How does structural violence cause vulnerability to HIV/AIDS?

Peace and Conflict Studies

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Abstract

This essay responds to the question "how does structural violence cause vulnerability to HIV/AIDS?". The central element of peace and conflict theory in negative peace, structural violence, is applied as a lens through which the global HIV/AIDS pandemic can be examined; the most prominent factors involved in producing the risk of infection to the disease are identified and analyzed.

These factors include economic inequality and class, the resultant ineffective health systems, dearths in resources, education and gaps of HIV prevention, and the feminisation of HIV/AIDS through gender inequality. While it incorporates range of global statistics and information, the essay focuses on Sub-Saharan Africa, wherein the effects of structural violence can be considered the most evident and severe in the world. The analysis of structural violence, specific national and population studies, the pandemic and current hindrances to aid and/or developmental progress has been undertaken with references to significant 'voices' on the issues of structural violence, global health and HIV/AIDS - namely Johan Galtung, Dr. Paul Farmer, Irene Khan, Barnett and Whitestead and reports from global organizations, including the Joint United Nations Programme on HIV/AIDS. The essay incorporates past and recent statistics and the theoretical arguments made by such voices, using the framework of structural violence for analysis.

The examination of the collected information highlights the manifested conflict of the disproportionate vulnerability to HIV/AIDS faced by individuals living in poverty and lower income, as well as the 'brunt' of vulnerability that has been borne by women of lower socioeconomic circumstances, showing an intersectionality of susceptibility. The essay deduces that structural violence ultimately creates the social determinants of vulnerability, through the contextual restrictions imposed to individuals and the subsequent inevitability of infection due to the risk environments generated by negative peace.

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Introduction

Human immunodeficiency virus and acquired immunodeficiency syndrome, abbreviated as HIV/AIDS, is a predominantly sexually-transmitted disease spectrum of the immune system, induced by infection with human immunodeficiency virus. The chronic and potentially fatal disease has been a global pandemic that has caused the deaths of over 39 million people so far, claiming 1.5 million lives in 2013 (UNAIDS). Once contracted, HIV cannot be removed by the human immune system; after being transmitted through modes such as sexual contact, occupational exposure, use of drugs via injection or pregnancy/childbirth, the person is infected for life. HIV destroys CD4/T cells over time, weakening the immune system and hindering the body's ability to fight infections and/or diseases (AIDS.gov). There is currently no safe or effective cure for HIV or vaccine to prevent infection. If given proper and consistent treatment, however, - i.e. antiretroviral therapy (ART) - before the progression of the disease, the levels of HIV in the patient's body can be kept low and the preservation of near-normal life expectancy is possible. Without treatment, HIV infection can lead to AIDS, which is the final stage of HIV infection; after acquiring AIDS, medical intervention is necessary to prevent death. In 2013, there were an estimated 35 million people living with HIV and 2.1 million new infections - statistics that not only show the global breadth of the disease, but also its nature as an ongoing major public health risk.

In an era of ubiquitous, incessant issues of public health that devastate populations, the examination of the root causes of such extensive and preventable suffering is of utmost importance. In order to appropriately address any development challenge or global issue, including those of health, our societies must be diligent in uncovering the true sources and propagators of widespread harm; without this, any attempts to alleviate the suffering induced by various issues will have the likelihood of being superficial or ineffective. Due to the pervasiveness of 'topical' treatments merely applied to symptoms of deep-seated, global challenges, rather than to their provenances, the discussion of structural violence in relation to the HIV/AIDS epidemic is particularly relevant today. Unless the systemic origins of the world's problems are recognized, they cannot be dismantled; the questioning of how structural violence causes vulnerability to HIV/AIDS, through the concepts of Peace and Conflict, has thus allowed the international body to produce effective responses to the pandemic, and its active continuation is necessary to achieve the UNAIDS' and global objective of "zero AIDS related deaths", as well as the United Nations' Millenium Development Goal to reverse the spread of HIV/AIDS. This essay will examine the public health threat of HIV/AIDS through the lens of structural violence, analyzing the distinct risk posed to certain populations.

