A STUDY TO ESTABLISH THE CONNECTIONS BETWEEN HIV/AIDS & CONFLICT

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By

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EXECUTIVE SUMMARY

INTRODUCTION

This set of papers was commissioned by DFID to explore specific elements of the relationship between conflict and the HIV epidemic. The full Terms of Reference can be found in Annex 1.

Specifically, the papers consider the possible contribution of the epidemic to the build-up towards conflict (Paper 1) and how, if at all, HIV prevention and mitigation efforts might reduce this (Paper 2). Paper 3 explores key aspects of the relationship between peacekeepers and the epidemic, while Papers 4 and 5 consider, respectively, issues of HIV prevalence and sexual exploitation among conflict affected-populations. The final Paper (6) explores the implications of HIV in post-conflict situations. While each paper is intended to address discreet issues, some overlap is inevitable. This has been kept to a minimum.

For the purposes of this study, *conflict* is understood to refer specifically to '*armed* conflict'. Consideration of the relationship between HIV and armed conflict highlights the importance of *violence* (actual or threatened) - and sexual violence in particular - as well as of *power* and *gender*, not only as these are manifested in situations of actual conflict, but also as pervasive, powerful phenomena which shape social relationships.

The data on which these papers are based draw from a broad range of sources. The perceived sensitivity of the issues explored makes it even more important than usual to consider available statistical data critically, bearing in mind the range of variables, methodologies and timescales employed in the various studies cited.

The geographical focus of these papers is largely upon countries of sub-Saharan Africa since this is where both experience (and documented evidence) of the HIV epidemic and vulnerability to armed conflict are most profound.

1. ANTICIPATION OF CONFLICT

To what extent is there evidence to suggest that HIV/AIDS may be contributing to a build up towards conflict?

The paper notes that while there are no past or current armed conflicts in which there is evidence that HIV can be said to have contributed in a significant way to the build up of conflict, there is an emerging consensus that the longer term economic, political, governance and social implications of the epidemic together with the impact on security forces, are such that *at a certain level of prevalence, HIV could significantly increase the risk of conflict.*

The argument that HIV has the potential to accentuate exactly those weaknesses and problems, which are usually identified as sources of armed conflict is basically sound, if largely speculative. While this argument could provide further justification in support of DFID's focus on medium to long term economic, political/governance and social implications of the HIV epidemic, available evidence of the impact of the epidemic on poverty and development is sufficiently clear to justify action, irrespective of whether or not the epidemic also contributes to conflict.

In heavily affected countries, the impact of the epidemic across a number of sectors is reflected in increased social instability including growing numbers of orphans, economic decline and increasing inequalities together with depleted institutional capacity and integrity in the political/governance sphere. The possibility exists that HIV could have a negative effect on political participation, legitimacy and the behaviour of elites. In the security sector there are signs that HIV is undermining the effectiveness, morale, discipline and combat readiness of armed forces.
However, it is not clear that these impacts will necessarily materialise at a certain level of HIV prevalence. Nor is there clear evidence that, even if they do, they will actually lead to conflict. The possibility exists that HIV could present opportunities for conflict prevention and resolution, and if this is the case, raises further questions for exploration. For example, the extent to which HIV could be an issue around which parties in conflict could be brought to negotiation? At the same time HIV could be an issue on which political leaders are compelled to seek greater legitimacy by taking decisive action to tackle the problem. The examples of Uganda and Senegal may be instructive in this regard.

2. PREVENTION OF CONFLICT

Could efforts to mitigate the effects and prevalence of HIV/AIDS help to reduce the build-up towards conflict?

The bulk of the available literature considers how conflict can exacerbate HIV transmission and increase vulnerability. A far smaller body of literature explores how HIV might, in some cases, drive conflict. No unequivocal evidence has been found to support the hypothesis that efforts to prevent and mitigate HIV reduce the build-up towards conflict. However, nor has data been identified to prove that it does not. Moreover, there are at least three reasons to believe that efforts to prevent and mitigate HIV could prevent the build-up towards conflict.

First, both conflict and HIV share common drivers in the form of poverty, inequality, discrimination, exclusion and insecurity. Available evidence suggests that a synergistic, mutually reinforcing relationship can soon become established when both conflict and HIV exist in the same place and time. Therefore, efforts to address these, whether intended primarily to tackle conflict or HIV, seem likely to have secondary benefits in terms of the other.

Second, both conflict and HIV erode the social capital upon which societies depend for mutual cooperation and survival. Therefore efforts to increase and strengthen this (again whatever the primary motivation) are likely to be of mutual benefit.

Third, recent demographic work suggests that global efforts to promote reproductive health services could ease the transition towards demographic stability in those countries in which (together with other variables) high HIV prevalence currently may suggest the likelihood of conflict.

Finally, consistent with the current emphasis on mainstreaming, the paper considers examples of ways in which HIV interventions might also contribute to a reduction in conflict.

3. PEACEKEEPERS

What do we know about HIV/AIDS and peacekeepers in situations of conflict?

In several countries HIV prevalence rates among military personnel are of such an order as to pose a threat to security. Within the context of the HIV epidemic, the presence of peacekeepers may represent a ‘paradox of protection’: their presence may offer protection from immediate risks posed by armed conflict, but may also increase the risks of HIV transmission through sexual relations among key populations affected by armed conflict including local communities, military personnel (including sub-contracted security personnel) and civilians working in humanitarian assistance and relief agencies.

Behaviour of military personnel is affected by several factors. These include whether their presence results from conscription or voluntary enrolment, the level of disposable income, length of deployment, effectiveness of disciplinary regimes, perceived differences in terms of gender and sexual culture between home and new environments, knowledge and perceptions of condoms and willingness to use these, reflecting in turn attitudes towards sexuality (including those relating to sex between men and women and between men), risk and danger.

The predominantly masculine nature of military culture is reflected and sustained through intense socialisation (which may include brutal initiation processes), strong peer solidarity and pressure both in combat and recreation, submission to discipline on-duty and compensatory behaviour off-duty, including drinking and sex.

Increased understanding of the HIV-related risks associated with military personnel and peacekeeping have resulted in a number of important initiatives including the issuing of the UN Secretary General's requirements in relation to the conduct of UN personnel, UN Department of Peace Keeping Operations guidelines on training and employment, training programmes for national militaries together with regional initiatives and mechanisms for monitoring the conduct of peacekeepers.

4. LOCAL POPULATION

What do we know about the prevalence of HIV/AIDS amongst conflict-affected populations?

In relation to its effects upon HIV prevalence, armed conflict creates the possibility of social collapse, which is often reflected in the disintegration of norms relating to sexuality and sexual conduct.

Increased risk of transmission during armed conflict is associated with economic vulnerability among women and girls, disruption of health services (especially those providing condoms and STI services), and sexual violence from males other than established partners. It also depends in part on the existing levels of infection among the local population as well as among groups of combatants.

Overall, social and physiological factors make women and girls more vulnerable to infection. Moreover, particular groups of women and girls may be at even greater risk than others: for example younger girls and women may be selected as partners on the assumption that they are less likely to be infected, sex workers who are unable to insist upon condom use, displaced persons and refugees. For others – such as women in temporary or established relationships with military personnel – the risks may be more complex. In some instances, the absence of male partners during conflict has led to increased responsibility and confidence among women, which may extend into the area of sexual decision-making.

A number of interventions have been implemented including a recognised example of good practice related to rapid intervention among Rwandan refugees in Tanzania occur. UNHCR has developed its HIV strategy and has initiated assessments of HIV programmes in several African countries. Data on the issue of ARVs in situations of armed conflict, both as prophylaxis and as treatment, are scarce, with the exception of the MSF initiative in the Democratic Republic of the Congo.

5. SEXUAL EXPLOITATION

What do we know about reducing the vulnerability of conflict-affected populations to associated exploitative sexual behaviour during conflict?

A comprehensive response to this question demands consideration of 'normal' relationships in which gender and power combine to impact upon sexual behaviour. Within the narrower focus of this paper, the emphasis is on the relationship between militarization of societies, social chaos, breakdown of protective institutions and sexually predatory, risk taking behaviour.

Evidence demonstrating sexually exploitative behaviour on the part of the military against local populations during armed conflict indicates a range of contexts and motivations for such behaviour. These include group rape of 'enemy women'; the use of rape as an instrument to suppress dissent and terrorise populations; large scale abduction and sexual abuse of women, girls and boys; taking 'temporary wives' whose function is to provide sexual and other services; demands for sexual services to be provided by female recruits to insurgent forces; and 'checkpoint rape'. Vulnerability to sexual exploitation extends beyond the conflict vicinity and abuse may occur during flight, in IDP and refugee camps, in other households and while returning home. Particular groups may be vulnerable: these include very young girls, the elderly, sex workers, men and boys, and women and girls all who are known to have been raped.

Perpetrators are overwhelmingly male and include potentially any male in a position of power or responsibility, including extended family members and partners, employers, camp residents and staff, and of course combatants. The potential scale of sexual abuse and exploitation within situations of armed conflict is clearly reflected in the use of mass rape in the former Yugoslavia and Rwanda.

The implications for HIV transmission of such pervasive abuse and exploitation are becoming clear, as is the importance of addressing sexual violence during conflict as a key element of human rights, health and development interventions. The profile of the issue has been raised considerably by the 'Bulletin' on this topic issued by the UN Secretary General.

Reducing vulnerability to sexual exploitation demands interventions at micro, meso and macro levels and needs to address development and humanitarian assistance agencies, military institutions and personnel (building upon the increasing openness to address HIV within this sector) together with civilian society including displaced populations and local communities.

A range of interventions have been undertaken with the military, with displaced populations and with people living with HIV. These have included awareness raising, condom promotion and distribution and the provision of treatment, including ARVs.

Nonetheless, reducing vulnerability to sexual exploitation will depend upon the extent to which it is possible to tackle the structural determinants of gender and sexual inequality.

6. POST-CONFLICT

What do we know about the effect and prevalence of HIV/AIDS after a conflict has ended (i.e. on sexual partners of returning combatants, refugees, IDPs, peacekeepers,) and what follow-up measures could be taken? What constitutes best practice in HIV/AIDS interventions when moving from immediate post-conflict or transitional support to a broader development agenda?

The post-conflict period presents the opportunity to initiate the move from relief to development. It also raises particular threats and opportunities in terms of HIV.

Cessation of hostilities provides opportunities to re-establish delivery of vital health services, including condoms and drugs. Activities and services associated with demobilisation and reconstruction also provide opportunities for the integration of HIV-related information and services. However, the increased mobility, which characterises post-conflict societies, is also associated with increased risk of HIV transmission. Furthermore, the ending of hostilities does not necessarily mean that violence will disappear from daily life. In fact, evidence suggests that abandonment and domestic violence can actually increase after demobilisation in response to the frustrations and tensions involved in the demobilisation process.

Demobilisation processes present a potential opportunity to integrate HIV-related interventions. This could include consideration of the specific issues raised by HIV and reintegration.

Post-conflict HIV-related interventions should consider the needs of combatants and their sexual partners, taking into consideration critical personal, social and health issues raised by the effects of conflict, separation and reintegration. These could include issues relating to disclosure of HIV status, treatment and care; the impact of trauma (including HIV); issues of trust and suspicion (possibly raised by requests for condom use); and the desire to conceive. Groups with particular needs will include returning refugees and internally displaced persons who may or may not return to their place of origin. Particular sensitivity will need to be paid to any intervening changes, which may impact positively or negatively upon gender relations.

Most significantly, the shift from relief to development will ensure that key drivers of both conflict and the HIV epidemic are tackled, thereby establishing a more solid foundation on which to conduct immediate and medium term interventions.

RECOMMENDATIONS

It is recommended that DFID,

Anticipation of Conflict

1. Support work to address the lack of data on the role of specific economic, political and social aspects of the impact of the HIV epidemic in increasing the risk of conflict.

2. Support ‘HIV mainstreaming skills ’ for conflict specialists working in areas affected by the epidemic and promotes ‘conflict awareness’ for HIV specialists whose work includes countries vulnerable to or affected by conflict.

Prevention of Conflict

3. Identify and disseminate examples of good practice in relation to work that addresses HIV and conflict issues, specifically in relation to:

    - HIV prevention and care with vulnerable populations in conflict situations;
    - Military institutions and personnel;
    - Building capacity in relation to conflict resolution at community level and beyond.

4. Mainstream HIV within conflict-related work supported by DFID - for example, by providing guidance on the preparation of project/programme documents to ensure that possible synergy between conflict and HIV is taken into consideration in relation to countries/regions where these are of particular relevance.

5. Address the relationship between conflict and HIV as appropriate within the development of PSRPs.

Peacekeepers

6. Follow up and disseminate examples of good practice involving military and civil-military interventions including UNAIDS 2003 East African workshop and UNAIDS Eritrea.

7. Identify existing approaches of military institutions in relation to prevention (of STIs and HIV) testing and treatment (including the provision of ARVs).

8. Given the increasing presence of sub-contracted security personnel in peacekeeping operations, review and disseminate examples of good practice on lines of accountability e.g. through memoranda of agreement, contracts etc, with particular reference to monitoring the conduct of personnel on DFID funded contracts.

Local Population

9. Review the progress of the UNHCR initiative on HIV.

10. Build the capacity of all development partners to mainstream HIV into conflict work

11. Analyse the MSF programme currently providing ARVs in the Democratic Republic of the Congo in relation to cost, replicability and longer-term sustainability.

Sexual Exploitation

12. Identify effective approaches to addressing issues of HIV, masculinity and gender inequity undertaken in a range of contexts and settings with a view to relevance and potential transferability to military settings

13. Support the development and implementation of policies and strategies for post exposure prophylaxis for women or men who have been raped.

14. Review the extent to which current training programmes for military/security personnel (including civilian police) address the issue of sexual violence.

Post Conflict

15. Mainstream HIV within all stages of DDR operations.

16. Integrate within conflict assessment methodologies and all elements of post-conflict planning, specific consideration of young women and girls.

17. Explore the extent to which Security Council Resolution 1325 (on the integration of women into peace negotiations and peacekeeping) might be expanded to address HIV-related issues.

PAPER 1: ANTICIPATION OF CONFLICT: TO WHAT EXTENT IS THERE EVIDENCE TO SUGGEST THAT HIV/AIDS MAY BE CONTRIBUTING TO A BUILD UP TOWARDS CONFLICT?

1. INTRODUCTION: IDENTIFYING LINKS BETWEEN HIV/AIDS AND CONFLICT

1.1. For some time there has been a consensus, backed up by concrete evidence, that wars have both facilitated the spread of the HIV/AIDS and hampered international and local efforts to control and treat it[1].

1.2 Some experts are now taking seriously the proposition that HIV/AIDS may be contributing to a build up towards various different kinds of armed conflict, including internal, regional and inter-state conflicts[2]. Both the UN Security Council[3] and the US intelligence community[4] have posited that the HIV/AIDS pandemic represents a threat to international peace and security.

1.3 Development actors need to take this seriously, because armed conflict is usually recognised to be (along with HIV/AIDS itself) one of the main obstacles to development in many poorer parts of the world[5].

1.4 As yet there is little hard evidence for the assertion that HIV/AIDS contributes to armed conflict in any direct causal way. In central and southern sub-Saharan Africa, which is experiencing the highest prevalence rates in the world, none of the worst affected countries (Botswana, Zimbabwe, Lesotho, Swaziland, South Africa, Zambia, and Malawi) are currently suffering from armed conflict.

1.5 In Zimbabwe there is speculation that HIV/AIDS is among the many causes of the political crisis there[6]. But that crisis has continued now for several years *without* leading to armed civil conflict. Angola, the one country in southern Africa, which has borne significant levels of armed conflict in the past decade, has one of the lowest civilian HIV/AIDS prevalence rates in the region[7].

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[1] However, by reducing access, wars can also hamper the spread of the disease among some segments of a conflict-affected population. Furthermore a conflict could leads to the replacement of a government that is not capable of or committed to fighting HIV/AIDS by one that is. These points underline the complexity of the factors involved in any correlation between HIV/AIDS and conflict.

[2] See for example: "Strategic Implications of HIV/AIDS", Stefan Elbe, Adelphi Paper, IISS, July 2003; "HIV/AIDS as a Security Issue", International Crisis Group Report, 19 June 2001; "AIDS As a Threat to Global Security", International Conflict Research Group, Conference Proceedings, November 2002; "HIV/AIDS and Security", M. Carballo, J. Cilloniz, S. Braunschweig, International Center for Migration and Health, 2001; "How Will HIV/AIDS Transform African Governance in Africa", Alex De Waal, African Affairs (2003), 201, 1-23; "AIDS and Violent Conflict In Africa", United States Institute for Peace, briefing on workshop, November 2001.

[3] UN Security Council Resolution 1308 (2000).

[4] "The Global Infectious Disease Threat and its Implications for the United States", US National Intelligence Council, January 2000.

[5] Though it should also be noted that some development projects can help spread HIV/AIDS, e.g. by increasing access and mobility. See "HIV/AIDS and Governance in Uganda and Senegal", James Putzel, report for DFID, May 2003.

[6] "'AIDS-Related National Crises', An Agenda for Governance, Early-Warning and Development Partnership", Alex De Waal, September 2001, Justice Africa.

