of stigma too echoes broader issues of integration and discrimination in any polity.

*Swarna Rajagopalan opens discussion on Gender dimensions of HIV/AIDS in India*
• As the HIV/AIDS epidemic matures, the pharmaceutical industry, and society at large, must face the challenge posed by the emergence of drug-resistant strains of the virus. Keeping research and development ahead of this, and making sure that adequate and reasonable supplies of drugs are made available are likely to become economic and political flashpoints.

**Governance**

• Governance failure creates conditions in which HIV/AIDS can spread. However, the reverse relationship is not as easy to establish. It was suggested that spread of the disease and resulting absenteeism could weaken institutions over time.

**Complex emergencies and HIV**

Some of the situations and problems described by the Forum participants suggested that HIV/AIDS epidemic is not unlike other complex emergencies like disasters or war.

• Like other complex emergencies, the HIV/AIDS epidemic alters social equations in areas of high prevalence and creates new insecurities.

• The discussion about rebuilding the lives of those whose families are affected by HIV/AIDS runs quite similar to the discussions about the right of refugees to return to their home country.
What it means to live a ‘normal’ life after your life has been turned upside down by HIV/AIDS or a positive diagnosis is not unlike what disaster or conflict victims or the displaced experience. This suggests avenues of comparative analysis between these instances and potentially lessons to learn.

**Conflict**

Conflict and conflict-induced displacement generate new sources of vulnerability.

- The question of access to treatment is a critical one in this context. When treatment is paid for by a government, funded by tax-payers, how does a refugee access treatment in a foreign country?
- Refugees who are infected while displaced may not be allowed to return to their home-states if an HIV test is imposed as a precondition to return. What is to be their fate?

Thus, HIV/AIDS raises new questions about boundaries and citizenship, and potentially who belongs gets articulated in terms of first entitlement to testing and treatment.

**Violence**

The common thread to all the sessions was violence.

- The importance of understanding what one speaker termed the “abuse-desire” continuum was reiterated in session after session.
- The inside-outside distinction in public policy means there has traditionally been a reluctance on the part of the state and policy community to cross the threshold of the home and take cognisance of violence within the house. Women and children are at greater risk of violence within the home than without.
- Vulnerability to HIV/AIDS is linked to physical abuse, including child sexual abuse. The silence that surrounds physical, particularly sexual abuse, has an adverse effect on prevention efforts.
- Desperation, greed and violence conspire to facilitate the trafficking of women and children. Continuing to be defenceless, those who are trafficked are not in a position to protect themselves from the risk of HIV infection.
- Violence by the state’s armed forces – its causes, its investigation and punishment and transparency and accountability issues – were discussed at the Forum. The linkage between the uniform, power (and its abuse) and violence was made in this context.
Security-HIV Relationship

Most Forum participants associated the term ‘security’ with the nation-state and as such were hesitant to read security implications from HIV/AIDS or the other way around.

- In session after session, Forum participants were primarily interested in the fate of individuals, individual stories and solutions for individuals. Making the individual the referent of ‘security’, as human security scholarship does, would make it easier from the point of HIV/AIDS activists and scholars to make the connection between the epidemic and ‘security.’

- The scale of the epidemic determines the level of its impact, and therefore, the various units or levels of analysis that we could adopt. The smaller and more localized the spread of the disease, the harder it is to imagine posing questions about security beyond the level of the individual and the community. As the epidemic matures, it affects more people and larger categories such as the economy and society.

- Thinking about HIV/AIDS and security reinforces the idea that in South Asia, the family is almost always a salient analytical unit for the study of security. The first impact of HIV/AIDS is on the patient and the patient’s family, and the family either faces the impact of the disease together or ostracises the patient. Either way, it is affected by the positive diagnosis of HIV/AIDS.

- HIV/AIDS poses a survival threat to communities where the infection is widely spread.

The discussions highlighted another issue, that of the very utility (or not) of trying to link HIV/AIDS to security.

- The inclusion of HIV/AIDS into the security agenda gives administrators, analysts and advocates a way to also include issues relating to food and livelihood security, public health, violence against women and economics into their agenda. Bringing security into the HIV/AIDS agenda opens conversations about state power, globalisation and migration into the debates surrounding the spread and curtailment of the disease.

