

Preventing and Coping with HIV/AIDS in Post-Conflict  
Societies: Gender-Based Lessons from Sub-Saharan  
Africa

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**HIV/AIDS, CONFLICT AND  
RECONSTRUCTION IN SUB  
SAHARAN AFRICA:**

**DRAFT NOTES FOR A SYMPOSIUM**

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## GLOBAL NATURE OF AIDS

**Evolution of problem.** In the course of less than 20 years, AIDS has become a global pandemic, and at the end of the 20<sup>th</sup> century there were few if any countries or regions of the world that could say they were free of the disease. In many of them the pandemic may still be at a stage where it's evolution could be interrupted. In others the challenge is to mitigate the impact of a problem that has already assumed relatively irreversible proportions.

*...a global problem affecting some countries and people more than others...*

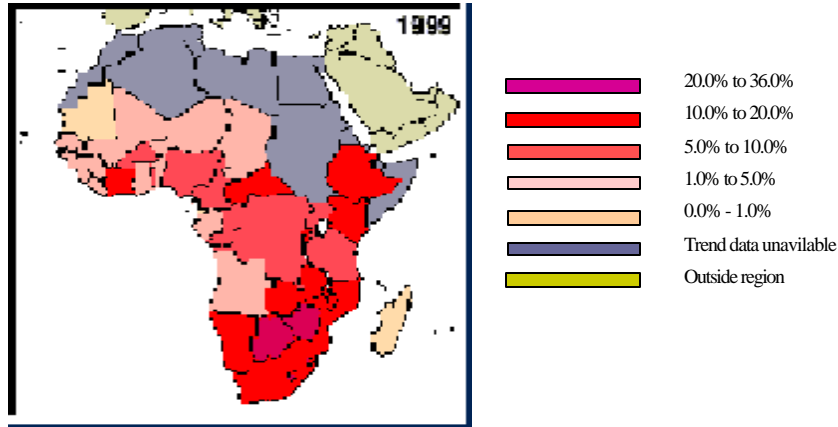
**Variability by time & location.** As with most diseases, the evolution and distribution of AIDS has been variable in terms of timing and location, and has also been influenced by social and economic factors. Some countries and regions were affected earlier than others, some have been more affected than others, and within most societies, some population groups and people have proved more vulnerable to AIDS than others.

**Sub Saharan Africa.** Sub Saharan Africa and Asia are, and will continue to be, two of the most badly HIV/AIDS affected regions. Over the past two decades HIV/AIDS has spread unabatedly throughout the region and it is now estimated that over 70% of the world's total number of HIV infections have occurred in that region of the world. Estimates place the proportion of the adult population infected with HIV at over 30% and the number of people living with AIDS in at over 24 million (UNAIDS). Since 1981 AIDS has killed 10 times more people than all the conflicts in the region (UN Security Council, 2000).

*... over 70% of HIV infections have occurred in Sub Saharan Africa...*

*... AIDS has killed 10 times more people than wars have done in Sub Saharan Africa...*

**Spread of HIV in Sub-Saharan Africa,  
1984 to 1999**  
**Estimated percentage of adults  
(15-49) infected with HIV**



**UNAIDS**

**Impact of HIV/AIDS.** AIDS has touched all sectors of society and all age groups. In Sub Saharan Africa, life expectancy at birth, which had risen to almost 59 years in the early 1990s, is expected to drop to below 45 years between 2005 and 2010 as a result of AIDS. By 1997, life expectancy in Zimbabwe was already 22 years lower than it would have been without the AIDS pandemic. In Burkina Faso and Cote d'Ivoire it was estimated to be 11 years lower and in South Africa 7 years lower.

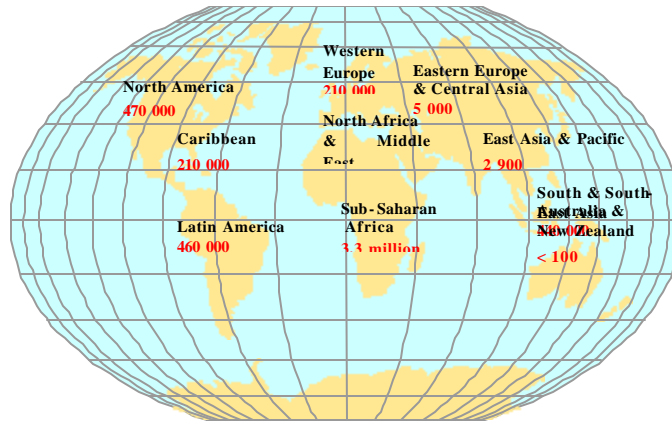
*Life expectancy is falling and millions of orphans are being created...*

**Mother-to-child.** Almost 90% of all the world's vertical transmission infections (mother to infant) of HIV have also occurred in Sub Saharan Africa. Meanwhile as a result of the death toll in adult populations of reproductive age, the number of children orphaned as a result of AIDS is expected to reach 40 millions over the

*...almost 90% of all mother to child HIV infections have occurred in Sub Saharan Africa...*

next 5-10 years. This will confront countries in the region with uniquely difficult and complex challenges.