[7] Un-sourced evidence provided by the US National Intelligence Council estimates very high prevalence among the Angolan armed forces – but this did not stop them from achieving peace through a comprehensive victory over the UNITA rebels.

1.6 There is little indication that populations have anywhere mobilised politically in a sustained manner against their governments on the issue of HIV/AIDS. If anything, HIV/AIDS may perhaps be said to have contributed to greater political quiescence and resignation on the part of the populations of worst affected countries (though this in itself may in the longer term contribute to political instability).

1.7 In those countries/regions where relatively high prevalence of HIV/AIDS coexists or has co-existed with widespread internal or regional armed conflict (e.g. in the Great Lakes or in Cote D'Ivoire) there is no evidence to suggest that HIV/AIDS is or was a cause of conflict. Outside of Africa, where prevalence is much lower, there is no war, past or present, in which HIV/AIDS can be said with any plausibility to have been or be a contributing factor to the build up, outbreak or prolongation of the conflict.

1.8 However, past and present experiences may not be a useful guide when looking for a possible causal link between HIV/AIDS and the build up towards armed conflict. The argument that HIV/AIDS is a threat to political stability of nations and could contribute to violent conflict is based on three premises.

1.9 The first is that we do not yet have a complete picture of the impact of an epidemic that is *still in it early stages in many countries in the developing world* and that, according to most projections, is *likely to get a lot worse*. Until now we have only witnessed the medical and humanitarian impacts of HIV/AIDS – morbidity, mortality and personal and family crises. The full political, economic, social and strategic implications of the pandemic have yet to be realised[8].

1.10 The second premise is that the contribution of HIV/AIDS to political instability and armed conflict is largely *indirect* and *cumulative*: at a certain (relatively high, but as yet unknown) level of prevalence, HIV/AIDS has the potential to exacerbate (and in some cases may already be exacerbating) exactly those social, political and economic conditions that are known to contribute to an increase in political instability and vulnerability to violent conflict. According to this argument, the impact of HIV/AIDS is *stealthy* and *unseen.* It accentuates *existing* weaknesses and fissures that can cause conflict – especially the kind of internal conflict associated with weak and failed states.

1.11 The third premise is that *perceptions* about HIV/AIDS may contribute to the build up of armed conflict as much as the reality. For example perceptions that certain groups may be carrying and spreading the virus; that certain groups may be being denied treatment on the basis of class, ethnicity, race or religion; that a government is not doing enough to deal with the epidemic; or that the military preparedness of an adversary may have been undermined by HIV/AIDS.

2. REGIONAL FOCUS AND VARIATIONS

2.1 So far most of the discussion of the connections between HIV/AIDS and political instability or violent conflict has focussed on southern and central Africa, because of the exceptionally high HIV/AIDS prevalence in that region.

[8] "De Waal, African Affairs, *op. cit*; see also Tony Barnett and Alan Whiteside, AIDS in the Twenty First Century, Disease and Globalisation, London, Palgrave MacMillan, 2002; The Long Run Economic Costs of AIDS: Theory and an Application to South Africa, World Bank, June 2003 p 95.

2.2 There are several other parts of the world where projected increases of HIV/AIDS will undoubtedly have significant economic, social, and political impacts. But the impacts of the disease over the coming decade will vary a lot from one region to another, given the large number of differentials. These include different projections and actual trajectories of the disease, different demographic profiles, different socio-economic and political situations, different capacities and responses of governments and leaders in affected countries, and, on the part of donors, different perceptions of strategic interest and responses[9].

2.3 Apart from southern and central Africa, west Africa and the Horn are regions where there is potential for HIV/AIDS to contribute to serious political instability and conflict because of a combination of high projections of HIV/AIDS prevalence, lack of government capacity or incentives to respond effectively, and existing vulnerabilities to instability on account of prior conflicts, weak institutions, poverty and poor governance (among other factors)[10].

2.4 Other parts of the world where projections indicate significant increases in prevalence over the coming decade include: China, South Asia, Russia and other parts of the FSU. But there is probably less potential for HIV/AIDS to impact on overall political stability in these regions[11]. This is because the much larger populations of states like China, Russia and India will be better able to absorb the economic and social impacts of the disease, and because their governments are more capable of responding effectively to the disease. This does not mean that *localised violence* may not occur in these countries due to perceptions that governments are failing to address the issue of HIV/AIDS (there has already been unrest in China) or due to manipulation of perceptions and prejudices about HIV/AIDS.

2.5 If HIV/AIDS did reach significant levels of prevalence in non-African countries where there is already vulnerability to conflict and instability (e.g. in the smaller countries of the southern FSU and in some of the poorer and more vulnerable parts of South Asia), this could contribute to a build up towards conflict and/or hinder post conflict peace building along the lines predicted for parts of Africa.

3. ECONOMIC IMPLICATIONS

3.1 There is already a significant body of work on the economic implications of HIV/AIDS[12], particularly its impact on economic growth and development. A lot of the findings are contradictory. Economists are working to develop models that can help provide more accurate and reliable measurement.

3.2 There is general agreement that the impact in badly affected countries will be negative, but there is less agreement as to how serious it will be. Initial World Bank and other estimates for Sub Saharan African countries ranged from a decline of 0.3% to 1.5% of GDP annually, depending on level of HIV/AIDS prevalence. But more recently predictions have become more negative. A 2003 World Bank study warns that, in a country with prevalence rates as high as those of South Africa, "if nothing is done to combat the epidemic, a complete economic collapse will occur within three generations"[13]. The change of assessment results from factoring into the calculation the cumulative loss of human capital and diminishing capacity of affected states to replenish it.

[9] "The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China", US National Intelligence Council Report, September 2002.
[10] *Ibid*.
[11] *Ibid.*
[12] "The Macro-economic Impact of HIV/AIDS in Sub-Saharan Africa", World Bank Report, 1992; "Confronting AIDS: Public Priorities in a Global Epidemic", World Bank Report, 1997; "Confronting AIDS: Public Priorities in a Global Epidemic", World Bank Report 1997; "HIV/AIDS: does it increase or decrease Economic Growth in Africa?" World Bank Report 2000; Barnett and Whiteside *op.cit*; De Waal African Affairs *op. cit.*
[13] World Bank, "The Long Run Economic Costs" 2003 *op. cit.*

3.3 In order to predict and measure the economic costs of HIV/AIDS accurately it is necessary to factor in both the direct costs (e.g. costs of treatment, losses due to sickness, costs of training etc.) and the indirect costs resulting from structural transformations due to changed demographic patterns like reduced longevity and a removal of large numbers of productive adults from the work place[14].

3.4 This leads to the broad conclusion that high prevalence of HIV/AIDS could well lead to: economic stagnation and decline, (significant cuts in economic growth and productivity); an increase in economic inequalities[15]; a loss of food security as agricultural yields fall; and an increase in competition for fewer economic resources as economies shrink.

3.5 These phenomena are all generally recognised as among the structural causes of political instability and conflict[16]. Furthermore it is likely that HIV/AIDS will also make it more difficult for governments to tackle some of the existing weaknesses in economies that have been identified as important indicators of future conflict, including: lack of economic diversification, over dependence on a single commodity (such as oil or diamonds); and a high level of criminal involvement in mainstream economy.

3.6 However, the hard evidence from those countries like Uganda and Tanzania where HIV/AIDS peaked in the early 1990s and where infection rates have, at least for the time being, been brought down, shows just how difficult it is to make broad generalisations about the impacts of HIV/AIDS. Both these countries experienced significant economic *growth* at the time when they were grappling with the worst of their HIV/AIDS crises and continue to do so. (They also underwent an improvement of political governance – see below).

3.7 The experience of Uganda and Tanzania raises important questions to which we do not have good answers. Was the pandemic brought under control before infection rates reached a level at which they would have had the kind of catastrophic economic impact envisaged for South Africa in the World Bank report cited above? If this is the case, can one identify a tipping point, or threshold, beyond which a more serious economic (or political or social) impact is likely? To what extent were the high levels of foreign aid instrumental in reducing the economic impact of HIV/AIDS? Can these "success stories" be replicated in countries of southern Africa where prevalence is already much higher?

3.8 Undoubtedly there are and will be negative economic impacts of high HIV/AIDS prevalence in many countries. But with bold leadership HIV/AIDS crises could also have some economic benefits. It has been suggested that in countries where economies are anyway in trouble there may be opportunities to use the HIV/AIDS crisis as an occasion for pushing through economic measures that could have important longer term positive economic effects such as much needed fiscal reform[17].

[14] Potential structural economic implications of HIV/AIDS include: changed dependency and gender ratios; lower return from investment in human capital (i.e. training); loss of incentives for saving (linked to an increase in consumption); lower incentives for investment, both foreign and local (e.g. in industry, manufacturing); higher incentives for trade, rentier and informal sector activities and corruption; change in employment patterns (short term or informal employment contracts favoured over long term) as the private sector seeks to shift the burden of care. See De Waal, African Affairs, *op. cit.*

[15] The Long Run Economic Costs of AIDS: Theory and an Application to South Africa, World Bank, June 2003, *op cit.* p. 9.

[16] See for example Breaking the Conflict Trap, World Bank, 2003; Causes of Conflict in Sub Saharan Africa, UK Government policy document, September 2001.

[17] See "HIV/AIDS and Governance in Uganda and Senegal", James Putzel, report for DFID, May 2003.

4. POLITICAL/GOVERNANCE IMPLICATIONS

4.1 Less work has been done on measuring or predicting the political/governance impacts of HIV/AIDS. However this is a growing area of interest for researchers[18]. It is widely recognised that there is a link between decline of political governance and armed conflict. And there is some concrete evidence to suggest that in badly affected countries (many of which already have serious governance problems), HIV/AIDS is already having a negative impact on governance. (This is particularly unfortunate as there is good evidence to suggest that strong political governance is an essential pre-requisite for fighting HIV/AIDS[19]). There are four principle areas of concern.

Institutional Capacity And Competence

4.2 Evidence from southern Africa points to HIV/AIDS contributing to an ongoing hollowing out of important state and non-state institutions, including key ministries of state, security forces, public services, parliament, the judiciary, NGOs, the media, political parties etc. (For the impact of HIV/AIDS on the security sector see below, paragraphs 5.1 ff.) HIV/AIDS may also already be an obstacle to reversing the institutional "brain drain" or persuading qualified members of diasporas to return home. It has also been suggested that high prevalence of HIV/AIDS among government officials and private sector or NGO workers could affect the integrity of institutions by providing an extra incentive for corruption (which is already a serious problem in many countries with high prevalence of HIV/AIDS). Officials and employees who are HIV positive, or whose relatives are, will have a pressing incentive to divert public or company funds to pay for expensive, but life prolonging, ARV treatment[20].

Political Participation

4.3 Limited research suggests that HIV/AIDS has the potential to undermine political participation by weakening the capacities and effectiveness of the largely voluntary civil society organisations that are at the vanguard of grass-roots democratisation[21]. It is also possible that, where large numbers are battling for survival in the face of HIV/AIDS, whether people are themselves sick or caring for sick dependents, they will have less time and energy for political participation of most kinds[22]. This of course can cut both ways. On the one hand it undermines an important component of stability, namely political participation. But on the other hand it also undermines the capacity and will of populations to challenge the state, including through violent uprising – and this may contribute to a reduced risk of violent conflict at least in the shorter term. It should also be noted that in spite of the impact of HIV/AIDS on capacity of NGOs and activist groups, there is also the *potential* for the epidemic to encourage peaceful and constructive political mobilisation and participation in the face a major existential threat[23]. Indeed in the worst affected countries in Africa the HIV/AIDS epidemic has seen a large increase in activity by local (and international) NGOs, which are able to access resources precisely because they offer to address the HIV/AIDS problem.

[18] See International Crisis Group Report, 2001 *op cit.* pp 17-21; and De Waal "Modeling the Governance Implications…" *op cit.*; and De Waal, African Affairs, *op. cit*.
[19] Putzel, 2003, *op. cit*.
[20] "Modeling the Governance Implications of the HIV/AIDS Pandemic in Africa", Alex De Waal, Justice Africa, June 2002 *op cit.*
[21] "AIDS and Democracy: What Do We Know? A Literature Review", Ryann Manning, paper presented to workshop, Cape Town, April 2002.
[22] *Ibid*.
[23] Putzel, *op. cit.*

Legitimacy

4.4 Continued failure of many governments to tackle the HIV/AIDS problem effectively or to show that they are taking the problem seriously may lead to erosion of their political legitimacy in the eyes of the population at large. There is no evidence for this happening as yet but it cannot be ruled out. However, it should be also noted that HIV/AIDS might have positive impacts on legitimacy. In Uganda and Senegal Presidents Museveni and Diouf both increased the legitimacy of their administrations by taking bold steps to tackle HIV/AIDS.

Behaviour Of Political Elites

4.5 Little research has been done in this area. On the one hand, one can speculate that in the face of decimation by HIV/AIDS ruling groups may opt for repressive and corrupt strategies for regime survival, such as buying off potential opponents, or resorting to intimidation and violence. (It is worth asking whether HIV/AIDS plays a role in the decline of governance in Zimbabwe where three cabinet ministers are known to have died of AIDS and where others may be HIV positive). On the other hand one cannot rule out the possibility that, given the right internal and external incentives, a regime might see an HIV/AIDS crisis as a reason to introduce greater political pluralism.

4.6 All four of the governance related issues discussed above have a bearing on conflict. Rapid decline in effectiveness, capacity and integrity of state and non-state institutions, is recognised as a major structural cause of conflict. Likewise loss of legitimacy on the part of the government and absence of avenues and opportunities for political participation are also known to be key factors contributing to conflict. Destabilisation of political transitions and unpredictable behaviour and decision making by ruling elites (whether in government or opposition) could also contribute to conflict[24].

5. IMPLICATIONS FOR THE SECURITY SECTOR

5.1 The security sector is a particularly important building block of effective state machinery. But the security sector is also particularly vulnerable because of higher prevalence of HIV/AIDS among soldiers and law enforcement officers – and among non-state military actors.

5.2 There is a lack of reliable evidence on HIV/AIDS in the security sector because of a culture of state secrecy on matters related to the security. But there are indications that HIV/AIDS is already having a dramatic impact on armed forces in badly affected countries including: poor morale and discipline, a diminished pool from which to recruit, loss of experience and expertise, lower levels of combat readiness, impaired cohesion of units, a weakening of command and control[25].

5.3 We know that in a pre- or low-HIV/AIDS context (e.g. Liberia or Sierra Leone in the early 1990s) such phenomena contributed to internal conflict. We do not know for sure what the impact of the disintegration of the security sector might be in a context of high-HIV/AIDS prevalence. It is important to identify the variable factors that might determine the actual impact of HIV/AIDS on military forces. These might include: HIV/AIDS prevalence, levels of AIDS mortality, the type of armed forces (conscript army, volunteer, rebel or government force etc.), level of technical proficiency (hi-tech armies likely to be worse affected because the cost of retraining is higher), relative size of the army to the civilian population and leadership[26].

[24] Breaking the Conflict Trap, World Bank, 2003 *op cit.*; Causes of Conflict in Sub Saharan Africa, DFID, FCO and MOD, September 2001 *op cit.*.
[25] See Tsadkan Gebre-Tinsae and Alex De Waal, HIV/AIDS and Conflict in Africa, Report for DFID, Feb 2003; also Elbe *op cit.*
[26] Elbe *op cit.*

5.4 There are two different scenarios in which high prevalence of HIV/AIDS in armed forces (including state and non-state forces) could lead directly to conflict. One is that soldiers or rebels may be tempted to pursue wars for financial gain in order to pay for life prolonging ARVs. (This may coincide with increasing brutality against civilians perpetrated by soldiers and/or rebels traumatised by high levels of sickness and death in their ranks). The other scenario is that a state or armed faction may be tempted to attack an adversary (a neighbouring state or an internal rival) on the assumption that the adversary's combat readiness had been undermined by HIV/AIDS.

5.5 There is anecdotal evidence that senior Congolese, Ugandan and Rwandan officers have paid for ARVs with the proceeds of looting and business opportunities presented by the war in Congo. There is also anecdotal evidence that HIV/AIDS has encouraged brutality among combatants in West Africa[27]. But even if true, this would not constitute a cause of the war, merely one of many obstacles to its resolution. There is no evidence that either of the above scenarios has materialised anywhere to date and some argue that both scenarios are somewhat unlikely[28].

5.6 The disproportionate impact of HIV/AIDS on the military may in some circumstance have positive strategic consequences for example by limiting the ability of warmongering leaders to pursue military adventures. In countries where the military has played a negative political role some may welcome the weakening of the military through HIV/AIDS. But there are real risks here too, as a weakened military that is used to wielding considerable political power could also be a source of instability and hamper processes of political transition and security sector reform.

6. SOCIAL IMPLICATIONS

6.1 Loss of social cohesion and increase of social divisions along class, ethnic, religious or regional lines are important indicators of future conflict[29]. But what is the evidence that HIV/AIDS is undermining social cohesion or increasing tensions and divisions within AIDS afflicted societies?

6.2 One major concern is that the HIV/AIDS epidemic is leaving in its wake large numbers of orphans in the worst affected countries. Some have speculated that AIDS orphans could swell the ranks of rebel armies and militias that already give employment to large numbers of child soldiers[30]. But there is no hard evidence for this happening.