- Securitisation increases the importance given to a particular issue. Thus, to answer the question, “Is HIV a Security Issue?” in the affirmative, is to increase the attention and resources devoted to it manifold. However, the other consequence of securitisation is that it depoliticises issues. Taking HIV/AIDS out of the political realm is to stifle the already muffled discussion about social factors, economic structures and politics that relate to the epidemic. To this end, securitisation of any issue is singularly undesirable.

- A human security perspective on HIV/AIDS is also a human rights perspective. In practice, securitisation usually runs contrary to human rights approaches.
While the analytical universe of ‘security’ now extends to include a wide range of issues, in the realm of governance, security issues are dealt with by the armed forces and law enforcement and small select sections of the bureaucracy. For such an issue as HIV/AIDS, these are neither appropriate nor qualified agents. There is a proliferation of actors so that it is hard to pinpoint responsibility and this reinforces the tendency to depoliticise and classify information. In the case of HIV/AIDS, this could be lethal to thousands.
A SUMMARY OF THE SESSIONS

Session I

GENDER DIMENSIONS OF HIV/AIDS IN INDIA

The Forum Concept Paper posed two questions to orient the discussion in this session.

- How many of the observations made about the relationship between gender inequity and HIV/AIDS obtain in India as well and in what way?
- Which of these gender-related issues may also be defined as security concerns relating to the HIV/AIDS epidemic?

In the briefs that they submitted, the two invited discussion leaders for the session drew attention to social security issues relating to food and livelihood security, medical expenses, disrupted education of children, violence, and denial of rights, stigma and discrimination. Primarily addressing the problems of women, both experts were concerned with the creation of social security safety nets.

Such safety nets should not just deal with access to anti-retroviral therapies in the public health system but also in the private sector, and they should go beyond making drugs accessible to assuring quality care. They should address concerns like widow pension, life and health insurance policy. Finally, whether disasters or conflicts, all complex emergencies pose particular challenges to social security. The displaced have no papers and an ambivalent legal status that makes their access to health care problematic and re-entry into their countries complicated. The need to survive makes women and girls more vulnerable – to forced marriages to infected men, to violence, to take care with diminishing household incomes of families left behind by others. Stigma and discrimination make it hard for them to seek help. In spite of this, positive women face their lot with fortitude and courage.

The session on Gender Dimensions of HIV/AIDS was merged into subsequent sessions for time management reasons. Both speakers opened discussion sessions with extended commentaries in place of their own session. The complexity of issues made the distinctions between sessions virtually irrelevant in any case.

(L-R) Millie Nihila, Shyamala Ashok, Uma Vangal
Session II

THE DEVELOPMENT, SECURITY AND HIV/AIDS INTERFACE

The framework for discussing the mutual impact of development, security and HIV/AIDS raised the following questions:

- What have been the important markers of the development-HIV/AIDS relationship in India?
- What are the security consequences of this relationship?
- In future, which consequences in India will prove critical enough to merit treatment today on par with traditional security imperatives?

Challenges associated with the prevention and treatment of the HIV/AIDS epidemic reflect but are also a subset of Indian society’s gender and governance challenges. The discussion in this session amplified the following concerns:

1. “Gender” in a discussion on gender and HIV/AIDS refers not just to women or even women and men but sexual minorities as well.
2. Most women are left out of HIV prevention programmes.
3. Access to treatment remains a challenge.

Shyamala Nataraj makes a presentation in the session on Development, Security and HIV/AIDS interface.
Gender concerns can be integrated into HIV programs but HIV programs cannot solve all the gender issues in Indian society. Much of this discussion presaged those to follow in the sessions on livelihood and food security, public health and violence.

1. What should a “gender” discussion encompass?

A gender perspective, in addition to a human rights perspective, was seen as essential for any HIV/AIDS program. Gender as a category is as relevant to men as it is to women. But this session provided a further corrective by drawing attention to other minority groups whose vulnerability escapes the radar of gender debates. Effeminate men, who are the receptive partners in MSM relationships, and transgender individuals were two minorities specifically mentioned. The inability to be open about sexuality also results in the vulnerability of both the person in question and that of people with whom s/he is intimate.