Structural Violence and HIV/AIDS in Peace and Conflict Studies

The term 'structural violence', coined by Johan Galtung, refers to the existence of social, economic, cultural or political systems that disadvantage or harm individuals by restricting their ability to meet their basic needs and/or by limiting individual potential and agency, or choice. The examination of structural violence provides insight on the role of the human organization and social matrixes as systemic, rather than individual perpetrators of suffering on societal victims. In the context of Peace and Conflict Studies, structural violence exists as a constituent of negative peace, depicted as one of three 'points' of Galtung's "Violence Triangle", causally linked to direct and cultural violence. Galtung deems peace the absence of violence, and the former term is divided into the classifications of positive peace and negative peace. In positive peace, along with an absence of war, or direct violence, there is a significantly lower level of structural violence, regarded as social justice, that allows for "egalitarian distributions of power and resources" (Galtung, [183]). Conversely, although 'negative peace' equally denotes an absence of direct violence (such as in the form of war), it is often characterized by the presence of indirect violence, a term synonymous with structural violence; Galtung describes this violence as being present "when human beings are being influenced so that their actual somatic [physical] and mental realizations are below their potential realizations" (Galtung [168-9]), as well as that which "increases the distance between the potential and the actual, and [...] which impedes the decrease of this distance", including hindrances to individual fulfillment and limiters of social mobility. Unlike direct violence, where "means of realization are not withheld, but directly destroyed" - as in the cases of war and physical violence - indirect violence can allow "insight and resources" to be "channelled away from constructive efforts to bring the actual closer to the potential". Galtung further explains the distinction as follows:

"Violence with a clear subject-object relation is manifest because it is visible as action. . . . Violence without this relation is structural, built into structure. Thus, when one husband beats his wife there is a clear case of personal violence, but when one million husbands keep one million wives in ignorance there is structural violence. Correspondingly, in a society where life expectancy is twice as high in the upper as in the lower classes, violence is exercised even if there are no concrete actors one can point to directly attacking others, as when one person kills another." (Galtung [171])

Galtung also uses the example of a tuberculosis death in the eighteenth century being relatively "unavoidable", while the occurrence of the same death today, despite the existing "medical resources in the world", would indicate that there is violence present; like direct violence, in this way, structural violence, can and often leads to death, though its mechanisms are typically hidden or ignored.

The term 'vulnerability' in the title connotes an individual's imposed susceptibility, or risk of contracting the disease, due to contextual factors; it refers to "any set of factors determining the rate at which the epidemic is propagated" (Barnett and Whiteside [89]). An individual's subjection to infectious contact is equated as vulnerability, that is "reinforced, if not exclusively caused, by the combination of unstable personal conditions and their social exploitation in the self-protective neglect of the dominant economic and political classes" (Keenan and McDonagh [14]). The term's root - "vulnus" - has been said to imply a "breach or openness in a person's or a society's defences" that has

psychological and social implications, often inhibiting agency - i.e. limiting the ability of individuals to make independent choices that affect their lives. Dr. Paul Farmer, a medical anthropologist and physician, highlights the necessity to examine the role of concurrently detrimental factors, or "axes" that are to be considered the cause of widespread suffering, stating in his article, On Suffering and Structural Violence, that "no single axis can fully define increased risk for extreme human suffering" (Farmer [49]). Farmer also quotes that "events of massive, public suffering defy quantitative analysis" (Rebecca Chopp, The Praxis of Suffering) and references a similar notion made by Amartya Sen, to emphasize the need to "move beyond the 'cold and often inarticulate statistics of low incomes' to look at the various ways in which agency is constrained" [Farmer, [50]]. Farmer describes the effects of structural violence on its victims, whose agency is restricted, as "afflictions [that] are not the result of accident or force majeure; they are the consequences, direct or indirect, of human agency", implying the origin of structural oppression. Although a relationship between structural forces is commonly recognized in producing susceptibility to disease, these will be examined distinctly for the purpose of categorized analysis; due to the pervasiveness of structural violence across societies, however, its impact on an individual's life could range from solely involving one axis, or all of them, in varying degrees. Structural violence causes individuals' vulnerability to HIV/AIDS infection through the structural facets of economic inequality and its consequences, including its manifestations in weak health care systems and restricted access to resources, as well as gender inequality - which equally produce 'social identities' that are susceptible to the disease.