6.3 As HIV/AIDS crises unfold and ever growing numbers of people falling ill and die, affected societies may become increasingly susceptible to millenarian, nihilistic or fundamentalist ideologies and groups – particularly those that might offer welfare support or employment. This too could have an impact on political stability and possibly contribute to future conflict. But again there is no hard evidence for this[31].

[27] Author interviews with RUF rebels and CDF fighters in Sierra Leone, 1998.
[28] Elbe *op cit.*
[29] Incidentally, experience in Senegal and Uganda show that these factors also increase vulnerability to HIV/AIDS. See Putzel, *op cit.*
[30] USIP Report, *op cit.*
[31] However, as noted above, there is some anecdotal evidence to suggest that one of the reasons for the brutality of the rebels of the Sierra Leonean RUF was despair induced by fear of AIDS. Author interviews with RUF rebels, 1998.

6.4 By presenting a common threat to nations and societies, HIV/AIDS may engender greater social solidarity and co-operation within and between communities. But there is little sign of this as yet. HIV/AIDS is just as likely to become yet another source of polarisation in a world increasingly divided by haves and have-nots. Indeed, there is some evidence that differences in HIV/AIDS prevalence may already be increasing tension between social and ethnic groups. For example it has been clear for some time in South Africa and Zimbabwe that HIV/AIDS is disproportionately affecting blacks and this has led not only to conspiracy theories about the origin of AIDS but also to heightened racial tension over the issue. Even where such differences do not in fact exist, there is often the perception that they do and a tendency to blame the spread of HIV/AIDS on the "other", e.g. refugees, neighbours, minorities. This too could contribute to conflict.

6.5 Social tensions could be further exacerbated by disparity or discrimination on the basis of ethnicity, religion, social class or professional status by governments or employers in provision of access to medical care or distribution of life prolonging ARV drugs. Again the *perception* of such discrimination may be enough to fan contribute to a rise in tension. In Ethiopia, the Oromos (who have been fighting a low level insurgency against the EPRDF government for years) allege that they are being denied access to HIV/AIDS care on the basis of ethnicity[32]. There is no evidence to support the claim, but the allegation itself could be enough to exacerbate conflict.

6.6 As the cost of ARV drugs drops and poor, badly affected countries start to roll out drugs treatment programmes, authorities will have to make hard choices about rationing drugs and treatment. The opportunities for discrimination and accusations of discrimination are likely to increase.

7. CONCLUSION AND RECOMMENDATIONS

7.1 Although there is little empirical evidence for a *causal* correlation between HIV/AIDS and conflict, HIV/AIDS is likely to amplify and exacerbate those economic, political, and social weaknesses that contribute to a build-up of violent conflict. At a certain level of prevalence, HIV/AIDS will probably therefore increase the risk of conflict.

7.2 The fact that there is little hard evidence for a causal correlation between HIV/AIDS and conflict does not matter very much. The case, in terms of capacity building and poverty reduction, for addressing the medium to long term economic, political, and social implications of HIV/AIDS is already strong enough. Paper 2 shows how efforts to reduce the impact of HIV and efforts to reduce conflict could be mutually reinforcing. Donors are already beginning to focus on mitigating the negative economic, political and social impacts of HIV/AIDS, and on adjust existing development policies to take into account the impacts of HIV/AIDS. This work needs to continue.

7.3 HIV/AIDS could also provide some new economic, political and social opportunities that might contribute to a reduction of conflict. For example, could HIV/AIDS be an issue on which bring parties in conflict to negotiation? Could it be an issue on which to mobilise greater political participation or social cohesion? Could it be an issue on which political leaders are compelled to seek greater legitimacy by actually doing something about the problem?

7.4 There is a real lack of reliable data to go on. Much of the evidence that does exist is inconclusive or anecdotal. Research is required:

[32] Author e-mail exchange with Trevor Trueman, Oromo Support Group, 2002.

i. to identify and elaborate on the key economic, social, military and political variables that might determine the impact of HIV/AIDS on conflict; and
ii. to analyse and assess these variables on a case-by-case basis in individual regional or country conflict assessments.

Potential partners for this work include the World Bank, UNAIDS and the UN ECA, as well as academic institutions working on conflict and HIV/AIDS. DFID could engage with the private sector on some aspects of the issue. A number of companies are already working on this topic, including a major scenario planning exercise undertaken by UNAIDS and Shell.

7.5 There is a need for greater understanding of HIV/AIDS (including the potential contribution of HIV/AIDS to conflict) among those working on conflict and for a greater understanding of conflict among those working on HIV/AIDS. HIV/AIDS literacy should be a requirement among conflict specialists in regions of high prevalence. DFID should consider incorporating HIV/AIDS into its work with the FCO and MOD on conflict prevention and in particular on security sector reform. This work should look at ways of gathering more reliable information on HIV/AIDS prevalence and impact in military forces in priority countries.

PAPER 2: PREVENTION OF CONFLICT: COULD EFFORTS TO MITIGATE THE EFFECTS AND PREVALENCE OF HIV/AIDS HELP REDUCE THE BUILD-UP TOWARDS CONFLICT?

1. INTRODUCTION

1.1 A substantial body of literature exists on the subjects of conflict and HIV, and increasingly on the relationship between them. However the bulk of this literature considers how conflict can exacerbate HIV transmission and increase vulnerability. A far smaller body of literature explores how HIV might, in some cases, drive conflict.

1.2 No unequivocal evidence has been found to support the hypothesis that efforts to prevent and mitigate HIV reduce the build-up towards conflict. However, nor has data been identified to prove that it does not. Moreover, there are at least three reasons to believe that efforts to prevent and mitigate HIV *could* prevent the build-up towards conflict.

1.3 First, both conflict and HIV share common drivers in the form of poverty, inequality, discrimination, exclusion and insecurity. Therefore, efforts to address these, whether intended primarily to tackle conflict or HIV, seem likely to have secondary benefits in terms of the other.

1.4 Second, both conflict and HIV erode the social capital upon which societies depend for mutual cooperation and survival. Therefore efforts to increase and strengthen this, (again whatever the primary motivation) are likely to be of *mutual* benefit.

1.5 Third, recent demographic work suggests that global efforts to promote reproductive health services could ease the transition towards demographic stability in those countries in which (together with other variables) high HIV prevalence currently may suggest the likelihood of conflict.

1.6 This paper is based upon a review of available published and grey literature together with opinions solicited from a small group of experts in the fields of HIV, conflict and development[33].

2. COMMON DRIVERS OF CONFLICT AND HIV

2.1 The nature of the HIV epidemic as both an acute crisis and a chronic challenge to sustainable development is described by Cohen (2002):

[33] Kate Butcher (JSI UK), Desmond Cohen (formerly HIV & Development Programme, UNDP), Judy El-Bushra (Independent Consultant, Gill Gordon (International HIV/AIDS Alliance) and Ulf Kristoffersson (UNAIDS Office on AIDS, Security and Humanitarian Response).

"The HIV epidemic is flourishing in a region that has witnessed continuous crises over the past 50 years from a multitude of causes ranging from conflict to natural disaster, and countries are becoming increasingly impoverished. These conditions are exacerbated in many countries by policy responses that often worsen the underlying conditions in which people live."

2.2 The tension between the need for immediate and longer-term action has been an implicit element of the response to the epidemic since it began. Effective responses need to address both immediate needs in terms of prevention, treatment and care, as well as being placed within the framework of a development response to the epidemic, which tackles broader socio-economic and political factors that construct vulnerability and determine impact.

2.3 Liberia and Sierra Leone both demonstrate the devastation that conflict can produce, while the HIV epidemics in Botswana and Swaziland (with the highest HIV prevalence in the world) indicate how rapidly and extensively the epidemic can spread, and with such potentially devastating results. Where both conflict and HIV co-exist – for example in Rwanda or the Democratic Republic of the Congo – each can amplify the impact of the other with calamitous results (see below).

2.4 According to Harvey (2003), in those situations where they co-exist, the spread and impact of the HIV epidemic can exacerbate the extent and consequences of conflict. In turn, conflict increases risk and vulnerability to HIV infection and undermines effective interventions.

"HIV/AIDS deepens existing vulnerabilities and underlying political weaknesses limit the ability of governments to respond adequately to HIV/AIDS."

2.5 Thus, it is not suggested that HIV leads inevitably to conflict or vice versa in a simple cause and effect relationship. According to UNAIDS[34], there is no evidence that the impact of the HIV epidemic upon armed forces is inspiring or 'foreclosing' the outbreak of armed conflicts, nor have armed conflicts been initiated primarily as a result of the undermining effect of the epidemic upon a country's armed forces. The important point is that where factors combine to give rise to either conflict or the epidemic - depending upon prevailing socio-economic, political and epidemiological vulnerabilities - the *opportunity* is created for the other, not only to emerge, but also to thrive.

2.6 While the effects of conflict upon HIV transmission and vulnerability are better understood than the impact of HIV upon conflict, nonetheless exploratory work has been undertaken with a view to exploring how extensive HIV infection in a population (or particular segments of it) might contribute directly or indirectly to social unrest and conflict. For example, in consideration of the Rwandan genocide, Reid (1998) highlights the need to consider the role of particular features of Rwandan society such as population density, cultural values, its social structures and poverty. She goes on to raise the possibility that the behaviour of the perpetrators of the Rwandan genocide may have been affected by the very high levels of HIV infection which were known to exist in the country before the genocide, particularly among sex workers, the military and among the urban educated and wealthy segments of Rwandan society. Knowledge of the epidemic clearly informed the adoption by the militia of the deliberate strategy of sexual violence perpetrated on a mass scale by militia members who were believed to be infected with HIV. It is estimated that over 250,000 women were raped, tortured and left to live. Reid draws a comparison between the distorted demographic profile of Rwanda, which was the result of the genocide (with 60% of the population female, of whom 60% were widows) with that of post-war Cambodia, which has also been heavily affected by the HIV epidemic and argues that:

[34] Ulf Kristoffersson. Director UNAIDS Office on AIDS, Security and Humanitarian Response. Personal communication 23.01.04

"The direct outcomes of the spread of HIV in conflict and post conflict situations are psychological and social trauma, illness and death. As this increases, the ensuing adverse impact on social relations and productive capacity leads to destitution, insecurity, lawlessness, political unrest, violence and even conflict. Effective prevention, support and care programmes may minimize the extent of these dislocations."

2.7 Given the potentially synergistic relationship between HIV and conflict, it seems reasonable to assume that action to prevent one can contribute to the prevention of the other. The possibility of such complementarity was recognised by the Secretary-General of the UN in his (2001) report to the Security Council, in which he urged the General Assembly - at its then forthcoming special session on HIV - to examine how HIV prevention strategies could be broadened to take into account the important contribution that they could make to conflict prevention.

3. SOCIAL CAPITAL

3.1 Community norms and values play an important role in terms of responses to the epidemic. When these norms and values are negative, they can increase risk and vulnerability. This can occur, for example, when one group excludes or discriminates against members of another, such as sex workers, drug users, men who have sex with men, and people living with HIV. It can occur when community norms implicitly condone destructive aspects of male behaviour such as heavy drinking or domestic and sexual violence, or when they reinforce patterns of gendered roles and behaviour that add to the demands on the time and resources of girls and women, and that increase their vulnerability to infection by leaving them no option but to rely upon trust as a primary protective strategy.

3.2 Conflict reinforces destructive patterns of gender relations. However, research from Uganda, conducted by El Bushra et al[35], suggests that the relationship between HIV, gender and conflict is dynamic. Considering people as '*gendered actors* in conflict' suggests the possibility of resisting the reinforcement of negative gender dynamics and of renegotiating gender values, norms and relations in ways that are compatible with peace and cooperation.

3.3 According to Putnam (2001), the central idea of *social capital* is that networks and the associated norms of reciprocity have value. Reid (2000) argues that there is evidence that communities with stronger *social capital* may be more able to change harmful norms and values as these relate to the HIV epidemic. Such communities are more likely to be able to generate discussion of problems, leading in turn to the development of new norms, collective action and social change. Communities with strong social capital may also develop and implement initiatives more effectively through rapid diffusion of information and innovations and through the active participation of community members:

"Whether an epidemic is nascent, concentrated, contained or generalised, it is the density and nature of the patterns of social connectedness, the existence of a sense of the common good, of a capacity for collective reflection, that enable communities to build and protect themselves. Strengthening social connectedness and concern, working through social conflict or apathy, then, become the primary focus of our work. For a successful response, these same qualities need also to reside in the community's organisations, in non-governmental organisations and in national institutions. These too need to become reflective, inclusive and cohesive, with a strong sense of the common good". (Reid 2001).

3.4 Consistent with this emphasis on social capital, Gill Gordon[36] identifies a number of goals and means of working with communities to reduce vulnerability to conflict and HIV (see Annex 4).

[35]Personal communication and see research papers by Judy El Bushra at www.acord.org.uk
[36] Personal communication 15.01.04

4. THE 'SECURITY DEMOGRAPHIC'

4.1 According to Population Action International (Cincotta et al 2003), most countries are moving towards a *security demographic* - a 'distinctive range of population structures and dynamics that make civil conflict less likely' and progress through this demographic transition reduces the risk of civil conflict, and contributes to a more peaceful and secure world.

4.2 In isolation from other socio-economic and political factors, demographic processes, in themselves, neither cause nor prevent civil conflict. Nonetheless, according to PAI, particular demographic factors - by interacting with each other and with non-demographic factors such as historic ethnic tensions, unresponsive governance and ineffective institutions - *are* associated with increased risk of conflict.

4.3 In this report, PAI argues that the demographic factors most closely associated with the likelihood of civil conflict during the 1990s were a high proportion of young adults (15 to 29 years old) — a phenomenon referred to as a' *youth bulge'* — together with a rapid rate of urban population growth. Countries in which young adults comprised more than 40 percent of the adult population were more than twice as likely as countries with lower proportions to experience civil conflict. States with urban population growth rates above 4 percent were about twice as likely to sustain the outbreak of a civil conflict as countries with lower rates. Furthermore countries with low-availability of cropland or renewable fresh water were 1.5 times more likely than others to experience civil conflict.

4.4. Gebre-Tinsae and de Waal (2003) also draw attention to the 'youth bulge', urbanisation and unemployment, to which they attribute (at least in part) the emergence of large-scale criminal activities contributing to corruption and the availability of weaponry on the market.

4.5 While a connection between high death rates among working-age adults (as a result of HIV) and vulnerability to conflict was not proven, nonetheless, PAI concludes that as evidence of impact (which is projected to be significantly worse in the present and coming decades) - loss of key professionals, the weakening of the military and unprecedented numbers of orphans - are strongly indicative.

4.6 In the near future, according to PAI, the highest demographic risks of civil conflict are concentrated in sub-Saharan Africa, the Middle East and in South Asia. For the period 2000-2010, twenty-five countries were selected on the basis of 'high' or 'extreme' categories of stress in three or more of the key demographic factors. Working-age deaths were *not* used to determine this list. Nonetheless, 10 of the 25 countries were also in the 'high' or 'extreme' stress category for this factor. The ten countries are: Burkina Faso, Burundi, Congo, Ethiopia, Kenya, Liberia, Malawi, Rwanda, Sierra Leone and Tanzania.

4.7 According to PAI, vulnerability to conflict can be reduced by facilitating the 'demographic transition'. Key measures suggested by the authors include: increasing political support for and access to modern contraceptive methods and reproductive health services (including those relating to HIV infection) for those who need it, particularly to refugees, supporting HIV prevention programmes for military personnel, and enhancing educational opportunities for girls, and promoting women's participation in civil society and government.

5. CONCLUSIONS

5.1 According to UNAIDS, an *expanded response* to the epidemic can shift social norms, decrease stigma and increase political commitment to addressing the deep-seated gender and economic disparities which drive the epidemic. The document - *Global Strategy Framework on HIV/AIDS* (2001) - describes such a response, designed to address the dynamics of the epidemic by: i) *decreasing the risk of infection* (to slow the epidemic); ii) *decreasing vulnerability* (to decrease the risk of infection and the impact of the epidemic); and iii) *decreasing impact* (to decrease vulnerability).

5.2 In order to explore potential and practical linkages between conflict and HIV-related work, two Annexes have been included in this paper. The first (Annex 3) comprises a table which draws on the UNAIDS Global Strategy document in identifying ways in which HIV-specific interventions could contribute to inhibiting the development or escalation of conflict. Annex 4 is based on experience and provides examples of goals and ways of working with communities to reduce vulnerability to conflict and HIV[37].

5.3 The table, Annex 3, refers to 6 broad goals. Under the heading of each goal, examples are provided of objectives (column 1), possible interventions (column 2) and potential linkages to the reduction of conflict. As with any intervention, impact is assumed to occur as the cumulative result of a set of mutually reinforcing activities.