Beyond drawing attention to these groups however, the discussion remained centred on women and girls, in the main setting out the various circumstances that made them vulnerable: girls married off to infected older men; lower status within a marriage means women have to ask for permission to take the pill, asking for condom use is impossible; sex workers; mother-to-child transmissions.

2. Preventing HIV/AIDS

One of the invited speakers for the session made the point emphatically that most AIDS prevention programmes for women are either meant for sex-workers or to prevent mother-to-child transmission. Most women get left out as a result.

“What is the empowerment NOT to be infected?” asked another speaker. “Awareness, accessibility and affordability” was a maxim offered for any prevention programs. There is no single solution to assuring that women can access the tools and information needed to protect themselves from infection. Primary prevention programs could include health education, condom promotion, access to care for sexually transmitted infections, HIV testing with follow-up counselling and access to anti-retroviral treatment. The female condom project, dispensed to female sex workers in Tamil Nadu, could be an element, allowing women to protect themselves without their male partners knowing.

The discussion stressed the importance of addressing women’s needs in the context of the family unit, taking into account the rights women actually enjoy within the household. The participants challenged the idea that women should always carry the burden of prevention. Given social realities, several expressed the idea that women would not have the right to ask that their husbands (or prospective husbands) be tested.
HIV/AIDS prevention should not be considered in isolation of other public health and development programs; indeed they should be designed keeping in mind structural failures as well as individual needs.

The question of women undertaking sex work arose in both the previous contexts – of family needs and social welfare programs. There was a brief comparative consideration of the approaches to sex work in Thailand and India, in terms of legalization/decriminalisation of such work as also the success of Thailand’s strategy to combat HIV/AIDS in this community. More relevant to the object, however, one of the discussion leaders contrasted on a life-stage continuum, the points where women and girls are most vulnerable in socio-economic terms and where interventions are focused. The absence of efforts to help women and girls when they are most in need of various kinds of support leaves them powerless to resist a range of threats, including trafficking and HIV/AIDS infection. Rehabilitation is the need of the next phase. Finally, beyond rehabilitation, she made the point that those working in the field needed to coordinate and pool their skills to provide education, employment, skills training and thereby, empowerment. This is something that the Confederation of Indian Industries (CII) is beginning to work on.

3. Ensuring access to treatment

The discussion at the Forum raised important issues relating to access.

1. In order to provide life-saving treatment, it is essential to identify the thousands of women who are HIV+. The effort to reach out and provide treatment cannot wait for the necessarily long-drawn out process of identification of every positive person. More importantly, being identified as HIV+ means they have to face the discrimination and social stigma that attaches to this disease. As one speaker phrased it, they can then have a “long life but a sad life.” When a husband is first infected and passes the infection on to his wife, the stigma attaches primarily to the wife. She has to battle the infection with depleted household and personal resources (having spent them on the husband’s treatment), and she has to fight the stigma of being infected.

2. Experts at the session said women were willing to be tested, but the challenge is to provide the facilities for testing in ways that are discreet and “not hurtful”. Related to this, the importance of positive networks reaching out to villages was mentioned.

3. Should government money go primarily to HIV/AIDS prevention, treatment and support services when there are so many other problems, even so many other prevalent fatal health conditions like tuberculosis or cancer?
Session III

HIV/AIDS AND FOOD & LIVELIHOOD SECURITY

The agenda envisaged for the session on HIV/AIDS and food and livelihood security was far narrower than the discussion that followed at the Forum:

- What are the dimensions, present and potential, of the food and livelihood crises in India?
- What is the degree and nature of mutual engagement between those working in the areas of food and livelihood security on the one hand and HIV/AIDS policy on the other?
- What might be the threshold at which the food and livelihood crises may be classified as security crises?

In addition, it took in some of the issues of the preceding sessions placing issues of economic survival in a broader context. The session placed in the spotlight the experiences of HIV widows and HIV/AIDS-affected children.
HIV/AIDS Widows

Findings from a study commissioned by the National Council for Applied Economic Research, the National AIDS Control Organization and the United Nations Development Program were the point of departure for the discussion.