Economic inequality and class (poverty) as axes of HIV/AIDS susceptibility

The concepts of economic inequality and poverty are perhaps the broadest axes of structural violence. As causes of susceptibility to HIV/AIDS, their rife effects can be found in and related to the majority of other structural causes of vulnerability, and are "differentially weighted in different settings" [Farmer]. In contexts of economic inequality, also referred to as wealth disparity, there is often an extensive dearth faced by people disadvantaged by the uneven economic distribution, manifested in deprivation to basic needs and resources. Farmer states that the world's poor are the "chief victims of structural violence", as forces of inequality put some at risk for human rights abuses or HIV infection, while others are shielded from the same risk. As a result of "inequitable distribution of economic resources"(Farmer [6]), poverty and its conditions created by structural violence - which allots minorities power in the form of access to resources while having the reverse effect on majorities of populations - are described as issues of human rights. Irene Khan, the previous Secretary General of Amnesty International, states that poverty is "not just about deprivation", but equally about the "other threats and challenges faced by those living in poverty" (Khan [5]); the health risk imposed by structural violence is implied in these terms, as well as in the statement that "deprivation dramatically affects the security of poor people" (Khan [9]) in a spectrum of ways. The notion that disease infection and epidemics are "shouldered by the poor" (UNFPA) is reflected by the number of people living with HIV in sub-Saharan Africa, the world's "poorest region". Sub-Saharan Africa accounts for almost 70% of the global total of new HIV infections, showing that the epidemic has spread to generalized population in a region that has "a high proportion of poor people", who "carry the highest burden"; in 2013, the region had 24.7 million people living with HIV (among whom 2.9 million were children), 1.5

million new HIV infections, and 1.1 million AIDS related deaths out of 1.5 million global deaths [UNAIDS]. Asia and the Pacific had the next largest population of people living with HIV, at an estimated 4.8 million people; when comparing these statistics to those of Eastern Europe and Central Asia - with 53 000 deaths in 2013 and 110,000 new infections - a distinction of the correlated elements of both vulnerability and impact is evident in areas facing poverty versus those that are not to the same degree. A 2013 survey of the socioeconomic index (SEI) of low (poorest), middle and upper groups contextually highlighted this "disproportionate burden" faced by the poor in South Africa - the nation with the largest HIV population in the world, at 5.9 million; HIV prevalence was highest among the poor (20.8%), followed by the middle SEI groups (15.9%) and considerably lower in the upper groups (4.6%) (Wabiri and Taffa). It is the socio-economic inequality created by such gaps that produces increased vulnerability to HIV infection, demonstrated in the 16.2% difference of HIV prevalence between the examined poorest and wealthiest populations in South Africa. Among the effects of structural violence in the form of economic inequality are hunger and food insecurity, which can make people more susceptible to HIV through individuals' consequent behaviors with negative effects or actions for subsistence, such as "selling assets, migrating in search of work, taking children out of school or engaging in commercial sex" [UNAIDS]. Although people engage in behavior that increases the risk of HIV transmission, some aspects of the structural violence of poverty, such as food insecurity "can increase the likelihood of such risky behavior" [Farmer]. The role of structural violence in creating a "risk environment" for HIV/AIDS is equally significant, as "individual, group and general social predisposition to virus transmission is increased" due to socioeconomic circumstances and/or historical "junctures" that allow sexual relations of any kind to "carry an unusual or raised risk" (Barnett and Whiteside [99]). The significance of the 'risk environment' has been demonstrated by the percentage of HIV-related deaths (83%) that have occurred in sub-Saharan Africa and by the fact that HIV-related mortality rate is over 20 times higher in the region that anywhere else in the world. The effects and conditions of poverty additionally allow individuals to be susceptible in the same way to most infectious diseases, including malaria and tuberculosis (TB), the leading cause of death among people living with HIV, which caused an estimated 320,000 deaths in 2012. An illustration of the vulnerability created by this form of structural violence is that members of the lower income population are frequently faced with lower standards of living and often hygiene, such as having to co-inhabit small spaces, which leads to overcrowding and facilitates the transmission of disease. This has occurred in Haiti, for example, where "political and economic forces have structured risk for AIDS" (Farmer [30]) as well as infectious diseases. The high risk factors of vulnerability to HIV include having been diagnosed with hepatitis, malaria or tuberculosis - which can create coinfection; in 2007, HIV and TB coinfection cases accounted for more than 26% of TB deaths and 23% of all deaths among people living with HIV. Thus, both the contextual risk environment created by economic inequality and the consequent survival measures individuals take create susceptibility to HIV/AIDS.