Estimated adult and child deaths due to HIV/AIDS from the beginning of the epidemic to the end of 1999



Source: UNAIDS June 2000 Epidemic Update

## INTRINSIC FACTORS AFFECTING HIV

**Biological factors.** The transmission of HIV, the AIDS causing virus, occurs under relatively specific conditions. The most common form of transmission is sexual contact where one of the partners is already infected and where precautions are not taken to avoid exchange of infected

body fluids. Transmission of the infection from mother to child, or “vertical transmission”, has now also become a major problem and is the single most important cause of HIV infection in infants and children. HIV transmission through blood and blood products, although efficient, is far less common and occurs most in the context of injecting drug use where needles and syringes are shared.

**Women and HIV.** For a variety of biological and social reasons women are uniquely at risk of HIV infection in

*...the most common HIV transmission is through unprotected sex...*

*...for a variety of bio-social reasons women are at greater risk of being infected than infecting others...*

sex relations. The HIV “load” in semen of infected men is higher than in the mucosal fluid of infected women. Thus non-infected women who have unprotected sexual intercourse with infected men are more exposed to HIV than uninfected men who have unprotected sexual intercourse with infected women.

**Behavioral factors.** Transmission of HIV is essentially a behavioral phenomenon that revolves around the personal actions of individuals. People engaging in sex relationships may or may not know about the dangers of HIV, the ways in which it is transmitted from one person to another, and the ways in which it can be prevented. They may also have or not have access to methods of prevention or choose to or not to use them.

*...HIV transmission is a behavioral phenomenon that calls for behavioral change...*

**HIV prevention.** Because of this, preventing the spread of HIV means getting easily understood and acceptable information to people so that they can take steps to avoid exposing themselves and their partners to the virus and the disease. For safe behavior to be reinforced and unsafe behavior to be changed, people have to (a) know how HIV, the AIDS virus is transmitted from one person to another, (b) have the motivation to prevent it happening to them and their loved ones, (c) believe they have the power to change and control their lives, (d) be willing to practice safe sex and (e) have access to, and be able to use existing methods for reducing the physical risk of transmission.

*...people need to know about safe sex, be willing and able to practice it...*

**Psychosocial factors.** In human beings, sex is a complex phenomenon that is prompted and modified by a variety

of social situations and psychological conditions. In stable situations a mix of social controls, cultural traditions, values and structures typically mediate sexual behavior. Sexual behavior, however, is highly labile and when these mediating influences are absent, sexual behavior tends to change and be influenced more by factors such as low self-esteem, fear, absence of social and personal support, and pressures to conform to new demands and power.

*...sexual behavior is highly labile and prone to change in new situations and new pressures...*

## **EXTERNAL FACTORS AFFECTING HIV**

**Economic Poverty.** The risk and spread of HIV (as well as other diseases) has been linked to poverty in a complex dynamic. It is not a question only the fact that the poor tend to have the worst housing, lack privacy, live in poor environmental conditions, have the worst jobs, high unemployment and have least access to health and social services.

*...poverty in the context of HIV/AIDS is often poverty of education access to services and the feeling that the course of one's life cannot be controlled ...*

**Poverty of life.** It is also the fact that the poverty translates into poverty of education and information, poor access to services and most importantly that poor people may feel they have (and actually may have) little control over their personal lives. These are all conditions that increase the vulnerability of people to HIV. They are also all conditions that are produced, among other things, by political instability and war.