HIV+ widows have to cope with three challenges. First, they have to take care of their deteriorating health. As HIV strikes men in their prime, their wives are also young when they are infected and given access to anti-retroviral therapy and look forward to living with the disease for many decades. Health care means having access to both medicines as well as proper nutrition over many years.

The second challenge is that the husband’s illness consumes most, if not all, of the family assets. The study found that households headed by a HIV+ widow had an income just over half that of other average HIV-affected households. Their expenditure on food is lower. In addition to medical expenses, deteriorating health also reduces the capacity to go out and earn. Just when nutrition and health care matter most, they are least available.

Stigma and ostracism by family make both these challenges harder to cope with. In many cases, the death of the husband results in the eviction of women from their married homes, often along with their daughters, sometimes with all their children.

Children

The first challenge is identifying children with HIV, because they tend to be hidden. The necessity to keep the children’s positive status confidential is in conflict with the need to ensure that the children are well cared for, whether it is to get them to further testing and medications or proper nutrition.

Apart from identifying children who need help, there is an additional challenge to make sure that the supply of nutrition is uninterrupted. Moreover, it is important to make sure that while service programs provide nutrition to families for the infected child, those are not distributed to other children as well. Given that families and service providers are resource-strapped, this is a challenge that has to be thought through in structural terms. Indeed, this connects the food security issue to the broader consideration of development, HIV/AIDS and security in the previous section.

The discussion centred for a while on the question of providing a home for orphaned children and the relative merits of institutional housing vis-à-vis staying with relatives. It drew on the experience and lessons of various efforts, including the fact that when such children leave their institutional home at 18, they die soon after for want of clinical care and nutrition. The challenge for institutional arrangements was whether to mainstream the children or keep them permanently in these homes. In general, it was felt that children fared better when housed with extended family, where the experience
of the mostly Tamil Nadu based fieldworkers at the Forum was that the children were welcomed and treated well. Anecdotal evidence from other states underscored the importance of humane institutions as well.

**Other issues raised**

- Assuring access to testing and treatment is not just about making them available but (a) making them available where people can reach them easily and (b) making it possible for people with the least resources to get to them whether by providing rail and bus passes or by other means.
- The question of property rights also came up in the context of widows not being allowed to inherit the property of their husbands.
- The importance of transparency in what is received by field organizations and what is disbursed by them is important to guarantee that help reaches the needy.
Session IV

THE HIV/AIDS PUBLIC HEALTH CRISIS, GENDER AND SECURITY

The concept paper laid out the following questions for the session on public health issues:

• What are the most pressing issues, from a security perspective, to the public health crisis posed by HIV/AIDS?

• What is the difference, if any, between this public health crisis’ security implications and that of others like SARS or plague?

However, those who spoke at this session made it clear through the content of their interventions that these questions were far from salient to their interests or their everyday experiences. Where the concept paper’s questions were posed at the societal level, to the participants in the discussion clearly it was the individual level that was most important.

Using anecdotes and examples from their work experience, participants underscored the fact that structural and societal problems complicate the way individuals are affected by the HIV/AIDS infection. They argued that a consideration of the infection as a public health crisis in isolation of these structural factors was meaningless.

Patriarchy/ Gender and Power

Women enjoy very little say within most traditional Indian marriages; participants offered many illustrations to make this point. In a patriarchal society, marriage is about security, the speakers pointed out, with even positive husbands being seen as a source of security. Without a husband in such a setting, and usually lacking employable skills, women face security issues, poverty and survival challenges for themselves and their children.

Young girls enter marriage with no preparation at all for the intimacies that lie ahead. As one speaker put it, “Sexuality is seen as a right of a
male and duty of the woman”. Women are expected to experience sexual intimacy not as desire but as duty, and because they feel obliged to always submit to the husband, without having the ability to negotiate condom use, their vulnerability to infection increases. Somewhere in the way we have come to talk about HIV/AIDS, it has come to be associated with extra-marital relations, although the reality is that most women are infected by their husbands.

Infection neither appears to encourage condom use nor abstinence, and infection is passed on from husband to wife sooner or later. Medicines dispensed to the wife are also handed over to the husband so that he is well enough to go to work. Women value their own health and survival less than that of the men in their lives.