Ineffective health systems, resource/HIV prevention gaps and stigma

Structural violence in the form of class-based poverty has been manifested in the elements of access to health resources, systems of public health (or the lack thereof) and gaps in HIV prevention, which simultaneously cause populations to be susceptible to HIV/AIDS. The 2014 gap report by UNAIDS shows that globally, 19 million of the 35 million people living with HIV do not know their

HIV-positive status; in the aforementioned SEI study, only 20.5% of those in poor SEI had "good access to HIV/AIDS information" compared to 79.5% in the upper SEI. In 2013, 11.7 million people were receiving antiretroviral therapy (ART) in low and middle-income countries, representing 36% of the 32.6 million with HIV living in those countries. This relates to structural violence in that individuals are at high risk of infection based on social identity, as "typically access to HIV prevention and treatment services is lowest among poor and marginalized populations". Since treatment service delivery in the past has largely depended on specialist doctors, populations in countries with a lack of trained medical staff or who live far away from specialized facilities have limited access to treatment. A risk is created by the structural gap in HIV prevention, as populations are not provided the resources of testing and health information, and other economic factors, such as the cost of accessing service, including visit fees/transport costs can also be a barrier, particularly "among food-insecure people". Poor quality services also hinder treatment "uptake and adherence" to treatment, and along with the lack of access to treatment, other individuals who are not infected are made vulnerable to infection. Additionally, preventative resources such as condoms are frequently not provided to lower-income populations, as a result of ineffective health systems and lack of public access; vulnerability is perpetuated this way, whereas consistent condom provision and use would reduce the risk of HIV transmission by "approximately 80% over the long term" [9], and the use of condoms in a couple in which one person is infected would make the rate of HIV infection less than 1% per year (UNAIDS). The indirect violence of the individuals' restricted access to basic preventative resources puts them at high risk of infection. According to Farmer, many countries with concentrated HIV epidemics still fail to "scale up necessary, evidence-informed interventions, such as harm reduction, peer-led prevention outreach and male and female condom programming" (Farmer). The class-driven barrier to HIV testing and counseling is also a product of stigma and social discrimination, resultant of limited educational and public health resources, the fear of "infection all too easily translates into fear of the infected" and the disease has been used to stigmatise various out-groups" (Farmer [71]). Stigma and the "social exclusion of particular groups" is considered to be part of the "harmful social, sexual and gender norms that drive vulnerability" [Farmer [71], as treatment is not sought, is disregarded or not requested for fear of social consequences. The effect of limited sexual education as a result of structural violence - along with the limitation of resource access - has been manifested in the global incidence of HIV/AIDS among younger people (aged 15-49), as they account for 41% of all new infections (UNAIDS [18]). In 2002, 8.6 million youth (aged 15-24) in Sub-Saharan Africa were living with HIV/AIDS, in comparison to 240,000 cases in "industrialized" countries (UNAIDS/UNICEF [19]). The vast majority of young people, according to the report, remain "uninformed about sex and sexually transmitted infections (STIs)", as well as the modes of transmission of HIV and areas of "risk", while those aware of HIV "often do not protect themselves" because of the lack of "skills, the support or the means to adopt safe behaviors" (UNAIDS/UNICEF [19]).

Gender inequality and the Feminisation of HIV/AIDS

One of the most significant forms of structural violence that disproportionately makes populations vulnerable to HIV/AIDS is gender inequality. Although it is not always overtly spoken, women throughout the world are confronted with various forms and degrees of sexism, "an ideology that situates them as inferior to men" (Farmer, 43) and bear its social, economic, political and cultural