5.4 A first principle of HIV interventions must be to 'do no harm'. The spread of the virus in any society tends to follow existing patterns of inequality, with the result that those who are already vulnerable socio-economically or culturally may also be those most affected by the epidemic's impact. HIV is strongly associated with stigmatisation, scapegoat and blame. Efforts to mitigate the epidemic have sometimes (usually unintentionally) reinforced prejudice and stigma, with the result that the burden on those most adversely affected by the epidemic is actually increased. Careful consideration therefore needs to be to be given to any unintended effects particularly in relation to people living with HIV and those who may be members of vulnerable groups associated with the epidemic (whether or not this is consistent with the epidemiological reality).

5.5. While no clear evidence has been found to support the hypothesis that efforts to prevent and mitigate HIV can also reduce the build-up towards conflict, nonetheless. evidence does suggest that a synergistic, mutually reinforcing relationship can soon become established when both exist in the same place and time.

6. RECOMMENDATIONS

6.1 Given the commonality of many of the factors that drive both phenomena together with the potential cumulative effects of each on economies, social structures and governance, it seems sensible to explore the issue further by recommending that DFID:

i. Identifies and disseminates examples of good practice in relation to integrating work that addresses HIV and conflict issues specifically in relation to:

- HIV prevention and care in conflict situations
- Working with military personnel
- Skills and mechanisms for resolving conflict at community level and beyond

ii. Mainstreams HIV within conflict-related work supported by DFID for example by providing guidance on the preparation of project/programme documents to ensure that

[37] Gill Gordon, personal communication January 2004.

possible synergy between conflict and HIV is taken into consideration in relation to countries/regions where these are of particular relevance.

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FRAMING STATEMENT FOR PAPERS 3-6

1. ESTABLISHING THE PARAMETERS OF 'CONFLICT'

1.1 As DFID recognises: "Conflict should not be seen as something which is always negative. It is an inherent feature of change in society. It becomes a problem when society cannot manage or resolve its different interests in a peaceful way and violent conflict emerges" (from Tools For Development no. 11: Conflict Reduction, November 02).

1.2 These papers will examine a range of situations involving '**armed** conflict' which have a bearing on the HIV/AIDS-conflict nexus. This use is compatible with the current understanding that historical notions of warfare do not reflect contemporary complexities characterised by stop-start campaigns, fluid boundaries, civilians as prime targets, contesting sets of irregular forces etc.

However, specifying the presence of actual physical violence would restrict analysis of highly relevant data on social relationships which may not overtly present this aspect but which are nevertheless 'loaded' with potential threat This is particularly the case when examining gendered relations of power in relation to sexuality e.g. male teachers threatening girl students with failing grades unless they consent to sex.

1.3 At times therefore, it will be essential for these papers to refer to knowledge/concepts, which are not about either armed conflict or actual physical violence. This approach is supported by authors such as Campbell (2003) who consider that "HIV/AIDS is a microcosm of the way in which social contexts, social inequalities, the disempowerment of women, the disempowerment of young people impacts negatively on people's health. In some sense what we have to do is look at the fact that many people live in social contexts which prevent them from being healthy".

1.4 This approach meshes with the factors which all the leading institutions recognise as driving the HIV/AIDS pandemic: poverty; mobility, especially transport routes/migrant labour); armed conflict; unequal gender relations; multiple sexual relationships, especially those of men (e.g. Barnett and Whiteside, 2002; (Foreman 1999)

1.5 The overall relevance of 'gender' to HIV/AIDS is firmly established in the literature; there is also a recent consensus in the health field that this must encompass gendered relationships of **power**, especially those characterised by sexual violence e.g. "Violence, including the fear of violence, is emerging as an important issue for women and HIV transmission" (Watts, 2002: 1). This consensus in the health field matches that in development research and development institutions over violence against women (VAW), development and human rights (see Annex 2 UN Secretary General's Bulletin, 8 October 2003.)

1.6 However, there remain many knowledge gaps over the extent of sexual violence. This is the result of a complex of factors including: the outcome of denial by 'official' sources e.g. police/legal/educational institutions of its existence or scale; lack of disclosure by (female or male) victims because of risk of social stigma and further retaliation; differing cultural concepts of what constitutes sexual violence; ethical reservations on the part of researchers.

1.7 The ToR ask "What do *we* know about …" (emphasis added). In order to respond meaningfully, it is necessary to acknowledge that there are quite disparate trajectories of knowledge in this field. For example, macro-epidemiological studies from the public health field are not of the same order as the reports of women's organisations operating in war zones about the incidence of sexual violence against women, girls (and sometimes boys). This is illustrated by the experience of women's organisations in Mozambique and Cambodia (see Annex 5).

There are further conspicuous knowledge gaps in relation to gender and violence/violent conflict. This relates to the absence of analysis of **masculinity/masculinities** in development literature. It is only in the last decade that gender 'experts' in development organizations have really attempted to view gender as a relational issue, let alone make tentative attempts to address the issues of masculinity." (Oxfam, 1997: 2-7). Such gender analysis as exists comes principally from the field of international relations e.g. Cynthia Enloe on the US military (Enloe 1989); there are severe problems in generalising from this to the diverse categories of forces involved in peacekeeping.

This conceptual debate lies outside the scope of this project, but these papers will take the position that the processes by which men are constructed/experience themselves as 'real men' in any given context is a central feature. This is particularly the case with institutions such as the military and other security forces.

1.8 Statistical data. In addition to all the problems affecting reliable data on HIV/AIDS in populations as a whole (lack of testing, inappropriate extrapolation, long non-symptomatic period etc), these papers have to operate with context-specific constraints on data. For obvious reasons, military institutions have their distinctive medical regimes, which do not necessarily operate on the same basis as those in the public health field. They may resist disclosing any statistics in the name of 'national security'; in the past, HIV/AIDS figures have been deliberately misreported (Soeprapto W 1995). At present, some militaries e.g. South African Defence Force are conducting an open debate with civil society about others resist disclosing any statistics in the name of 'national operational security'.

1.9 It has been particularly difficult to draw on large scale, comparative data sets establishing reliable benchmark indicators for the military. Even with growing awareness of the implications of HIV/AIDS, researchers from UNAIDS/the Civil Military Alliance (CMA) only obtained 62 responses to their 119 questionnaires (Yeager et al, 2000)**.** In South Africa today, there is speculation in the media that HIV/AIDS infection within the SANDF ranges from 40% to as high as 90% in some military units, especially in Kwa-Zulu Natal. On the other hand, recent comprehensive health assessments conducted by the South African Military Health Service (SAMHS) among the units most frequently deployed unit's places HIV infection at around 20%, close to the national average. However, this figure cannot be confirmed, as only selected units were tested, tests were voluntary and HIV positive members could already have self selected themselves away from these units, knowing that they could be tested. Thus although the epidemic is being researched by the SANDF, the exact level of infection within the SANDF remains uncertain.

1.10 A further problem has been the differing chronologies of awareness. For example, it is may be misleading to extrapolate from the evidence of Cambodia in the mid 1990s to today's context where the HIV/AIDS pandemic is much more acknowledged.

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PAPER 3: WHAT DO WE KNOW ABOUT HIV/AIDS AND PEACEKEEPERS[38] IN SITUATIONS OF CONFLICT?

1. INTRODUCTORY NOTES

1.1 The ToR for this paper require that 'conflict' is primarily addressed in the context of episodes of armed conflict which have given rise to intervention of military personnel involved in peacekeeping/peace support operations, other uniformed services e.g. police, and civilians. Their presence indicates that, in DFID's terms, a society has not been successful in managing or resolving its different interests in a peaceful way."

1.2 Military personnel: the national militaries who have operated in UN operations (the 'blue berets') such as Cambodia, Namibia, Mozambique, Angola and E. Timor are drawn from a widely different range of socio-economic backgrounds e.g. the UK, the USA, Zambia, Nepal, Ukraine. The category also involves non-UN operations, such as NATO and ECOMOG in Sierra Leone[39]. Some countries have experienced both UN and non-UN peace support interventions: Somalia; Sierra Leone and the DRC.

1.3 Other actors:

- In addition to 'frontline' combatants, peacekeeping and peace support currently involves a substantial range of policing, security and technical tasks e.g. armed site security. There has been a significant increase in recent years in the practice of sub-contracting these tasks out to for-profit operations (International Alert, 2001). It is calculated that over half of the personnel on the ground in Iraq are from this category (Traynor 2003). The status of these personnel is neither categorically 'military' or 'civilian' (see below).

- Civilian personnel cover UN humanitarian agencies; other agencies from the international community e.g. ICRC; NGOs operating on a diversity of mandates and memoranda of understanding. There are also commercial operations that obviously have a different position in relation to their responsibilities.

1.4 It is beyond doubt that the intervention of these actors can literally make the difference between life and death for civilians (and the combatants from the opposed forces) e.g. by protecting displaced people, organising emergency medical aid etc). In the medium term, they contribute to a return to 'normal life' and to governance, through ensuring that free and fair elections can take place. From this point of view, 'peacekeeping' occupies a historically distinctive place within the broader area of military operations, and the countries providing troops to UN or other peace support operations are justly proud of their contribution.

[38] 'Peacekeepers' are defined as encompassing "UN and non-UN missions and personnel working for and alongside these missions (e.g. UN Agencies, Civil Society Organisations etc)."
[39] Under the mandate of ECOWAS

1.5 There are other outcomes to the presence of peacekeepers. Historically, STI infection rates among soldiers are typically 2 to 5 times higher than in the general population (Carballo 2001). The advent of HIV/AIDS along with UN experience in Cambodia (see Annex 5) and other UN missions has brought this issue to the forefront, in terms of a postulated 'paradox of protection'. This has a dual significance: on the one hand, peacekeepers as vectors of HIV and on the other as being vulnerable to infection when coming from high incidence communities. There is as yet no definitive causal link, but the UN Security Council Resolution 1308 of July 2000 acknowledges that this is an issue of major concern. It underscores the need for the Department of Peace Keeping Operation (DPKO) to incorporate HIV/AIDS prevention awareness skills and advice in its training for peacekeepers; encourages troop contributing countries to provide voluntary and confidential HIV/AIDS testing and counselling; develop long term strategies for education and prevention.

- STI rates among the US military have at times increased by a factor of 50% during military engagements (Kingma, 1996 in Carballo, p. 10).
- In Cambodia in 1995, 8% of military personnel overall and of the police was infected with HIV; the prevalence in the civilian population was 4%.
- In 1993, prevalence in the Cameroon military sector (contributors to ECOMOG operation in Sierra Leone) was 6.2% while the civilian prevalence was 2%.

1.6 With the exception of a relatively small percentage of cases associated with intravenous drug use (IDU), these figures are evidence of a high incidence of unprotected penetrative intercourse on the part of at least some elements among military and uniformed personnel while on peacekeeping/peace support operations. This is confirmed anecdotally by observers in the locale, especially in interviews and reports from women's organisations, in grey literature and, by deduction, from the concern of national militaries to introduce HIV/AIDS awareness programmes and condom distribution.

During their period of deployment, sexual activity by male soldiers takes place: within barracks (with other male or, in certain contingents, female soldiers); with sex workers (SW) in the immediate vicinity of a military base; in transit/'R&R' areas; other sexual relationships with civilians. Infection may be bi-directional.

Field studies such as Bazergan 's on the UN mission in Sierra Leone (Bazergan 2002) suggest that testing of military personnel is not routine: she states that:

"None of the contingents[40] tested troops as a matter of course in the field; most stated a policy of post-deployment. There was a marked confusion about policy regarding troops found to be HIV-positive in the mission, with commanding officers and medical staff often at odds. Approaches to confidentiality and permission to test also differ…. Eight of the ten battalion level medical facilities visited did not have HIV test kits."

It should be noted that testing per se is not in itself a strategy; where staff are encouraged or obliged to go forward for testing, policies should be in place, which articulate care and treatment available to those personnel who test positive.

1.7 In addition, it is particularly important to note that this sexual activity is very frequently associated with younger women and girls (see Annex 5 for Mozambique, Cambodia and Kosovo data).

[40] UNAMSIL contingents included: Bangladesh, Ghana, Jordan, Kenya, Nepal, Nigeria, Pakistan, Russian, Ukraine and Zambia

2. INDIVIDUAL VARIABLES[41]

2.1 Among the individual factors in the HIV/AIDS-conflict nexus are:

- Age: there are likely to be individual behavioural differences between younger conscripts/recruits and older career professionals with established family relationships.
- Formative psycho-emotional experiences: ability to form loving relationships and to handle crisis.
- Education (level of literacy).
- Cognitive/intellectual ability: ability to absorb information.
- Sex – military forces in the North are increasingly recruiting women volunteers who are now being deployed on peacekeeping. There are also female military in most Southern militaries, usually in a very small minority[42].
- Sexual orientation – likelihood of seeking same sex relationships.
- Individual faith - as regulating personal conduct and attitudes to condom use.

3. COLLECTIVE VARIABLES

3.1 The collective behaviour of military personnel will be affected by:

- Conscription or voluntary enrolment.
- Military rank.
- Entrenched patterns of relationships in their societies of origin: this may be reflected, for instance, in racist conduct within their own institutions and towards civilian populations in the area of operation. This will reduce the motivation for avoiding inflicting harm on civilian populations.
- The specific forms of gender relations in their societies of origin. For example, if troops from countries where there are strict controls on the mobility and conduct of young women find themselves in contexts where these do not exist, then they may categorise local women as 'loose' and therefore sexually available.
- Knowledge and beliefs about condom use. For example, military personnel may share lack of knowledge of the correct use and degree of protection provided but be unwilling to acknowledge this.
- Prevailing attitudes towards sexuality - is only unprotected penetrative intercourse regarded as 'real sex'?
- The threat of danger. Existing research in this area (e.g.(UNAIDS; Carballo 2001; Sarin 2003) sees this as a cause for the 'enjoy today, for tomorrow we may be dead' attitude demonstrated by the military.
- Disposable income. This is particularly relevant to regular forces deployed in peacekeeping. Accounts from health, human rights and women's organisations confirm that commercial sex zones spring up in a very short period in any situation where troops are allowed outside their barracks e.g. Cambodia; Mozambique; Kosovo. In other situations, the military themselves designate 'R & R' zones outside the area of operations e.g. Mombasa for troops in Somalia.
- Length of deployment. Extended periods on peacekeeping operations, with or without dangerous confrontations, impacts on behaviour.
- Attitudes towards sex between men. It is highly difficult to get reliable data, but it is at least probable that it occurs more than is publicly acknowledged but remains a largely taboo subject, particularly in the context of 'manliness'.

[41] This and subsequent headings follow the headings stipulated by the ToR
[42] Although the Eritrean national forces contain approx. 30% female conscripts

- Effectiveness of disciplinary regimes, particularly in relation to 'fraternisation' with civilian populations, including punishments.

3.2 Altogether, when examining sexual behaviour, it is essential to bear in mind that the military is a pre-eminently male institution, which requires a very specific form of gender relations between men. This may be manifested in various ways including:

- Submission to discipline within a hierarchical structure may require a display of compensating behaviour when off duty e.g. alcohol; fighting.
- The peer group solidarity and trust which is a prerequisite for effective combat. This makes it difficult for any individual soldier to dissent from the prevailing norms about alcohol, attitudes to commercial sex workers (CSW) and attitudes to women as a whole.
- Generally, this group solidarity involves what is acceptable and not in the area of sex, and emphasises obtaining sexual gratification from women (even where there is actually quite a high incidence of men having sex with other men).
- It may also involve the deliberate use of humiliation/brutalisation e.g. in initiation ceremonies to 'toughen' new recruits, which in turn affects their relationships to more vulnerable members of society, including women and girls. The growth in recruitment of women in certain militaries e.g. in the US appears to be only slowly altering this pattern (DPKO, 2003).

Differential Outcomes: Military

3.3 In the pre-AIDS era, regular military forces have had relatively easy access to effective medical treatment against STIs such as syphilis. Thus, although use of condoms was usually advocated, it was not a matter of 'life and death' in terms of military discipline. The human rights aspects of their conduct e.g. the risk of infecting their partner(s)were not a central element of military training or discipline.

3.4 The first large scale documentation of the relationship between the presence of UN peacekeepers and HIV/AIDS arose during the Cambodian operation (see Annex 5). The subsequent public health research concentrated on Thai and Cambodian militaries.

3.5 Subsequently, the focus has shifted to military interventions by external peacekeepers and African forces, including:

- Countries which have provided peacekeeping contingents to several UN operations e.g. Zambia; Kenya; Senegal.
- The intervention of West African forces in Sierra Leone during the 1990s has had an effect on HIV rates.
- Peace support operations in Sierra Leone.
- The current intervention in Liberia.

3.6 The known rates in several African militaries are now considered to constitute a national security crisis. Seropositivity rates of 50-90% are believed to be common in armies in eastern and southern Africa(de Waal 2001).This has fundamentally affected priorities for recruitment, training, deployment and demobilisation. The emerging crisis in other regions of the world will also have specific implications for peacekeeping operations and for longer-term conflict prevention (see Papers 3 and 6).

3.7 As a result, there is much more awareness of the urgent need to provide HIV/AIDS information and programme programmes among national military institution, which then affects the personnel deployed on peacekeeping. These initiatives are supported at international level by the UN e.g. Guidelines for Peacekeepers from the DPKO. Until recently, the DPKO guidelines did not preclude HIV-positive individuals from deployment on peacekeeping operations if they did not show clinical manifestations of AIDS, they only recommended that they not be deployed. These guidelines are now under review.