Violence

This session brought violence to the centre of the discussion. One speaker spoke of the close relationship between abuse and desire – women do not talk about desire, and men do not talk about abuse.

Women are not encouraged to think about their own pleasure, and not taught that they have any autonomy over their bodies. Consequently, they are subjected to sexual violence and become vulnerable to battery and extortion if they resist their husband’s advances. There is no space for a discussion about condom use in such a relationship.

The reluctance of infected husbands to reveal their positive status to their wives is also violence. They continue to have sex without condoms, and once the wife is also infected, claim it does not matter anyway.

Ignorance/ lack of public education about health and sexuality

Forum participants debated the scope of public educational initiatives that could tackle the social and public health crisis that is HIV/AIDS in a substantive way. Two problems were specifically identified.

First, leave alone teaching young people and adults about HIV/AIDS, the view around the table was that at all levels ignorance about sexuality was appalling. Adolescents face contradictory messages about sex and sexuality – school and teachers do not want to talk about sex and would like students not to think about it, but the popular media projects nothing else. The ignorance of parents does little to help. Where schools and teachers are willing to talk to students about HIV/AIDS, they are unwilling to do so in the broader context of sex and health education.
Second, there is not enough public education to help uninfected women stay uninfected. Resources are poured into testing and into providing treatment to positive persons but very little into counselling about prevention of infection or into patients’ rights. Related to this, there also needs to be more outreach to those who do test positive.

In a broader sense, the session briefly alluded to the cost of medicines and testing and some speakers questioned the lack of engagement on the part of civil society with agenda setting at the policy level.
Session V

VIOLENCE AGAINST WOMEN AND HIV/AIDS

Searching for what HIV/AIDS means for security and vice versa, the concept paper sought to relate forms of gender-based violence such as domestic violence, rape and trafficking to HIV/AIDS, asking:

- Are there particular and peculiar ways in which these forms of gender-based violence and the spread of HIV/AIDS intersect in India?
- How do we presently view the intersection between security and violence against women in the Indian context, and how does the overlay of the HIV/AIDS epidemic alter the picture?
- Does the Violence Against Women (VAW) – HIV connection reinforce the case for including VAW in the purview of ‘security’?

The discussion in this session reflected on the various situations in which women are vulnerable to violence, which was equated to vulnerability to HIV infection.

That violence against women needs to be recognized as violence, was the point of departure. Women are vulnerable to violence, as they have less control over their bodies and less negotiating space. This is especially so when they are married in their adolescence. This, in turn, makes them more vulnerable to HIV infection. The vulnerability of women in one generation opens the probability of heightened vulnerability in the second generation.

For women, the home is not a safe haven. Domestic violence is an ever-present threat and increases the threat of infection. Women cannot ask men to use condoms, but men are suspicious of women who use the female condom. Male-defined morality issues and the rising percentage of women among the poor make matters worse for women’s physical security. Marital rape is still not recognized as rape and there is no law against psychological violence. These same factors have earlier been identified as complicating the plight of positive women. Where there are now laws, their implementation remains to be seen.

Trafficking of women results from their vulnerability but also contributes to it. Poverty is no longer the main factor behind trafficking, according to one of the invited speakers; runaways are the main group trafficked. Girls who run away from marriages or to get married, from caste problems, or because of teenage pregnancies, are easy prey for traffickers. Those who are forced into marriages are as well. Traffickers dupe the girls by expressing concern for them and offering (falsely) a sense of security to them. Children as young as 14 or 15 are trafficked and the experience benumbs them.
Traffickers also peddle drugs and substance abuse is common. Rehabilitation of traffickers and trafficked persons is very difficult and most cases are re-trafficked.

Other spaces set up ostensibly to protect women and girls, such as shelters and juvenile homes, are sites of physical violence and exploitation. In general, child protection needs to be examined and prioritised. Victims of child abuse need to know what protections exist; runaways especially have no support system. The juvenile justice system is in need of reform, even overhaul. Resources, time and sensitive, trained persons need to work with children’s programmes.