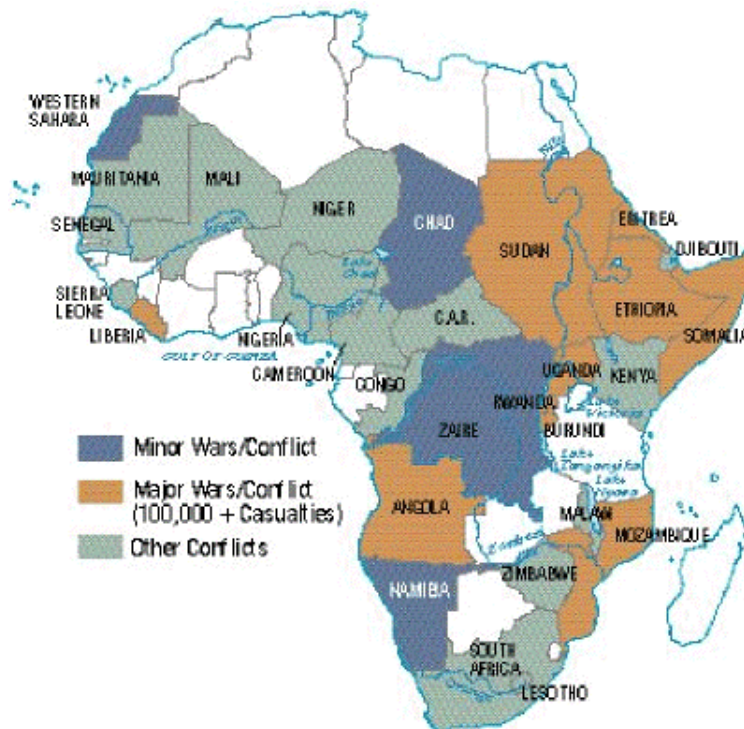
**Instability and war.** Political instability and war affects people and their vulnerability to HIV/AIDS in many ways. First of all it disrupts society and erodes its social institutions. It also splits families up, destroys the social status of people and causes them to be uprooted and displaced. These are outcomes that destroy self-esteem

*...war and upheaval destroys self esteem of uprooted people and calls for coping mechanisms that are sometimes risky...*

and the morale of the people caught up by them, placing people in social and psychological situations where they are easily at risk of HIV and other “social diseases” associated with the loss of place, status and tradition.

**Africa and conflict.** Over the past fifty or so years, and especially the last two decades, Africa has not been spared either political instability or war. In 1999 over half of the world's conflicts were concentrated in Sub-Saharan Africa, actively involving 75% of the countries in the region (IISS, 2000). Growing nationalism and ethnic/religious hostility has characterised these wars and made them all the more disruptive and bloody.

*...in 1999 over 50% of all conflict was concentrated in Sub Saharan Africa... practice it...*



**Impact on social and economic development.** The intensity and broad base of these conflicts has damaged and changed the social fabric of many of the societies concerned in profound ways. Defence budgets have taken increasing proportions of national budgets, draining funds from other pressing social development domains.

*...African countries have seen their social, economic and health development badly affected by war...*

**Impact on economies.** Conflicts have also interrupted if not actively destroyed local and national economies. Many African societies have seen their overall gross national product (GNP) fall, their quality of life deteriorate dramatically, and their people become poorer both relatively and grossly. Many of the hard-earned achievements in health have also been eroded. Old diseases have reappeared, and new ones have emerged to plague already under-financed and over-stretched health and social services.

**Breadth of conflict.** Even countries not directly involved in these conflicts have been gradually drawn into them in a variety of ways. Some have been called on to provide peacekeeping forces to both multilateral and bilateral efforts. Most have accommodated and provided support and services to the millions of people who have been displaced across borders as well as within their own countries.

*...in the last 20 years wars in Sub Saharan Africa have forced over 30 million people from their homes and lands...*

**Instability and forced migration.** Over the last twenty or so years conflicts have also produced other types of social instability, and have forced over 30 million people from their homes and communities in Sub Saharan Africa. Refugees and internally displaced people have been spread all over the region.

**Chronic displacement.** Although many refugees have been able to return to their homes, millions are still living as refugees in situations of crowding, lack of privacy and hopelessness.

## **MIGRATION AND HIV/AIDS**

There is growing evidence that both migrants and refugees are more vulnerable to HIV/AIDS than people who do not move or who are not forced to move.

**HIV prevalence.** In Uganda Decosas (1995) reported that HIV sero-prevalence levels were 5.5% among people who had never moved, 12.4 % in people who had moved to a different village, and 16.3% in people from another area (REF). In Cote D'Ivoire migrant workers constitute 25% of the population and have high HIV prevalence rates. Most of them are males living and working in plantation economies that attract sex workers and where migrant workers depend on prostitutes for sex. In many cases employers provide prostitutes.