Despite these advances, there is enormous variability in the extent and quality of the information that military personnel who will form peacekeeping contingents will receive about the risks of HIV/AIDS in the course of their military career. Even where military personnel have received adequate information about HIV/AIDS, the evidence from statistics, follow up evaluations etc strongly suggest that (in common with civilians) the impact on actual behaviour change is limited. The underlying reasons for this are complex. Existing studies of the military stress the impact of being removed from a social and family environment and facing immediate dangers, arguing that this will have an important affect on behaviour, including removing 'normal' sanctions on sexual conduct. However, this argument does not explain situations where p/k troops are not actually in highly isolated, threatening environments but where they still engage in high risk sexual activity with sex workers (usually, although not exclusively, with women or girls).

Similarly, there is great variability in the implementation of military disciplinary codes regulating the interaction of peacekeeping troops with the civilian population.

In some contexts of active service, troops can be confined to their barracks when they are off duty and be subject to punishment for infringement of these controls. In others, access to bars and brothels will be regarded as a necessary part of maintaining morale.

4. OUTCOMES FOR OTHER PERSONNEL IN PEACEKEEPING OPERATIONS

4.1 Sub-contracted security operations. As a relatively new development, it is much more difficult to find information in the public domain about HIV/AIDS rates among these categories of personnel. This is also associated with codes of protection of personal data of employees and with commercial considerations. They are operating within a militarised modus operandi, share isolation and risk and are in fact frequently former military personnel. It is therefore reasonable to assume that their conduct will be influenced by some of the factors listed under sections 2 & 3.

There is substantial anecdotal evidence from women's organisations and documented material from court cases that at least some of these personnel share the military behaviour in relation to sex workers (O Meara 2003; Traynor 2003). This has been demonstrated in Kosovo (Hughes 2001) and Angola (personal observation). There is no accessible data on associated HIV/AIDS infection rates among the subcontracted personnel; the outcomes for the sex workers are discussed in Paper 4.

4.2 Civilian personnel from humanitarian/aid agencies. There are the same constraints on data, although some agencies are adopting a much more pro-active position on HIV/AIDS prevention (Holden 2003). As civilians, they do not start with a militarised modus operandi and ethos. Instead, the emphasis is on the humanitarian and human rights ethos of their organisations. However, there is evidence that not all personnel may put this ethos into practice, and this must be assumed to involve some risk taking behaviour and resulting HIV infection. The numbers involved are likely to be considerably lower than those of military.

5. KNOWN SUCCESSES & GOOD PRACTICE

5.1 In recent years, the conduct of military peacekeepers has been discussed within a range of international institutions. Given the previous situation, where this issue was not even in the public domain, this can be considered as a known success.

In place of denial, there are now a range of resources and evidence of good practice:

- The UN Secretary General has issued very comprehensive requirements for the conduct of all UN personnel (see Annex 2).
- DPKO guidelines/mechanisms for pre-deployment testing, training, counselling and medical treatment for peacekeepers (see Annex 5).
- Other training programmes e.g. the Pearson Peacekeeping Centre for national militaries (including the UK).
- Mechanisms for monitoring of the conduct of peacekeepers, including by UN civil-military and human rights officers.
- Regional initiatives between national militaries e.g. Kenya, Tanzania and Uganda (UNAIDS, 2003).
- Several national militaries have also entered into dialogue with health and development professionals through organisations such as the Civil Military Alliance. This greater openness to the non-military world is essential for effective prevention.
- Some militaries are looking at the entire area of emotional and sexual relationships as part of their responsibilities to their personnel and to civilians e.g. the Dutch Defence Ministry provides counselling on sexual abstinence to troops (personal communication).
- Thailand's national strategy for reducing HIV prevalence was extended to the military, with the effect that the high rates seen after operations in Cambodia and in the border areas have been significantly reduced. This demonstrates that behaviour change is achievable.
- Recent initiatives covering Eritrean, Ethiopian and peacekeeping personnel (UNAIDS Eritrea, 2001) demonstrate highly effective learning approaches and initial indications of significant changes in attitude towards the need to change their attitude to condoms. [43] There did not appear to be a diminution in sexual activity overall (UNAIDS Eritrea, 2001).

5.2 Sub-contracted security personnel. This area is problematic. The evidence which reaches the public domain is much more related to 'bad practice' in the form of allegations and legal action involving private security companies such as DynCorp and individual ex-employees (O Meara 2003).

5.3 Civilian personnel. There is now a body of work from AIDS-related bodies on the general area of conflict e.g. UNDP; UK Consortium with guidelines for good institutional practice, including monitoring of personnel operating in emergency situations linked to armed conflict. British NGOs are also reviewing their internal procedures and codes of conduct in relation to national and international staff. (Smith 2002; Holden 2003).

[43] The motto was "Take guns to protect from the energy, condoms from HIV/AID" and condoms made available throughout the military base and in field rations

6. POTENTIAL PARTNERSHIPS AND THEIR COMPARATIVE ADVANTAGES

6.1 There is an obvious comparative advantage for DFID in working within existing military regimes, including the DPKO and the Ministry of Defence, particularly in the area of current operations (see Recommendations for specific suggestions). However, for the reasons noted in the overview paper, it is extremely difficult to get reliable baseline data on the activities of peacekeepers. DFID could use its existing position within the Global Conflict Prevention Pool to establish whether there is data, which is currently only available within military circles. It should also seek to establish partnerships with researchers and institutions which have done field work in this area, especially in Eritrea, Sierra Leone, E. Timor and Kosovo (see Recommendations for details)

6.2 Women's organisations in conflict-affected regions e.g. Association of Rwandan War Widows; African Women Living With Aids and in troop providing countries e.g. Nepal; Ukraine can offer insights into civil-military relationships which may not be covered in the public health or 'official' military documentation.

7. RELATIVE COSTS, RISKS AND DIFFICULTIES

7.1 The principal constraints on achieving behaviour change among peacekeepers fall into the wider domain of HIV/AIDS prevention. The specific constraints in relation to peacekeepers include:

- The operational conditions of UN missions, where troops are subject to their own national military regimes in terms of training, pre-deployment testing, medical support etc.
- Negative reactions to any attempt to impose any controls on what is regarded as 'normal' sexual access to sex workers[44].
- Providing accurate testing requires considerable investment in equipment and training of military medical personnel, which adds to military budgets at a time when these are a matter of concern in terms of governance. In addition, testing is not an end in itself. Both strategies.
- The Eritrean and Ethiopian intervention specifies that there needed to be a constant supply of free condoms, which has considerable cost implications.
- Even where there are considerable resources, as with the UK and Canadian military, the tendency has been to take a top down approach to HIV/AIDS education, which restricts actual learning.

7.2 Evidence from prevention campaigns among civilian populations shows the pivotal importance of national leadership and a sense of national acknowledgement and ownership. As yet, there are only limited models of this kind of leadership from top ranking officers, and some evidence of a contrary trend (see Paper 1).

7.3 The advent of ARVs has enormous potential implications for military institutions (see Paper 2). If sufficiently low cost, then some militaries could come to regard these as the 'solution' to their security problem, rather than looking at the wider implications for civilian populations.

7.4 Other personnel. The principal difficulty is unwillingness to enter into dialogue, either on the grounds of commercial needs or of denial and stigma. There may be specific faith-based objections from aid organisations to campaigns on condom use.

[44] An officer commanding a (European) peacekeeping contingent in Bosnia expressed this to UNIFEM researchers as "My boys have their needs" (Elizabeth Reid, Wilton House Conference, 2002).

8. GEOGRAPHICAL FOCUS

8.1 As Paper 2 establishes, the priority focus needs to be on the regions of SSA. There are presently/are likely to be peacekeeping/peace support operations in. Sierra Leone; Liberia; DRC; Cote D'Ivoire; Sudan (if the peace process is consolidated). This focus should be complemented by research on former peacekeeping troops in Southern and West Africa.

8.2 There are important lessons to be learnt from the experience of Thailand since its national HIV/AIDS programme appears to have succeeded in controlling the rates of infection among Thai military and police. This has implications for the emerging pandemic in South Asia and China.

8.3 Eastern Europe: the association between peacekeeping and organised trafficking of women and girls makes this a priority, within the broader framework of examining the conduct of peacekeepers (see example of trafficking involving Albania and Kosovo in Annex 5).

9. CONCLUSIONS AND RECOMMENDATIONS

9.1 The inter-relationships between the conduct of peacekeepers (including subcontracted and civilian personnel) and HIV/AIDS in any given context are complex and multi-directional.

At the same time, the evidence to date strongly suggests a connection between the presence of military personnel and:

- Escalation of HIV infection rates, resulting in impoverishment and social disintegration at family and community level.
- Marked implications for human rights and gender equity, particularly in relation to women, young girls and to young male recruits.
- Deterioration in good governance and human security, especially in relation to organized trafficking.

These factors are all central to DFID's objectives of an intensified multi-sectoral and multi-mandate response to the HIV/AIDS crisis. There are substantial obstacles to making a difference but these should be set against the comparative advantage of working with committed military personnel.

9.2 A great deal of the evidence around the conduct of military peacekeeping personnel is not in the public domain. This may be producing inaccurate and biased stereotyping of the conduct of peacekeepers.

9.3 To address this, the following research areas are recommended:

- Documentary and field research on the specialised military and grey literature in this field, with the aim of a better integration with existing conceptual and methodological frameworks on HIV/AIDS and gender.
- Reviewing DFID's current relationships with women's civil society organisations working on gender issues internationally and in the priority areas to establish what expertise they have to offer on peacekeeping.
- Following up existing examples of both good practice models involving military and civil-military interventions, including UNAIDS 2003 East African workshop and UNAIDS Eritrea.
- Exploring the implications of testing and treatment protocols in different forces.

9.4 As noted in the overview paper, the lack of field-based research on actual implementation of guidelines, codes of conduct etc is a serious obstacle to the production of evidence-based policy. This is compounded by a lack of specific gender analysis; for example, the Bazergan study specifically acknowledges that this aspect was not included. There is thus a particular need to identify researchers who can demonstrate expertise in gender analysis within the security sector.

9.5 Sub contracted security personnel on peacekeeping operations:

- Given the escalating presence in peacekeeping, this should also become a priority area of concern, under the rubric of corporate social responsibility (CSR). In these early stages, DFID should review and disseminate what information is available on lines of accountability e.g. through memoranda of agreement, contracts etc, with particular reference to monitoring the conduct of personnel on DFID funded contracts.

9.6 Partnerships: DFID is already in partnerships with the major HIV/AIDS organisations. It should use its leverage with its partners in the Global Conflict Pool to make contact with national militaries involved in peacekeeping. Contacts should also be made with former/serving Civil Police personnel, UN Human Rights observers etc.

Women's organisations in conflict-affected zones can be accessed via international networks such as CHANGE and Womankind. Consideration should be given to following the model of HIV/AIDS prevention in civilian populations and integrating organisations of sex workers, in the conflict zones and in transit/R &R areas.

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PAPER 4: RESPONSE TO CONFLICT (2)

1. LOCAL POPULATION: WHAT DO WE KNOW ABOUT THE PREVALENCE OF HIV AMONGST CONFLICT-AFFECTED POPULATIONS?

1.1 Parameters: 'conflict-affected populations' encompass a very wide spectrum of actors. As noted in the introductory overview, historical civilian/military distinctions are often not relevant. Instead, there are a range of armed actors - vigilantes and self-defence militias (Uganda, Colombia); state-condoned paramilitaries (former Yugoslavia) – who can wreak violence on civilian populations.

This paper addresses populations both in the immediate locale of armed conflict, as well as those moving to and from conflict zones.

1.2 In relation to HIV/AIDS, the vital differentiating factors lie in the attack and rupture of social order(s) and social institutions associated with armed violence. Even when a 'peaceful' society contains high levels of personal violence e.g. against women and ethnic minorities/lower castes, there is at least some capacity to address these through various forms of collective action. Armed violence brings the possibility of a collapse of social norms around sexuality and sexual behaviour. This affects military and uniformed services but also the wider community e.g. through the condoning of violent sexual assault against members of perceived 'enemy' groups (as in Rwanda). Girls (or boys) may be propelled into prostitution for survival.

1.3 'Snapshot' pictures of impact taken during or immediately after a period of armed conflict may be insufficient to reflect long term and mutually reinforcing patterns of vulnerability to HIV infection. However, it will be assumed that DFID needs to know about this immediate impact in order to investigate possibilities of reduction.

2. HIV PREVALENCE: MACRO-LEVEL

2.1 War and its after-effects is established as a potential causal factor in the pandemic elements: the UN General Assembly Special Session on HIV/AIDS recognised that "populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular, women and children, are at increased risk of exposure to HIV infection." (UN General Assembly Special Session on HIV/AIDS, Declaration of Commitment on HIV/AIDS, 27 June 2001). Evidence from refugee camps in conflict zones in South East Asia and throughout Sub Saharan Africa supports this, albeit with data which make it impossible to extrapolate conclusive statements about the chronology of infection (see UN HCR data).

Increased risk of HIV transmission is associated with economic vulnerability, particularly among women; disruption of preventive health services, particularly those providing free or low cost condoms, and of curative services for other STIs; sexual violence from males other than established partners. The interaction of these factors depends on existing HIV prevalence rates in the conflict zones, the surrounding regions and the HIV status of external interveners (if any). Isolated populations in contexts such as Angola may not be affected for the duration of the conflict itself, but become highly vulnerable as a result of a peace settlement.

2.2 The absence of testing and treatment and the long asymptomatic period make it difficult to obtain robust data on the specific extent to which populations are affected. Data from 'high intensity' conflicts such as Rwanda and the DRC may not be valid for other contexts. In Sub Saharan Africa, there is a consistent pattern of increased prevalence among civilian populations as a result of armed conflict; see data on Burundi and Eritrea in Annex 5.

3. INDIVIDUAL AND COLLECTIVE VULNERABILITY & OUTCOMES

3.1 It is difficult, sometimes impossible, to draw a dividing line between individual and collective behaviours in this context. For example, girls or boys may run away from home because as individuals they are experiencing physical or sexual abuse but it is the overall environment, which affects whether they end up as sex workers or find some other form of livelihood. 'Effects' are therefore linked to the underlying structural features of the society in question, including those of class, gender and ethnicity, which lie outside the remit of these papers.

3.2 Demographic vulnerability. It is clear that if young people/women are already living precarious existences, then the localised impact of conflict will be commensurately greater. Similarly, older widows of AIDS victims are less likely to find another partner.

3.3 HIV/AIDS and sex workers. As Paper 3 has established, the arrival of military and associated personnel will frequently intensify or create a demand for sexual services In some circumstances, troops will be confined to barracks and so sexual encounters will only take place in transit/R &R zones. The clients will comprise military personnel; other personnel attached to military operations; civilians who are in a position to pay, perhaps through employment on humanitarian and aid operations; other civilians who are in a position to pay.

Where sex work zones do spring up in the locale of the conflict, previously uninfected women/girls (and in some contexts boys/young men) will only be able to protect themselves by the use of the male condom[45]. There is very widespread evidence for elevated levels of HIV among sex workers but at the same time, this cannot be generalised. Outcomes are different where 'streetwise' women have the income to buy condoms (in bulk) and have developed collective strategies for insisting on their use by clients. Where women have been drawn into commercial sex after their husbands have been killed, disabled or simply disappeared in the course of the conflict, they are less likely to be able to take this kind of action.

The biomedical risk factors for women/girls will be intensified by repeated sexual intercourse without condoms and vaginal lubrication. Even with condom use, they may experience abuse and violence from their clients, which will impact negatively on their overall health status and associated emotional condition, which may affect their capacity to protect themselves. They may need to resort to abortions (legal or illegal), which themselves bring HIV/AIDS risks where medical treatment is needed and there are the risks of mother to child transmission.

3.4 Temporary sexual partnerships. In situations with regular troops under military discipline, there will be restrictions on the presence of women in barracks/military accommodation while the troops are on active service. However, there are many conflict situations where less controlled troops acquire one or more 'temporary wives' while in the field e.g. Mozambique (Jacobson, 2004); Uganda (Abwola 1999); Colombia (Human Rights Watch 2003). This is particularly the case where troops are not receiving salaries/services from their own structures. These women are used to provide a range of services e.g. washing/cooking, as well as sex. They may be regarded as 'safe' partners because of their age, background so there will be less motivation for the man to protect himself.

[45] The female condom is used by SW in conflict zones e.g. East Africa but there are major issues around cost

Where military personnel do not expect to have to bear any responsibility for children produced by these liasions, there is no particular concern to prevent conception by using condoms.

When troops move on, the women and their children are often left destitute and are sometimes outcasts from their home community. This sets up another cycle of future vulnerability, including sex work.

3.5 Established sexual partnerships with military. In certain contexts, conflict-affected populations will include women in established partnerships with military and uniformed personnel who accompany their partners (with or without official permission.) These women may be particularly vulnerable to HIV infection because of their inability to question their husbands' multiple sexual relationships. They themselves may also want to have unprotected sex in order to demonstrate their trust and/or to conceive. If they do become infected, they may not be able to receive medical support from the military.