(L-R) Gokul Chandrasekar, S. Swarnalakshmi, Rajesh Gopal
Session VI

CONFLICT, HIV/AIDS AND GENDER

The session on conflict and HIV continued from the session on violence against women, and was quite brief.

- What do we know about HIV prevalence in the Indian armed forces and police?
- What are the education and health care programs in place to prevent them from going the way of so many African forces?
- What do we know about the conflict-HIV correlation in India’s conflict zones?

By design, this was the only session that directly addressed traditional security concerns: governance failures, insurgency, conflict and military issues.

Governance failures and conflict

One of the speakers described the HIV/AIDS epidemic as a security threat because it undermines a country’s economy, social fabric, human resources and even traditional security. Development and governance failures contribute to the spread of HIV/AIDS, which in turn aggravate the security threat posed by the epidemic. In the case of India’s north-eastern states, Manipur and Nagaland, continuing conflict and a state whose legitimacy in under challenge together create the conditions where insurgency, narcotics trade, corruption, underdevelopment and linkages between the underground and the elite have together acted as “force multipliers” for the impact of HIV/AIDS. Government servants and primary teachers are likely two of the groups that are affected by the spread of the disease in such a fashion as to debilitate the running of institutions, the speaker offered on the basis of previous research.

It was also held that notwithstanding the impact on social security described here, to label HIV/AIDS as a security problem with the view of drawing to it resources and attention is not likely to be an effective solution in places where treating everything as a security matter is part of the political problem. Moreover, ‘securitising’ an issue leads to over-simplification and that is not desirable in this case.

The armed forces

Describing the stresses and challenges of soldiers deployed in a variety of conflict contexts, especially when they are in counter-insurgency and peacekeeping operations, the invited speaker outlined the
ways in which soldiers are at risk for infection and for spreading the infection. The speaker said the Indian army trains soldiers with a list of do’s and dont’s with regard to sexual activities/exploitation where they are deployed and then plans intensive recreational activities in order to divert the soldiers’ attention. The army also arranges for peacekeeping units to engage with the community’s needs, creating a relationship that goes beyond exploitation. The army has zero-tolerance for allegations of sexual exploitation. The media plays a very active part in keeping vigilance over military activities.

In the discussion, concern was expressed for the kinds of activities and training that were imparted to armies across history. For some time, the human rights concerns relating to army atrocities were the topic of discussion. Sensitisation to gender issues was emphasized as was including women in the peacebuilding engagements with the communities where the army is stationed.
CONCLUDING REFLECTIONS

The most striking feature of the discussions during the Forum was the lack of interest among the participants, mostly social workers and activists working in the area of HIV/AIDS, in relating HIV/AIDS to security. It is hard to see immediate action areas to which security scholars (of the traditional and non-traditional approaches) could contribute. Nevertheless, the Forum discussions did yield insights that bear repetition in this section.

A. There is an inalienable relationship between socio-economic conditions and structures on the one hand and the risk of disease on the other.

Forum participants suggested that the problem lay in the circumstances that placed individuals at risk and therefore, that was the right minute to intervene. The present policy of seeking out those already at high risk or trying to improve access to testing and treatment cannot be a substitute for that.

This reinforces the idea that freedom from want and freedom from fear are related, symbiotic elements of security. To look at the spread of HIV/AIDS and its impact as potential security issues without looking at underpinning structural inequities is superficial. The fundamental security problem lies there, and not in HIV/AIDS per se.

B. HIV/AIDS creates a situation at the individual and the societal level which is not unlike a complex emergency.

HIV/AIDS has a great deal in common with complex emergencies. The underlying structural problems that increase risk of disaster or conflict are similar to the ones that increase the risk of epidemic. The epidemic can have as profound an impact on pre-existing socio-economic conditions and political equations, as do disasters and conflicts. Economic and demographic profiles change and new insecurities are created, that make old ones more complex rather than obsolete.

This suggests that there may be lessons from conflict and disaster experiences that can be applied to HIV/AIDS, especially on the question of rehabilitating those diagnosed as HIV+ and helping their families regroup.