manifestations. Gender bias is a general problem that "applies even in Europe and North America in a variety of fields [...]" but the impact is deepened in poorer countries, wherein the disadvantage of women "may even apply to the basic fields of health care, nutritional support, and elementary education" (Sen/Farmer, 50). Gender alone "does not define risk for such assaults on dignity" (Khan [ix]) - it is poor women, in most settings, who are " least well defended against these assaults". This is true not only of issues such as "domestic violence and rape but also of AIDS and its distribution" (Khan [61]), as women account for 58% of the total number of people living with HIV in Sub-Saharan Africa (which amounts to 14,326,000, out of the total of 24.7 million). This is paralleled in the United States in that the majority of women "with AIDS in the United States are poor" (Ward/Farmer) illustrating that women are at risk of HIV because poverty is the "primary and determining condition of their lives". Gender inequality structures girls' and women's vulnerability to HIV/AIDS not only through the preexistent elements of indirect violence around the world, including poverty and economic inequality, resultant lack of access to resources and gaps in HIV prevention, but their systematic oppression based on gender heightens their susceptibility, to the extent that it can be considered another 'axis' altogether. Young women "experience markedly higher rates of HIV/AIDS infection than young men" (Khan, 61); according to a UNAIDS report, "adolescent girls and young women [in sub-Saharan Africa] account for one in four new HIV infections", and are as much as "eight times more likely to be infected with HIV than men of the same age" [Farmer, 51]. This increase in the number of women and girls becoming infected at younger ages, and distinctive vulnerability, is referred to as the feminization of HIV and AIDS. The ability of young women to protect themselves from HIV infection is "frequently compromised by a combination of biological, social, cultural, legal and economic factors. These factors, along with female subordination, influence the means taken by individuals for survival and the conditions therein; this issue is visible in the scale of transactional sex, a "survival strategy" (Kelly) that causes vulnerability to women due to their lack of choice. Transactional sex (otherwise described as risky sexual relationships for "sugar daddies", and/or prostitution), as mentioned before, is one of the most evident intersections with the structural violence of class, as women attempting to "escape from the harshest poverty" (Farmer, 52) view it as an economic "necessity" or their only currency "in places of dire poverty" (Helen Epstein - 16). The correlation between disparity and transactional sex is connoted in the book AIDS in the Twenty-First Century; "in the ebb and flow of global and local labour markets, [...] the quest for work and livelihood may take on a sexual complexion" (Barnett and Whitestead [7]). Furthermore, abstinence or the negotiation for safe sex is often not within the power of women; this is propagated by socioeconomic, structural elements that influence cultures of early marriage or intergenerational relationships. In cases of gender-based violence, another constituent of vulnerability, women's abilities to negotiate safe sex are more deeply constrained;

"[...]evidence from Uganda shows a high level of correlation between domestic violence and the spread of HIV/AIDS. In some instances, the tragedy of HIV/AIDS has become just another tool for those who want to dominate and inflict pain and suffering. In addition, a Zambian study revealed that violence against women was a significant barrier to women accessing HIV treatment, thus exacerbating the impact on victims' health" (Khan, 61)

Khan's analyses points to the structural violence of sexism that breeds direct gendered violence. Although a psychological analysis must rely on the evidence of specific cases, the role of structural

violence could additionally be considered an influence of the behaviors of the perpetrators of this violence, whose constrained agency produces a desire to "dominate" or control their 'inferiors', as insinuated by Khan. Finally, the lack of assistance and aid for women who are involved in such scenarios, presumably due to poverty, is in itself a form of structural violence, as their imposed limitations in acquiring health information, preventative resources and support contribute to their vulnerability to HIV/AIDS.

Conclusion and Solutions

The prevalence of diseases, the zones of most significant impact and the correlated factor of vulnerability indicate that there are social determinants of health and malady around the world; the most prominent in the context of HIV/AIDS in creating vulnerability are class and gender. Structural violence, as explored in the essay, deeply influences and drives these social determinants of vulnerability to HIV infection, in creating profound economic inequality and gendered disparities of power and rights, that create particular social identities that are disproportionately prone to infection, and ultimately more impacted. The structural violence of class, or poverty, restricts health and educational resources, both in terms of societies' systems and individual access. The structural axis of gender produces a high vulnerability for women to HIV/AIDS, through inequality, sexism and power discrepancies that are made manifest in both the means of survival and forms of victimization of women.

Addressing the issues of structural violence, through promoting human rights and gender equality is critical in combating the threat of HIV/AIDS. The Global Strategy Framework on HIV/AIDS (UNAIDS, 2001) underlines the interrelationship of the risk of infection and the impact of the epidemic, stating that "decreasing the risk of infection slows the epidemic" and reduces its impact, which in turn prevents more vulnerability of infection (17). The intersectionality of these axes, most evident in that of gender and class, necessitates a comprehensive approach - i.e. integrating the "HIV response with other health and development efforts" (UNAIDS). UNAIDS states that HIV prevention must be revolutionized, in terms of "politics, policies [and] practices", and must yield equitable access to "high-quality, cost-effective HIV prevention programs". In regard to the widening gap between the populations gaining access to HIV prevention, treatment, care and support, and the people being "left behind", or excluded from attention and aid, Farmer states that "focusing on populations that are underserved and at higher risk of HIV will be key to ending the AIDS epidemic" [13], as this gap needs to be covered in order to reduce sexual transmission of HIV. The socioeconomic empowerment of women through components of positive peace, such as education, access to reproductive/maternal health, and economic aids are equally essential.

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