3.6 Displaced and refugees. The largest percentage of displaced people in a conflict-affected population will be women with children and older dependents. This does **not** mean that men and boys are free from the disastrous outcomes of conflict; it may just represent differential ability to be mobile (Jacobson 2004). In terms of risk, however, this can result in vulnerability during the period of flight, in IDP/refugee camps (see below) and where they are absorbed into other households as dependents.

There is consistent evidence (Jacobson 1998; Indra 1999; Mertus 2001)that women and girls in these situations engage in sex with fellow IDPs and refugees, military and security personnel, local populations and personnel of humanitarian agencies. (see Paper 5). Young girls are likely to be the focus of attention as more desirable sexual partners and (where there is HIV/AIDS awareness) because of their presumed HIV negative status. The outcome is that, even when HIV prevalence is low, there is a gender-specific risk of the other STIs which raise risk in the future.

3.7 Female civilians. Armed conflict can sometimes protect women in a paradoxical way; if their male partners are absent, and the women themselves are not vulnerable to coercive sex, then they may paradoxically be less vulnerable than under 'normal' conditions. As wives, they would be expected to have sex at the behest of their husbands and be unable to control his other sexual relationships. There is some evidence (El Bushra, 2000) that women learn new skills and confidence during periods of war when they have to be heads of households, and this **may** give them more ability to negotiate safe sex. However, this does not apply to situations where there has been widespread sexual violence (see Paper 5).

3.8 Non-military male civilians. This is a noticeably under-researched area. The analysis of men's experiences as civilians and combatants suffers from highly stereotyped concepts and a degree of 'collective blame'. One of the very few studies which bears on HIV/AIDS is Dolan on northern Uganda (Dolan 2002), based on fieldwork over the period 1998-2000 in the context of endemic internal armed violence. His findings include psycho-social outcomes of powerlessness, including anger and depression, which are likely to affect sexual behaviour, lessening any motivation to protect their own lives or those of their partners.

3.9 Combatants (male and female) and their accompanying partners. In situations of intra-state war and disorder, these should be considered as forming part of the 'conflict-affected' populations. Where boys (or girls) have been forcibly recruited as combatants, or to accompany combatants, they are thrown into an environment where it is highly unlikely that there will be protective structures against HIV infection. There may also be substance and injecting drug use. These patterns will also affect adults, particularly personnel who have had harrowing experiences and are then left without any form of collective support.

4. ARMED CONFLICT AND ETHNICITY

4.1 Patterns of gender and ethnicity interface in situations where armed forces are deliberately intending to terrorise/humiliate local populations; this is generally associated with rape, as in the Rwandan genocide, in Myanmar, Bosnia and other contexts (see Paper 5). However, there may be less violent relationships where ethnicity plays a part in increasing vulnerability to HIV. For example, ethnic groups may be less available to access information which is written/transmitted in a majority language.

5. POTENTIAL INTERVENTIONS AND KNOWN SUCCESSES

5.1 For obvious security reasons, HIV interventions in the actual phased of armed conflict are highly restricted. Where NGOs and CBO have continued to operate e.g. .the Liberian YMCA in Monrovia during the recent fighting, they understandably prioritise survival issues like feeding programmes and immediate health needs. The courageous personnel involved may not be correctly informed about HIV/AIDS and anyway do not have facilities for testing and treatment.

5.2 Potential interventions after the fighting comprise: humanitarian and relief programmes for civilian populations still resident in the locale; for internally displaced (IDP); for refugees. The latter two categories involve a range of national and international humanitarian organisations providing health services. However, UNAIDS considers that "[u]ntil recently, relatively little attention had been paid to HIV/AIDS care and prevention in the context of a humanitarian response. Because of the incubation period of HIV, the disease was not considered an immediate threat to life and was therefore not thought of as a 'relief issue'." (UNAIDS 2003).

5.3 This situation is now changing, due in part to the escalating crisis of HIV/AIDS and also to the increased emphasis on the human rights mandate of the major institutions. The UNHCR has a Strategy Programme 2002-2004 for HIV/AIDS covering their entire area of operations (UNHCR 2001). It has initiated assessments of existing HIV/AIDS programmes in Eritrea, Ethiopia and Uganda, Kenya, Namibia, Guinea, Liberia, Rwanda and Zambia; produced a manual on HIV/AIDS education for refugee youth entitled *Window of Hope* that is being field-tested in numerous countries. Pilot projects are planned for: Kenya, Tanzania and Uganda; West Africa - Guinea, Liberia; South Africa and Zambia; Thailand and Nepal.

It also plans to reinforce surveillance, and monitoring and evaluation of HIV/AIDS programmes; strengthen biannual reporting for all refugee populations with a UNHCR presence; apply second generation surveillance systems for HIV/AIDS and its related diseases using qualitative and quantitative surveillance methodologies [46]; develop and implement a practical and informative monitoring and evaluation tool for HIV/AIDS refugee programmes using input, process and outcome indicators; ensure dissemination of results of evaluations.

5.4 There is also a model of best practice in the form of the rapid intervention carried out among the Rwandan refugees in Ngara, Tanzania that was implemented only four months after the huge population movements of August 1994. Among the lessons learnt were methodologies for surveys and treatment of STIs and the development of a Minimum Initial Service Package. The results as summarised in the UNAIDS document were that while there was no apparent dramatic change in the reported rates of STI and sexual behaviour, "the situation could have been considerably worse in the absence of any intervention.

[46] e.g. conduct serial behavioural change surveys, examine mortality and morbidity trends, and establish sentinel surveillance systems.

"At the end of 1996, the population of Ngara camps was repatriated to Rwanda. Soon thereafter a national HIV serosurvey was conducted … it appeared that the lowest rates among external refugees were noted among those returning from Tanzania, compared with those from Zaire or Burundi… the lack of increase in STI rates in the refugee population from Tanzania may, in fact, indicate a mitigation of the effect of the HIV/AIDS epidemic through the intervention programme." (UNAIDS 2003 n.p).

5.5 ARVs. At present, organised provision to conflict-affected populations is restricted to small-scale projects, noticeably the MSF programme in the DRC. This is, however, a major consideration for the immediate future.

5.6 Other small-scale interventions have focused on single categories of conflict-affected; sex workers in conflict zones, and street children who are at risk of becoming sex workers. These run a particularly high risk of HIV infection, especially since they are rarely in a position to practise the kind of collective action, which can ensure condom use.

6. POTENTIAL PARTNERSHIPS AND THEIR COMPARATIVE ADVANTAGES

6.1 Given the operational conditions in conflict-affected zones, there is a definite advantage to maximising civilian-military collaboration e.g. through increasing contacts between humanitarian bodies and local civil society organisations and faith communities.

6.2 Partnerships with the lead organisations like UNHCR should be complemented by working with women's organisations in the field, since these can give insights, which are not always accessible, particularly in 'public' forums with male community leaders.

7. GEOGRAPHICAL FOCUS

7.1 SSA. Given the scale of existing crises, constraints on resources and the likelihood of continuing armed conflict, there is a need for strategic allocation of priorities between preventive and palliative interventions. The latter approach demands attention to all the major regions; the former could select sites where infection rates are known to be at a low level (prevalence not consistently exceeding 5% in any defined subpopulation) e.g. Angola.

7.2 As noted in Paper 3, there are advantages to broadening the focus beyond the 'worst case' impacts to other contexts where there is little or no documented evidence of increased vulnerability to HIV such as the present situation in E. Timor. This approach may bring new insights.

8. RELATIVE COSTS, RISKS AND DIFFICULTIES

8.1 The most obvious non-financial cost of intervening during periods of armed conflict are physical and political: i.e. the security of personnel and not to seem to be supporting one particular faction against the government, or vice-versa.

8.2 There are also major constraints to working with military and security institutions. Even when goodwill is present, there are wide differences in institutional culture. There is also an emerging problem in several regions of an increasing interface between certain sections of the military and organised crime.

8.3 Financial constraints are already specified as a constraint in the UNHCR proposals of 2001. These constraints have escalated considerably, with major shortfalls in donor responses.

9. CONCLUSIONS AND RECOMMENDATIONS

9.1 There is considerable evidence that societies experiencing armed conflict are at increased risk of HIV infection, a. Prevalence rates are likely to be higher among women and girls, for a combination of social and physiological reasons.

9.2 The risk is not necessarily solely caused by the arrival of the conflict. Gendered relations of power place women and girls are at higher risk of infection globally, regardless of conflict. There may also be ethnic factors operating.

9.3 There is a gap in the literature between documentation on HIV/AIDS as a security crisis for the military/defence sector and the implications for civilian populations.

9.4 Despite these constraints, there is scope for interventions in partnerships with existing institutions. The priority should be:

- Reviewing the progress of the UNHCR initiative on HIV/AIDS in the context of current funding.
- Liasing with any NGOs in receipt of DFID funding to review their policies on HIV prevention.
- Initiating a discussion on how women and girls can be incorporated as actors into the planning and implementation of all HIV/AIDS initiatives for conflict-affected populations, rather than only as 'victims'. This to include DFID's own Conflict Assessment methodology.
- Investigating ARV provision by MSF in the DRC. This programme appears to be motivated by humanitarian and human rights concerns for the women and girls who have experienced extreme sexual violence at the hands of the various combatants and who have tested as HIV positive. In press reports, MSF stresses that the treatment regime has been simplified and that the health outcomes for the women have been transformed analyse this programme in terms of its cost, replicability and sustainability in the long term.

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PAPER 5: RESPONSE TO CONFLICT 3: SEXUAL EXPLOITATION: WHAT DO WE KNOW ABOUT REDUCING THE VULNERABILITY OF CONFLICT-AFFECTED POPULATIONS TO ASSOCIATED EXPLOITATIVE SEXUAL BEHAVIOUR DURING CONFLICT?

1. INTRODUCTORY COMMENTS

1.1 A fully comprehensive response to this question would involve going well beyond the actual site of armed/collective conflict into the area of 'normal' gendered relationships of power which impact on sexual behaviour e.g. marital rape; coercion of girl schoolchildren. While this is not feasible, it is essential to bear in mind that these issues have been the focus of human rights debates at the international level for several decades, as represented in instruments such as CEDAW, the Vienna Declaration of Human Rights and, most recently, the UN Secretary General's Bulletin of October 2003 (Annex 2). They have also come to the fore in the HIV/AIDS field (see framework statement for Papers 3-6). This issue is thus highly timely.

1.2 The focus of this paper will be on assessing the relationship between militarisation of societies, social chaos, the breakdown of protective institutions and more sexually predatory and risk taking behaviour. The ToR do not specify that this should only be in the context of HIV/AIDS; while this will remain the predominant theme, other forms of exploitative sexual behaviour will be considered. An example would be an aid agency worker who knows that he has no STIs having unprotected penetrative sex with a refugee who he know also to be infection-free. There is thus no risk of HIV infection but there is still an element of sexual exploitation if he does not intend to take responsibility for an ensuing pregnancy or any other consequences such as social stigma. There are also specific outcomes if the intercourse is with young girls or boys, for physiological reasons noted below.

This interpretation of 'sexual exploitation is broadly consistent with that taken by the UN SG's Bulletin (see below).

1.3 The question asks about knowledge fields in relation to reducing vulnerability "during conflict." Even if this is confined to sexual acts occurring only within the duration of armed conflict, there are definitional issues; are the combatants themselves included e.g. an increased likelihood of the sexual exploitation of boys/younger men?

1.4 The extent of knowledge on the scale of exploitative sexual behaviour is increasing as the issue comes into the domain of conflict analysis, human rights and post-conflict reconstruction. However, examples of successful **reduction** of vulnerability are highly limited, for reasons, which are themselves inseparable from the violent context. These range from the obvious difficulty of confronting bodies of armed men who are rampaging beyond any military discipline to the more complex issues around consent and coercion within less overtly violent contexts.

Nevertheless, the first step in reduction is naming the problem, and this has now been categorically done in the terms of the UN Secretary General's Bulletin (henceforth 'the Bulletin'). This document should thus be seen as establishing the new parameters for this issue; at the same time, there are areas of ambiguity (see below) and there it can reasonably be expected that there will be problems to be confronted in implementation.

2. UN SECRETARY GENERAL'S BULLETIN: BACKGROUND, CONTENT AND IMPLICATIONS

2.1 The debate around the sexual aspects of violence against women during war is very longstanding.[47] For present purposes, it is important to note the impetus given by the documents prepared for the 1995 UN Women's Conference in Beijing. These included specially-commissioned studies e.g. by the World Food Programme and the UNHCR, on the situation of women and girls (Jacobson 1998). Over the 1990s, there has been collaboration between civil society, UN institutions such as DAW, UNIFEM AND INSTRAW, and the Inter-Agency Standing Committee's[48] Task Force to put this issue into the forefront of human rights, health and development discourse.

2.2 As a result of these developments, the international community has paid more attention to the conditions of female civilians in war; this has been complemented by evidence of the planned use of rape in former Yugoslavia and Central Africa. More recently, allegations of sexual exploitation by aid workers in West African refugee camps run under the aegis of the UHCR have come to the fore.

2.3 The Bulletin makes specific reference to these allegations:

"The Secretary-General, for the purpose of preventing and addressing cases of sexual exploitation and sexual abuse, and taking into consideration General Assembly resolution 57/306 of 15 April 2003, "Investigation into sexual exploitation of refugees by aid workers in West Africa", promulgates the following in consultation with Executive Heads of separately administered organs and programmes of the United Nations."

However, it addresses a much wider area of relationships. For present purposes, the most significant elements are:

- Definition of "sexual exploitation" in Section 1:

  "For the purposes of the present bulletin, the term "sexual exploitation" means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Similarly, the term "sexual abuse" means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.

- Scope of prohibition: "UN forces conducting operations under UN command and control are prohibited from committing acts of sexual exploitation and abuse, and have a particular duty of care towards women and children".

&

[47] As well as feminist work on rape in war and peace, there is now attention in the historical record of 'old' wars e.g. On the Russian troops in Germany at the closing stages of WWII

[48] The members of the Inter-Agency Standing Committee comprise: FAO, OCHA, UNDP, UNFPA, UNHCR, WFP, WHO plus standing invitees including ICRC, IOM and the World Bank

"exchange of money, employment, goods of services including any exchange of assistance to beneficiaries or other humiliating or exploitive behaviour is prohibited."

- Definition of 'children': "Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defence"[49].

- Implicit recognition of gendered relationships of power: "Sexual relationships between UN staff and beneficiaries of assistance are strongly discouraged as often based on unequal power dynamics, undermine the credibility and integrity of the work of the United Nations".

  It also specifies obligatory dissemination to all UN personnel, sanctions for non-compliance and monitoring mechanisms.

- "Sexual exploitation and sexual abuse constitute acts of serious misconduct and are therefore grounds for disciplinary measures, including summary dismissal".

- "The Head of Department, Office or Mission shall appoint an official, at a sufficiently high level, to serve as a focal point for receiving reports on cases of sexual exploitation and sexual abuse".

2.4 Implementation. It is clear that the Bulletin represents a highly significant and laudable statement of intent by the Secretary General. Given its recent date, it has not been possible to find evidence about how UN institutions intend to implement the provisions. There has already been general dissemination e.g. a UNHCR Memo to all office and field staff, but the provisions clearly require additional pro-active measures.

2.5 Sub-contracted personnel. This issue is addressed in section 6:

- "When entering into cooperative arrangements with non-United Nations entities or individuals, relevant United Nations officials shall inform those entities or individuals of the standards of conduct listed in section 3, and shall receive a written undertaking from those entities or individuals that they accept these standards.
- The failure of those entities or individuals to take preventive measures against sexual exploitation or sexual abuse, to investigate allegations thereof, or to take corrective action when sexual exploitation or sexual abuse has occurred, shall constitute grounds for termination of any cooperative arrangement with the United Nations."

Considerably more information is required to assess how the wide range of sub-contracted non-profit and commercial operations intend to comply with these provisions.

2.6 The Bulletin implicitly takes the position that human sexuality is not to be considered as a 'natural drive', which cannot or should not be regulated. It does so in gender-neutral terms, but within a context where male sexual behaviour is at the forefront of concern.

2.7 In relation to HIV, it should be noted that there is no distinction in the Bulletin between protected penetrative intercourse (whether by use of the male or female condom) and other forms of sex which carry no, or very low, risk of STI infection. There is also ambiguity over prohibition of sexual acts with prostitutes.

[49] Staff legally married to someone under the age of 18 but over the age of majority or consent in their country of citizenship are exempt.

3. INDIVIDUAL AND COLLECTIVE BEHAVIOURS AND EFFECTS: MILITARY

3.1 The factors generally presented as underlying individual behaviour of soldiers - isolation from their families, living with danger – are associated with the premise of biologically-driven needs. This premise has been used to justify various aspects of male sexual behaviour, ranging from rape to reluctance to use condoms. It is clear, however, that an alternative perspective could be premised on evidence of the effects of a strongly masculinised and misogynist peer culture, which routinely denigrates women. This would encompass the incidents where individual soldiers commit rape against civilian women in situations where there is a specific military culture, but which are effectively quite free of danger e.g. British troops in Cyprus.