C. Elements of the social response to HIV/AIDS recall identity politics.

The stigma attached to positive status and to being members of a family affected by HIV/AIDS mirrors caste relations. Concerns about access to testing and treatment echo dilemmas of inclusion and
exclusion in other social, political and economic contexts. Discrimination also takes the form of making groups invisible and therefore, voiceless, whether they are positive people or sexual minorities. State programs to inform, test and treat underscore this because they are funded by citizens and in certain circumstances, such as in areas with a large migrant or refugee population, could have to make explicit who belongs and who does not and whose needs are prioritised.

The comparison of HIV/AIDS responses and identity politics draws attention to the potential for political conflict when humanitarian projects are thoughtless about the faultlines their services inadvertently draw within communities.

D. Violence is an inextricable thread in the HIV/AIDS narrative.

Gender-based violence, in the family, in the community, on the streets, in the workplace, is a constant in every discussion about HIV/AIDS. The risks are compounded by poverty and patriarchy, multiplied by silence about violence and silence about disease. The inability to negotiate safety in any setting makes women and children particularly susceptible.

The most useful way to bring the HIV/AIDS and security fields together might well be in the focus on gender-based violence. The first order of physical insecurities with which individuals live opens the door to second order insecurities like the risk of HIV/AIDS.

E. HIV/AIDS reinforces the case for admitting individuals and families as units of security analysis.

One reason that the Forum problematic of relating HIV/AIDS and security did not resonate for participants is that they work with individuals and communities. ‘State’ and ‘society’ with which they associated ‘security’ were too remote.

Newer approaches admit the individual as a unit of security analysis. The Forum discussions, by showing that a positive diagnosis affects the entire family, suggest that in South Asia at least, families should also be considered an analytical unit for understanding security. They might ostracise the individual (and become sources of insecurity) or they might deplete their collective resources in caregiving.

F. “Securitising” HIV/AIDS (or any other issue) is undesirable as it would depoliticise the problem and close the arena of policy debates and accountability.

Adding HIV/AIDS to the security research and policy agendas might make them more accurately reflective of human experience, but it does not do the cause any service. The price of the expedited
attention and additional resources afforded by the ‘security’ tag is that issues so tagged are removed from the arena of political debates. They are handled by technocrats at best and the traditional security sector in settings where transparency and accountability are both limited.

Ignorance being one of the chief factors for the spread of disease, further classifying information related to its nature, prevention and spread could prove counter-productive to the motivation behind tagging it as a ‘security’ issue.

HIV/AIDS reinforces and mirrors emerging perspectives on security, expanding its scope in terms of units of analysis and issues. At the same time, in so doing, this problem underscores the limitations of such expansion. For one, including HIV/AIDS in the agenda of security policy and analysis does not help prevent and curtail the epidemic. For another, its inclusion brings in poverty, patriarchy, violence, governance and issues of access bloating the agenda to the point of inutility.

Swarna Rajagopalan


http://genderandaids.org/downloads/conference
TransformingTheNationalAIDSResponse_summary_eng.pdf


United Nations Fund for Women. Issue Brief on HIV/AIDS. Womenwarpeace.org


APPENDIX A: LIST OF PARTICIPANTS

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* This individual was unable to attend the Forum, but contributed to the compilation of briefings that informed the discussions.
## APPENDIX B: FORUM PROGRAM

### DAY I: FEBRUARY 22, 2008

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<td>IV.</td>
<td>1:30-3:30</td>
<td>HIV/AIDS &amp; food &amp; livelihood security</td>
</tr>
<tr>
<td></td>
<td>3:30-4:00</td>
<td>Coffee</td>
</tr>
<tr>
<td>V.</td>
<td>4:00-6:00</td>
<td>The HIV/AIDS public health crisis, gender and security</td>
</tr>
</tbody>
</table>

### DAY II: FEBRUARY 23, 2008

<table>
<thead>
<tr>
<th>Session</th>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>VI.</td>
<td>9:00-11:00</td>
<td>Violence against women</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Coffee served in sessions at 9:30 and at 11:30</em></td>
</tr>
<tr>
<td>VII.</td>
<td>11:00-1:00</td>
<td>Conflict, HIV/AIDS and gender</td>
</tr>
<tr>
<td></td>
<td>1:00-1:30</td>
<td>Wrap-up and way ahead</td>
</tr>
</tbody>
</table>