*...women are migrating more than ever in and between countries...*

**Rural-urban migration.** High rates of HIV infection in conjunction with growing rural-to-urban migration have also been reported in East and Southern Africa where women are moving more than ever and constitute a large part of all new arrivals to towns and cities. In Kenya where the urban population has tripled between 1980 and 1995 46% of the women of reproductive age in 1989 had moved there in the course of the previous 10 years.

**Women refugees.** In addition women and their children also make up the highest proportion of refugees. Men are soon targeted in conflicts or are conscripted into armies and militias leaving women and children (and to a lesser extent the elderly) to form a large part of the refugee populations everywhere.

*...women and children constitute a majority of the region's refugees...*

**Migrants and sex work.** For many migrant women sex work is the only source of income when cultural, linguistic and political barriers otherwise exclude them from earning a living. They also often find themselves in situations where unemployment is high and where opportunities for economic integration are few. In Abidjan over half of the prostitutes are from Ghana, and as many as 80% of them are estimated to be infected with HIV.

**Refugees and sexual exploitation.** Refugee women are often forced into sex work and into providing sexual favors for a variety of reasons, but primarily survival and coercion. Women refugees alone with children are easy prey for others forcing them into providing sexual favors for rations and physical protection.

*...migrants are often forced into situations where they have to provide sex to survive*

**Dynamics of coping.** The psychosocial dynamics of uprooting, displacement and resettlement and sex are complex. Migrants and refugees are always confronted with new and sometimes hostile social environments that demand of them new ways of coping and behaving. Psychosocial as well as physical survival often means developing new sexual norms, and taking on new social relationships and opportunities.

**New attitudes.** Coping may mean throwing off old social restraints and surviving in settings where there are few social controls on interpersonal behavior and where young females may enter into serial casual relationships in the hope of finding emotional support and economic security. In the case of refugees it may also be a matter of finding extra food and physical security.

**Mobility and rape.** The reality, however, is also that women refugees and migrants are vulnerable to rape and sexual violence. Over 200,000 women refugees were estimated to have been raped in the course of the Rwanda crisis. ICMH studies in Tanzania moreover have also highlighted the fact that rape does not end with flight, but continues to be a threat in refugee camps where it is committed by relatives, other refugees, guards and people from local communities.

**Sex work and refugees.** The power dynamics of sexual relationships also mean that women are often forced into sexual relationships and sexual acts that place them in situations of high risk of HIV. In addition to rape and coerced sex, there is growing evidence that organized sex work emerges in many refugee camps where women are at the mercy of other refugees (men), camp guards, and local people who come into camps for that purpose.

**Mobility and services.** Migrants and refugees also fall outside of the normal spectrum of health and social services. Relief agencies have given little attention to preventing STIs or HIV/AIDS, nor have they developed much in terms of STI treatment. Migrants may be in situations where they are ineligible for and/or could not otherwise afford STI diagnosis and treatment. They go to

*...rape and sexual violence has become a key feature of conflict and a factor in HIV infection ...*

*...relief agencies have given little attention to prevention of STIs*

parts of cities and towns where health care services are few and poorly financed. Most of them are unlikely to have access to HIV antibody testing and counseling services. Cultural and linguistic barriers may also place them outside of the framework of HIV/AIDS prevention campaigns, including access to subsidized condoms.

**Status of women.** There are of course other reasons why women may be at special risk. Their social status in many cultures is such that they are often unable to insist on protected or safe sex. Men often refuse to use a condom even though the female partner requests it. At the same time men may refuse to have sex with women who use a female condom (when and where these are available).

*...the low social status of women migrants and refugees makes them vulnerable to HIV...*

**Family disruption and HIV.** One of the main impacts of uprooting and forced migration in the context of wars and complex emergencies is the violent breakup of families. Women and children often have to move in the absence of male partners/parents and are easily taken advantage of sexually. They are often responsible for ensuring the well being of children as well as themselves and can be easily exploited as a result of this by guards, other refugees and by people from local communities.

*...family disruption often leaves women migrants and refugees physically alone and vulnerable to sexual exploitation and*

**Low status and economic life.** Refugees in general lose more than their families and property. Despite the many international conventions on this issue, they lose many of their civil and human rights. Protection of those rights often comes late and is difficult to enforce legally and socially. The low status of women refugees prevents them from establishing the economic foothold required to reestablish normal life as refugees and enter civil society.

**Separation.** Although family reunification is given high priority by most international relief agencies, it is often difficult to accomplish and many women (and men) refugees find themselves separated from spouses and partners as well as other relatives for long periods of time, and in many cases well after conflicts have passed. As such they remain alone or with children in situations that are rarely conducive to psychosocial rehabilitation.