3.2 During actual armed conflicts, the strongest evidence for exploitative collective behaviour on the part of the military against local populations is:

- Group rape against 'enemy women' carried out in systematic form as part of strategy of ethnic cleansing (Bosnia; Rwanda; Somalia); the evidence suggests that this form of rape is intended to humiliate women **and** men (Cockburn; Hansen).
- Rape as an instrument to suppress dissent and terrorise populations, condoned by civil authorities (Chechnya); this may also be against ethnic minorities (Apple 1998).
- Large scale abduction of girls/women/boys who are then used sexually as well as for their labour e.g. Lords Resistance Army in Uganda.
- 'Temporary wives' to provide sexual and other services; these relationships are frequently characterised by physical and sexual coercion (Jacobson 1998; Abwola 1999).
- Demanding of sexual services from female recruits to insurgent forces; teenager girls who join the FARC in Colombia are routinely expected to form sexual liaisons with older protectors. As they are given contraceptive pills, it is evident that condoms are not regularly used (Watch 2003).This has also been the case in El Salvador (REF) and it is reasonable to expect that it will emerge in accounts of demobilised irregulars in Liberia.
- "Checkpoint rape": it is an open secret that in the disruption of war, it is more feasible to extract 'tolls' from all civilians, in goods (from men and women) and/or sexual services.[50]

3.3 There is also evidence that soldiers who have longer term postings in conflict zones may set up relationships which they want to make permanent by taking their partner back to their own place of origin; it will be assumed that these are non-exploitative inasmuch as the male military personnel will not want to endanger this prospect.

3.4 Cumulatively, the effects of sexual exploitation by the military are associated with a large scale impact on HIV/AIDS rates (see Paper 4 and Annex 5). This is particularly the case with rape. Currently, this is demonstrated in tragic form by the rates of infection among women who have experienced mass rape in the DRC, sometimes accompanied by penetration with sticks, guns etc.

[50] Women's organisations confirmed this to me in Angola prior to the ceasefire, also mentioning that the soldiers had been left for months or years without pay or supplies

4. INDIVIDUAL AND COLLECTIVE BEHAVIOUR: NON-MILITARY

4.1 As the Bulletin establishes, women and girls are not necessarily protected from sexual exploitation when they encounter non-armed men. The major sites of sexual violence during armed conflict are: during flight; in IDP and refugee camps; as displaced dependents within other households, especially as servants; while returning to place of origin (see Paper 6). Those responsible must be assumed to be overwhelmingly male[51] and include: members of the extended family or employers: co-nationals in the locale of IDPs camps; local populations in the host countries of refugee camps; fellow refugees; expatriate and national staff in the employment of the camp's administering organisation; other refugees or IDPs who are positions of responsibility. A great deal of this sexual violence has gone undocumented, particularly that taking place at community level.

4.2 Displaced populations: Sexual coercion in return for food, housing materials and access to other benefits was an 'open secret' during the 1980s in Mozambique (personal observation). The UNHCR's Guidelines for the Protection of Refugee Women and Children, 1991 then incorporated concerns at field level into an institutional response, along with guidelines for camp layout and management to minimise risk to women and girls.

More recently, attention has focused on the conduct of national and expatriate personnel at refugee camps in West Africa (Holden, 2003). A request to SCF UK from children and young people within the camps for their own clinic to deal with sexual and reproductive health led to a joint assessment UNHCR/SCF UK team. They took testimonies which indicated that sexual exploitation was widespread in the communities visited. Those alleged to be responsible included "UN staff, staff of international and national NGOs, government officials, community leaders, and peacekeepers." (op cit, p. 196). However, the team was not in a position to carry out an in-depth investigation. A subsequent UNHCR investigation "failed to substantiate the specific allegations against named individuals, although Save the Children UK still regards the general findings of the original study as valid." (ibid). This case raises complex issues about standards of evidence.

4.3 Effects. It is not possible to quantify the effects of this particular form of exploitative behaviour in terms of HIV infection rates, because of the need to disaggregate it from other consensual sexual relationships which might have been happening between refugees themselves and with local populations. The available data does not indicate whether the alleged sex included unprotected intercourse.The outcomes in terms of HIV/AIDS from this form of sexual exploitation may be small in comparison with large scale rape, but remains relevant in terms of institutional accountability.

Differential Vulnerabilities

4.4 Within the overall categories, there are some areas of specific vulnerability which are associated with violent conflict:

- It is known that soldiers and other non-military personnel deliberately seek out young girls for intercourse as a way of avoiding HIV infection.
- In some contexts, such as Somalia, irregular forces have carried out rapes against sections of the population which were previously protected by shared social norms, very young children and the elderly (Bushra 2000).
- Male sex workers may not be included in information programmes on HIV/AIDS which are being made available as part of the response to conflict, because of social taboo in acknowledging their existence.

[51] It is not denied that women have access to resources and may use this to demand sexual services, but the macro-context makes these instances marginal.

- Men and boys who have been victims of anal rape are similarly not included.
- Women and girls who have been raped during war are frequently rejected by their own communities and families, which may mean a further cycle of vulnerability.

4.5 As has been established, the literature on HIV/AIDS generally emphasises the vulnerability of sex workers,. However, it is possible that sex work in the context of displacement at least gives a sufficient income for displaced women to better fed than others, whose poor nutritional status will affect their resistance. The significant element, therefore, remains how the conflict impacts on pre-existing gendered relationships of power.

4.6 The effects of emotional trauma arising from experiences of violence (whether as combatants, onlookers or victims) is a significantly under-researched area. It can be assumed that this will contribute to despair or depression, further obstructing the motivation for self-protection.

4.7 Heightened prevalence of HIV produces inter-generational vulnerabilities through maternal transmission of the virus MTCT. Even non-infected children will have their life chances affected by the strains which the pandemic is putting on family and social fabric (see Papers 2 and 6).

Reducing Vulnerability[52]: Potential Interventions And Known Successes

4.8 Reducing vulnerability of civilian populations demands macro, meso and micro interventions. Preventing the proliferation of irregular forces, militias, rebels etc is obviously demands macro level action. It is further self evident that potential interventions to reduce vulnerability must take the form of pro-active programmes on the part of institutions that are most closely associated with sexual exploitation, as defined in the Bulletin. As DFID will be aware, this process is in its early stages. At present, there are few evaluations of programmes for reduction in rape and violence that have been evaluated (but see Dadaab example below).

4.9 Interventions from the military. These take the form of HIV/AIDS programmes, which act to protect military and civilians from infection, and human rights training, which has a broader remit. The latter is advocated by the DPKO and some national militaries have committed themselves e.g. through the Pearson Peacekeeping Centre's pre-mission and the OSCE's in-country training courses (for European personnel), each of which cover human rights, with some attention to gender, albeit generally under the heading of 'culture' e.g. the necessity to observe local norms with regard to contact with women and girls.

4.10 The increased openness of several militaries to engage with HIV/AIDS at the national and regional level is an essential first step, as Paper 3 demonstrates. The instances of Eritrea, Ethiopia and East Africa all contain valuable lessons learnt, particularly over capitalising on the existing strong sense of solidarity within peer groups. However, the evaluations do not indicate that there has been specific attention to sexual exploitation.

The same reservations apply to HIV/AIDS programmes in Thailand in Cambodia. One of the few interventions which may contain this element is that of 'health educators' in Bolivia, where recruits are sent out to establish relationships with local communities.

[52] This refers to vulnerability of civilian population – vulnerability of militaries/other security personnel is examined in Paper 3

4.11 Interventions for displaced populations. The UNHCR is the lead institutions and its guidelines have made an impact in physical terms e.g. the siting of latrine facilities, planting of quick-growing trees for fuel etc have all reduced the vulnerability of women and girls. In addition, there are models of best practice participative organisation, such as that in the long established camp in Dadaab, Kenya, which has received successive waves of refugees. This arose from the concern of the camp authorities and women at the high incidence of rape at the hands of surrounding populations and of domestic violence within the camp. The organisation of camp committees, training of male and female educators, involvement of religious leaders have resulted in a marked reduction.of these incidents and changes with regard to the treatment of girls e.g. access to education.

4.12 Interventions which give conflict-affected women and girls educational, vocational and personal resources have the effect of reducing their vulnerability to sexual exploitation based solely on the acquisition of material goods or services. Their impact on more violent forms is problematic; they may allow for a higher degree of personal security e.g. they then employ other women to do the domestic tasks involving dangerous areas e.g. collecting firewood. This further illustrates the need for a holistic approach.

4.13 The advent of ARVs has led to some entirely new interventions, noticeably that of MSF's programme for treatment of HIV positive women in the DRC. This reduces the consequences of infection though not necessarily vulnerability.

5. POTENTIAL PARTNERSHIPS AND THEIR COMPARATIVE ADVANTAGES

5.1 The humanitarian and development communities such as the UK NGO Coalition on HIV/AIDS (formerly the UK NGO Consortium) are now taking up this issue. Partnerships could be made with the more pro-active NGOs to make a strategic approach to those NGOs, which have not yet demonstrated their awareness of this issue, especially those, which are operationally involved in conflict areas e.g. Catholic Relief Services.

5.2 Development of more effective training programmes for the military offers major comparative advantage, given DFID's existing investment in this field. Partnerships should be consolidated with institutions that already have expertise in training militaries to explore how to address the difficulties of addressing the issue of sexual exploitation, rather than just the necessity of self-protection. This could be done in co-operation with the Strategic Defence Advisory Team.

5.3 The Bulletin requires that:

"If a UN staff member develops concerns or suspicions regarding sexual exploitation/abuse by a fellow worker, regardless whether in the same agency or not or whether or not within the United Nations system, he or she must report such concerns to established mechanisms".

There are similar mechanisms for reporting in all UN multilateral institutions, and all NGOs and international humanitarian bodies also have some form of monitoring and regulatory mechanisms. As donors, DFID could establish partnerships with the relevant sections of institutions already working in these sphere, particularly the UNHCR. They could also establish linkages with judicial bodies in relation to establishing rules of practice in regard to investigations.

5.4 DFID's linkages with UK Ministry of Defence are another entry point, particularly in getting information about how the training programmes for military and uniformed services at the UK Defence College and in country programmes e.g. Sierra Leone – are addressing this issue.

Geographical Focus And The "Politics" Of Intervention

5.5 There is already a consensus about the urgency to address the existing problem of HIV/AIDS in conflict-affected regions of SSA. However, this focus should not be at the expense of research in regions like South Africa, where there are collaborations at national and regional state level and women's organisations to reduce the current appalling high incidence of rape. In addition, there is a rationale for looking at non-Anglophone areas such as Mali, where NGOs such as ACORD have a long record of working with marginalized groups in conflict-affected areas. This kind of knowledge is essential for identifying innovative measures which could be adapted to conflict situations.

5.6 There is substantial evidence of organised criminal involvement in trafficking in Eastern Europe, particularly through Kosovo and Albania and some evidence of the involvement of military and security personnel. Partnerships with women's organisations in these countries would enable DFID to assess the possibilities of co-operation with OSCE and national bodies.

5.7 There are accounts of substantial sexual violence in Myanmar, which form part of the current scenario of escalating HIV infection rates in SE Asia.

6. RELATIVE COSTS, RISKS AND DIFFICULTIES

6.1 The costs of macro-level intervention for conflict-reduction are of a different order to those incurred to date in relation to the military. Testing and treatment facilities, training programmes for personnel, provision of the necessary supplies of condoms, institution of effective monitoring and disciplinary mechanisms, including prosecution for rape, will all substantially add to military budgets. This represents a particular problem in the context of governance initiatives, which are aiming to reduce military expenditure. However, **non-**provision also has its costs, both in replacement and training costs and the loss of institutional memory and capacity when it is senior ranks, which tend to be infected.

6.2 Risks of increased media coverage. It is important that the existence of sexual violence is becoming recognised on the international scene and by the media, as this recognition assists the process of accountability from political leaders. This has been established by the war crimes trials for former Yugoslavia and Rwanda. However, as the Channel Four documentary on rape of girls by the Lords Resistance Army demonstrates, this emphasis on 'extremity' can detract from the need to look at how military masculinity is constructed e.g. are younger male soldiers egged on by older ones? What happens to soldiers who try to stop their colleagues? This contributes to the overall lack of knowledge surrounding military conduct referred to in previous papers.

6.3 The increased emphasis on the conduct of humanitarian workers also risks stigmatising a category of men for what may in fact be the conduct of a minority. There are as yet no protocols for the investigation of allegations.

6.4 When there are profits to be made from operating brothels, whether open or involving covert trafficking, any 'whistle blowers' can be exposed to danger of dismissal or worse. It must also be recognised that sex workers themselves may not be consistently in favour of action against prostitution.

7. CONCLUSION AND RECOMMENDATIONS

7.1 Sexual exploitation in the form of coercion and rape has an immediate relevance for the reduction of HIV prevalence. However, this is not the same as addressing unequal gendered relations of power, which are present in intensified form.

DFID could support research into models of HIV, masculinity and gender inequity which are working in other contexts in order to develop potentially transferable models of practice for use within the armed forces (Promundo for example, in Brazil, works with young men to establish positive deviance which challenge traditional notions of macho and gender violent behaviour)

7.2 There are several immediate possibilities for DFID to consider in order to reduce vulnerability.

- Identifying additional initiatives to reduce the culture of impunity that allows sexual exploitation to flourish without fear of reprisal. Researchers in the field of sexuality find that it is extremely difficult to have a frank and rational discussion of the actual sexual conduct of men and women. This is of course intensified when the subject is sexual violence. In the first instance, DFID should consider the advantages of organising an event held under Chatham House rules to establish the views of senior operational military and civilians on the feasibility of implementing the UN SG Bulletin.

The issue of access to ARVs in conflict-affected zones is becoming increasingly relevant. DFID should support the development and implementation of policies and strategies for post exposure prophylaxis for women or men who have been raped:

- DFID should investigate the divergent positions of SCF and UNHCR on the case of the allegations from refugee camps in West Africa, with the aim of clarifying what they demonstrate about prevalence of sexual violence and the possibilities of reduction.

- DFID should initiate research on how current training programmes for military/security personnel, including civilian police address the issue of sexual violence.

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PAPER 6: POST-CONFLICT

What do we know about the effect and prevalence of HIV after;

A conflict has ended (i.e. on sexual partners of returning combatants, refugees, IDPs, peacekeepers,) and what follow-up measures could be taken?

&

What constitutes best practice in HIV/AIDs interventions when moving from immediate post-conflict or transition support to a broader development agenda?

1. INTRODUCTORY COMMENTS

1.1 Armed conflicts can end with a wide range of potential scenarios. The internal conflicts of the 'new wars' of the South are often more characterised by the gradual acceptance by the protagonists of negotiations than conclusive military victories. This acceptance results in a 'peace package' involving a ceasefire and a subsequent political settlement laying down the conditions for elections. Priority is given to demobilisation, disarmament and reintegration (DDR) of combatants overseen by the international community; and preparations are made for elections.

1.2 This period is of immediate significance to institutions such as DFID, the MoD as it offers them the opportunity to contribute to international peace support operations and to initiate the process of moving from relief to development. However, in the context of HIV/AIDS it is important to bear in mind that the fact of arriving at a 'post-conflict' stage does not mean that violence disappears from the realities of day-to-day lives. For example, there is considerable evidence that domestic violence actually increases after demobilisation; this is associated with the frustrations and tensions involved in the demobilisation process.

1.3 The ToR do not include combatants but they are vital actors in any post conflict accountable to civilian government or as militias, 'rebels' or irregular forces. The other categories specified need to be distinguished in terms of their likely post-conflict experiences and the feasibility of follow-up measures.

1.4 In the case of civil conflict, the sexual partners of returning combatants will be overwhelmingly fellow nationals; in other scenarios, they will be from the same region e.g. Angolan and Zimbabwean troops demobilised from the DRC. The sexual partners of external peacekeeping missions will be from such a diverse range of socio-economic regions e.g. Poland; Nepal; Bolivia that generalisation is impossible.

2. PREVALENCE OF HIV/AIDS AMONG SEXUAL PARTNERS[53] OF COMBATANTS: DEMOBILISATION

2.1 It is vital to bear in mind that, as stated in previous papers, all available statistical data on infection rates are likely to be unreliable. The reasons include general factors such as the unavailability of testing facilities; non-disclosure due to stigma and fear. There are additional factors involved where there are organised demobilisation programmes. These typically involved an accelerated process carried out in isolation from civilian population centres with little access for health organisations outside the military ones. Even with testing facilities, it is not uncommon for soldiers awaiting demobilisation in the centres to form new sexual relationships, so that the picture will change.

2.2 Jacobson's work on the UN'S Mozambican demobilisation in the early 1990s (Jacobson 1998) indicates the vulnerability of women to abandonment by their partners, leading to destitution. During this period, none of the bodies involved in the demobilisation paid specific attention to **any** forms of STI amongst dependents. There are indications that the current Angolan demobilisation process has been under such pressure to achieve rapid dispersal of troops that this has also been the case, despite the much greater awareness of the HIV/AIDS situation nationally and regionally.

2.3 Overall, there is no readily available evidence from the security sector literature of HIV/AIDS prevalence. The only extrapolations that can be made, therefore, are those cited in Paper 2 and in Annex 4, which suggest that sexual partners of demobilised combatants are definitely at risk.