*...the vulnerability of women to exclusion and sexual abuse is often chronic...*

**Exclusion.** Women refugees often find themselves socially and economically marginalized for long periods of time and well after conflicts have ended and yet still responsible for the care and upkeep of children and possibly other relatives. Their vulnerability to situations of economic and sexual exploitation and hence the HIV risk and other sexually transmitted infections is not only high but can often assume a chronic character.

## **POST-CONFLICT RECONSTRUCTION**

**Reconstruction.** Post-conflict reconstruction is the goal of all societies that have gone through war. One of the problems confronting many African countries, however, has been the chronicity of conflict and the difficulty they have encountered in finding time and opportunity to go from instability to stability and then re-development. The process of reconstructing societies following wars thus remains a challenge for the societies involved, the people affected by conflicts, and the countries and external agencies attempting to assist them in that process.

*...reconstruction in the wake of conflict remains a pressing challenge...*

**Relief to development.** One of the problems to date has been that many external agencies and organizations have conceptually separated relief and development to such an extent that different policies, budgets, and approaches have developed around these needs. Policy continuity between the two processes has been lacking and making the much-needed transition from war and war relief to stability and development aid has been all the more difficult. This transition nevertheless must be made and both national and international agencies must take on the challenge together with the people and the governments involved.

*...most agencies have conceptually separated relief from development...*

**Gender and reconstruction.** In the same way as gender can and often does define vulnerability in conflict it can also help define the nature of reconstruction and people's participation in it. Men are often targeted, conscripted, displaced within militias and armies, and moved away from places of residence early on in crises. They are then often difficult to reach if and when peace accords are signed and conflicts come to an end. There are problems of injuries, psychosocial trauma and the fact that in many instances men who have been conscripted into armies and militias are sometimes associated (wrongly or rightly) with atrocities and hence not easily accepted back into their communities of origin.

*...men are targeted early in conflicts and removed from their communities...*

**Men, the military and HIV.** From the perspective of HIV/AIDS, the growing prevalence of the disease in Sub Saharan African military forces means that many men are at high risk of HIV infection. In some armies such as that of Zimbabwe, the prevalence of HIV is estimated to be over 50%. Similar estimates have been made of South African forces. The re-entry of ex-combatants into civil

*...military forces are so seriously affected by HIV/AIDS that re-entry into civil society can be a problem...*

society is thus replete with questions about their impact on family and community, their possible progression to AIDS-related diseases, their economic productivity, and their need for health care and social support

**Women and reconstruction.** In different ways, women are faced with a wide variety of complex questions in the context of post-conflict reconstruction. Often separated from their partners and spouses for long periods of time, women have often been forced into situations where they have become heads of households and have assumed new roles. For many of them, the process of war has meant the development of new ways of life, the adoption of new values, and the emergence of new ways of seeing the world, themselves and their relationships.

*...women are often forced to assume new roles and adopt new values that influence life after conflicts are over...*

**Reconstructing families.** Experience from the European arena suggests that recreating family life does not come easily after long periods of separation. Both men and women often develop new relationships in wartime and learn to adapt without the traditional partner. Thus even when families are brought back together (which is not always the case), they have difficulties re-establishing the same patterns of life and family relationships as before.

**Children and parents.** Children develop new ways of functioning and adapting to crisis situations. These ways do not always involve attaching to fathers or mothers if the children have been separated from them for long periods of time. Separate identities are formed and the authority of parents (and adults in general) is questioned when they come together. War can mean precocious adulthood and new ways of believing.

*...war can mean the rapid transition of children to adulthood and adult-like behaviors...*

**Implications for HIV/AIDS.** Men in war, women who were refugees, and children who were separated from parents and families constitute a mixed challenge from the perspective of HIV/AIDS. Each of them may have become more vulnerable to HIV during and as a result of conflicts and for a variety of reasons may go into post-conflict situations with new levels of risk. How to reach them within the framework of reconstruction and at the same time promote the re-establishment of the infrastructure need for society to function has become a major challenge for the societies involved and the international community.

**Post-conflict reconstruction:** For reconstruction to be possible will require that far more attention be given to the confluence of HIV/AIDS and conflict. Each of them separately is capable of eroding the framework of society and its civil institutions. Together they constitute a formidable presence that is already at the root of many of Africa's health development process. Gender approaches will need to respect the divisions that have occurred in society as a result of wars and the AIDS pandemic. Both men (and boys) and women (and girls) have been pushed into new lifestyles and ways of seeing and approaching the world.