2.4 There are additional factors, which are particularly relevant for sexual partners of combatants:

- Returning combatants' ability to form loving, non-violent relationships will be linked to their willingness to disclose their status/under go testing/take preventive measures. This ability may have been affected by their experiences during combat.
- After wars, people want to produce new lives. Both women and men may refrain from condom use even where available because of their desire to have children. In societies where infertility is considered highly undesirable, women will be under collective social pressure from military partners. In all of these contexts, unprotected intercourse brings the additional risk of Maternal to child transmission. This raises the further issue of access to testing in pregnancy and to the necessary drug treatment to prevent transmission**.**
- There is also considerable anecdotal evidence e.g. from women's organisations, that male partners returning from military operations regard a request to use a condom as evidence of their partners' infidelity during their absence.
- Organised military establishments such as those providing UN peacekeepers are frequently close-knit communities. It is therefore more difficult for sexual partners to look for advice on avoiding infection, or even treatment because they fear others getting to know.
- Availability of ARVs. As previous papers, including Paper 1 indicate, this may already be impacting on the prospects for ending of conflict. There is no way at present of establishing whether HIV positive military personnel who do have the means to procure these are **also** ensuring that they take precautions with their sexual partners or provide them with the necessary means to obtain ARV treatment. Anecdotal evidence suggests that this is not the case.

[53] In some conflicts e.g. Eritrea; El Salvador women constituted a significant number of returning combatants. This was taken into account in the UNAIDS programme.

- Association between military service and drug use. Demobilised combatants may face social and economic rejection. In the former Soviet Union, for example, the 'Afghanis', military conscripts who had served in Afghanistan, are linked with the beginnings of that country's IVD problem. It is known that the leadership of irregular forces in Mozambique and West Africa distributed drugs to their soldiers.

3. RETURNING REFUGEES AND IDPS

3.1 Prevalence rates will be affected by the experiences during conflict. As noted elsewhere, in some contexts, refugees and IDP may actually be put at increased risk of infection in the immediate post conflict context. Health interventions such as that for Rwandan refugees in Ngarara need to be sustained, particularly since couples who have been separated over long periods from their partners because of recruitment, flight or displacement will be resuming sexual relations.

3.2 Refugees and IDPs will not always return to their places of origin as soon as it is safe to do so; the Mozambique experience is that many male heads of households sent their dependents back but remained in cities or in the locale of the camps for a considerable period, or permanently (Jacobson 1998). More broadly, the arrival of peace always involves increased mobility, as markets re start etc. This brings the renewed risks associated with transport routes.

3.3 The immediate post conflict context does offer health agencies the chance to mount vigorous campaigns of HIV awareness, start condom distribution schemes etc for populations who were not formerly accessible. Many agencies involved in the process of return, such as the IOM in Angola, are now mounting information campaigns.

3.4 Where refugees/IDPS return to their locale of origin, women may find that the self-reliance and skills they have acquired during the period of displacement place them in a problematic situation. Younger women in particular may experience strong social pressures to conform to their pre-conflict roles, including early marriage and child bearing. (This is also a longer-term issue – see Recommendations).

4. POTENTIAL INTERVENTIONS

4.1 At point of demobilisation. It should be recognised that quartering centres constitute a closed world, within which pressures to achieve a speedy disarmament and return of combatants may over ride any longer term considerations. At the same time, the camps may offer the first chance for regular and irregular forces and their dependents to have **any** contact with proper medical facilities and learn about HIV/AIDS. It has not been possible to establish the degree to which HIV/AIDS awareness is integrated into the demobilisation processes. Some agencies report that it is included in their programmes, but this may not be done in such a way as to promote learning. However, the fact that organised demobilisation processes now always involve some sort of package involving immediate cash payments, goods to help reintegration e.g. seeds and hoes do allow for follow up measures.

4.2 Former combatants often have formal or informal networks e.g. Veterans Association of Uganda. These are important for the support of those who have been identified as HIV positive whether symptomatic or asympotomatic.

4.3 Other follow up measures for military personnel in the immediate post conflict phase all fall into the areas of testing, disclosure, medical and other support referred to elsewhere. The indications from existing projects to change sexual conduct suggests that are that the comradeship of peer groups and the example set by senior officers is crucial. This is exemplified by the commitment of Ethiopian military authorities.

4.4 Re-establishment of health services. Testing facilities, counselling, follow-through medical intervention, including the provision of drugs to prevent mother to child transmission can be identified as priorities. Larger scale preventive measures involve the kind of public sector investment which falls within the development domain.

4.5 Security sector. The introduction of human rights training for state security forces in the post-conflict phase represents an advance in terms of reducing gendered violence e.g. rape within police stations

4.6 The immediate post conflict phase offers the chance to implement programmes of reconciliation, which include measures of support for PWA.

5. MOVING TOWARDS THE DEVELOPMENT AGENDA

5.1 There is an obvious synergy between DFID's existing objectives for poverty reduction and effective HIV/AIDS interventions. **All** forms of support to PWA and their carers represent 'development' goals.

DFID has also recognised the necessity of a multi-sectoral response in their longer term planning for conflict-affected countries (DFID web site, January 2004). The Call for Action **"**challenges the international community to intensify its efforts to tackle HIV/AIDS and to achieve real progress towards the international targets, including 25% fewer young people infected with HIV/AIDS by 2005, 3 million people receiving treatment by the end of 2005, in each country affected by HIV/AIDS one national HIV/AIDS strategy, one national AIDS commission and one monitoring framework to track progress."

Poverty reduction interventions will be strengthened when they are accompanied by gender analysis, particularly one which looks at men and masculinity. This is exemplified by the Soul City multi-media campaign in South Africa which DFID is funding, which addresses issues such as rape and violence against women.

5.2 DFID is working with the World Bank and other donors on "Accelerating the Education Sector Response to HIV/AIDS in Africa". The lessons learnt from this programme are particularly relevant to the issue of sexual pressures and coercion on girls in schools (from teachers) and in the community (from older men).

5.3 Partnerships with the private sector. The previous papers have noted how there is a major gap in knowledge about policies and practices of the private sector. Companies who receive UK and EU funding for major infrastructural projects in post war societies, such as road and bridge buildings, are already expected to provide assurances to donors e.g. on the proportion of women to be employed (Jacobson 1998).This could be extended to policies related to the provision of HIV awareness and testing to employees and their families.

5.4 Military and security personnel will continue to be a feature of post-conflict societies. They are sometimes themselves deployed in the service of national development e.g. conscripts in Cambodia are sent to rural areas to assist agricultural projects. Development programmes must be aware of the associated risks of spreading HIV infection.

5.5 Faith Communities. In the aftermath of protracted conflict, there are huge rifts in the social fabric, and faith groups often represent the only organisations which have an effective presence and/or which are trusted by local communities (see, for example, Moser on Guatemala (Moser 2001). However, this is not an entirely straightforward entry point for HIV/AIDS interventions in relation to Africa, where several faith communities do not share the medical and public health paradigm of HIV/AIDS causality and prevention – although they are simultaneously providing dedicated care to PWA. The Catholic leadership in much of SSA is divided, with some Bishops continuing to promulgate the Vatican's position on condoms, while others have moved to condone their use when abstinence and faithfulness are not sufficient to save lives. Some Protestant and Zionist churches continue to regard AIDS as a God given punishment. In regions where Islam is influential, however, there is often a more pragmatic approach (Janet Bujra, personal communication).

5.6 Ownership and Sustainability. Many post conflict interventions regard the involvement of 'traditional structures/systems' such as the chieftainship in Southern Africa as an important element in rebuilding fractured social relationships However, there are also problematic issues in this areas. For example, emphasising the role of traditional authorities in the re-integration of displaced communities can impact on women in terms of land allocation and inheritance. This may be particularly significant for girls and younger women in the community.

Geographical Focus

5.7 The most urgent need for development assistance is in SSA. However, there are competing strategic priorities. The scale of the epidemic is particularly devastating in Southern Africa, where it is interfacing with food security and governance At the same time, the scale of human rights abuses in the DRC is associated with escalating HIV rates, but large scale programmes will be much more difficult to implement here, even if there is a sustained peace. West Africa (Francophone, Lusophone and Anglophone) represent a crisis in the making, with the possibility of state collapse accompanied by massive corruption and globalised criminal networks e.g. in people and raw materials. Recent developments in Sudan provide an opportunity for DFID to ensure that HIV is mainstreamed into future government plans and strategies, especially in the light of the expected return of high numbers of refugees.

Relative Costs, Risks And Difficulties

5.8 There are major resource constraints on all forms of long-term development interventions. However, countries involved in formulating PRSPs can be encouraged to mainstream HIV throughout the plans (for example in Uganda) may also be under pressure to reduce military budgets, as part of governance agenda. In the transition to post-conflict multi-party elections, parties could use HIV/AIDS as a political tool, attributing blame to other parties, alleging favouritism in the allocation of resources.

Despite this, all forms of interventions to rebuild social capital (Paper 2) will have an incremental effect.

6. CONCLUSION AND RECOMMENDATIONS

6.1 There is considerable scope for making a difference at all points in the post conflict phase. Priorities should include:

- DDR operations. DFID should build on its existing acknowledged expertise to ensure that HIV is mainstreamed the earliest stages e.g. Needs Assessments. It should ensure that awareness and prevention programmes cover female as well as male combatants, that all sexual partners of combatants are included.

- All elements of post conflict planning should include a specific focus on young women and girls. DFID should consider their Conflict Assessment methodologies in this light.

- DFID should investigate whether the research and campaigning impetus which has built up around Security Council Resolution 1325 (on the integration of women into peace negotiations and peacekeeping) has an interface with its HIV/AIDS priorities.

REFERNCES

Jacobson, R. (1998). The Complex Political Emergency in Angola and Mozambique, with special attention to gender,, COPE Working Paper no. 8, University of Leeds.

Moser, C. (2001). The Gendered Continuum of Violence and Conflict: An Operational Framework. Victims, Perpetrators or Actors? Gender, Armed Conflict and Political Violence. C. a. C. Moser, F.C. London and New York, Zed Books.

ANNEX 1: TERMS OF REFERENCE FOR A STUDY TO ESTABLISH THE CONNECTIONS BETWEEN HIV/AIDS & CONFLICT & RECOMMEND APPROPRIATE WAYS TO PROCEED

SUMMARY

This study is designed to provide an overview of the possible connections between HIV/AIDS and conflict. Its purpose is to gather enough information for DFID to decide whether further work or support is merited and to indicate interventions that might have an impact if we proceed.

The audience for the study is DFID.

The study will, depending on its recommendations, provide a baseline for possible further targeted action by DFID in six areas. The study will aim: "to help mitigate the effects and prevent the spread of HIV/AIDS amongst conflict affected populations and military/civilian personnel associated with peacekeeping missions, before, during and after conflict." This purpose supports the Millennium Development Goal: "To have halted by 2015, and begun to reverse, the spread of HIV/AIDS."

The six topics under consideration are:

1. Anticipation of Conflict: to what extent is there evidence to suggest that HIV/AIDS may be contributing to a build up towards conflict?

2. Prevention of Conflict: could efforts to mitigate the effects and prevalence of HIV/AIDS help reduce the build-up towards conflict?

3. Response to Conflict 1: Peacekeeping[54]: What do we know about HIV/AIDS and peacekeepers in situations of conflict?

4. Response to Conflict 2: Local Population: What do we know about the prevalence of HIV/AIDS amongst conflict-affected populations?

5. Response to Conflict 3: Sexual Exploitation: What do we know about reducing the vulnerability of conflict-affected populations to associated exploitative sexual behaviour during conflict?

6. Post-Conflict: What do we know about the effect and prevalence of HIV/AIDS after a conflict has ended (i.e. on sexual partners of returning combatants, refugees, IDPs, peacekeepers,) and what follow-up measures could be taken? And, what constitutes best practice in HIV/AIDs interventions when moving from the immediate post-conflict or transition support to a broader development agenda.

[54] This definition encompasses UN and non-UN missions and personnel working for and alongside these missions (e.g. UN Agencies, Civil Society Organisations etc).

BACKGROUND

HIV/AIDS constitutes a current and growing international threat, including to international peace and security. HIV/AIDS threatens many people but it has strong effects on the poorest. It is often the poorest people who are most vulnerable in outbreaks of conflict. We are keen to begin to establish any connections between HIV/AIDS and conflict. And to consider which options, amongst several, we should pursue.

This information is widely sought in DFID. In addition to CHAD's responsibility under the UN Strategy of the Global Pool, this study will contribute to the work of the PD HIV/AIDS team, the CHAD / PD Joint Conflict Team and Regional departments – particularly in Africa, but also in Asia, Eastern Europe and the Middle East. The World Bank has also expressed an interest in our study. We will constitute a steering group from this group and others to help guide the study and its conclusions.

There is a lot of information of varying quality and reliability that needs to be sifted. Our intention is not to look at all of it but rather to undertake a rapid assessment of the most accessible information. For each of the six topics identified, we will be satisfied when:

- We can establish whether there is evidence for a connection between HIV/AIDS and conflict
- When we can make a clear choice on whether this is a topic that we should pursue[55]

We may then select one or more of the topics for further work.

OVERALL OBJECTIVES

Our goal is to inform ourselves of the impact, if any, of HIV/AIDs on the build up, consequences and resolution of conflict.

We think there are several factors to consider. It is possible that high general prevalence rates or prevalence amongst certain socio-political actors could be contributing to the build up towards conflict. We wonder whether there are ways to reduce this tension? If conflict breaks out, we wonder what the effects are on prevalence rates and what can be done to reduce the vulnerability of conflict-affected populations? We wonder what effect HIV/AIDS is having on peacekeeping troops and their families? And we wonder whether anything can be done to reduce sexual violence or exploitation associated with behaviour in times of conflict?

Our purpose in this study is to review the accessible evidence to see whether and how we should focus our future efforts.

The study should look at the relationships between the following issues in relation to the six topics of study):

(1) Individual or collective Behaviours and their effects	(3) Potential interventions and known successes	(5) Geographical focus and the "politics" of intervention
(2) Differential vulnerabilities and effects / outcomes	(4) Potential partnerships, institutions and their comparative advantages	(6) Relative costs, risks and difficulties

[55] We will pursue a topic if 1) it seems sufficiently important and related to DFID's objectives; 2) if there is a likelihood of being able effect a change and 3) if there are interested partners

OUTCOMES OF THE STUDY

The outcome of the study will be

- One summary paper (of no more than 3 pages) including strategic recommendations.
- Six study papers – one for each issue – summarising the information found, the conclusions reached about the information available; a recommendation about whether DFID should pursue the topic further; suggestions as to appropriate partners for further study (these should not be lengthy documents- between five and (maximum) ten pages and should be anchored to practical recommendations for further action, supported by clear, succinct evidence and narrative. Documentation could also take the form of action oriented tool kits or guidelines for programme managers and decision-makers who are working in pre/current and post-conflict situations.
- A seminar to present the findings of the study.

MANAGING THE STUDY

The programme manager for the study will be Toby Sexton (Programme Officer, UN Conflict Prevention). He will be supported by Judy Walker (Senior Social Development Adviser).

We will constitute a Steering Network Group for the study. Their task will be to:

- Comment on the TORs
- Provide briefing and materials for the consultancy team
- Answer any questions the consultants may have
- Review the study papers and comment on the recommendations

TIMING

Time allowed for the study will be limited. We will allow 25 working days for a senior researcher. We will allow 25 working days for junior research assistance.

The study will be completed within two months of commencement.

ANNEX 2: SECRETARY-GENERAL'S BULLETIN

United Nations ST/SGB/2003/13

Secretariat

9 October 2003

SPECIAL MEASURES FOR PROTECTION FROM SEXUAL EXPLOITATION AND SEXUAL ABUSE

The Secretary-General, for the purpose of preventing and addressing cases of sexual exploitation and sexual abuse, and taking into consideration General Assembly resolution 57/306 of 15 April 2003, "Investigation into sexual exploitation of refugees by aid workers in West Africa", promulgates the following in consultation with Executive Heads of separately administered organs and programmes of the United Nations:

1. DEFINITIONS

1.1 For the purposes of the present bulletin, the term "sexual exploitation" means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Similarly, the term "sexual abuse" means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.

2. SCOPE OF APPLICATION

2.1 The present bulletin shall apply to all staff of the United Nations, including staff of separately administered organs and programmes of the United Nations.

2.2 United Nations forces conducting operations under United Nations command and control are prohibited from committing acts of sexual exploitation and sexual abuse, and have a particular duty of care towards women and children, pursuant to section 7 of Secretary-General's bulletin ST/SGB/1999/13, entitled "Observance by United Nations forces of international humanitarian law".

2.3 Secretary-General's bulletin ST/SGB/253, entitled "Promotion of equal treatment of men and women in the Secretariat and prevention of sexual harassment", and the related administrative instruction[56] set forth policies and procedures for handling cases of sexual harassment in the Secretariat of the United Nations. Separately administered organs and programmes of the United Nations have promulgated similar policies and procedures.

[56] Currently ST/AI/379, entitled "Procedures for dealing with sexual harassment".

3. PROHIBITION OF SEXUAL EXPLOITATION AND SEXUAL ABUSE

3.1 Sexual exploitation and sexual abuse violate universally recognized international legal norms and standards and have always been unacceptable behaviour and prohibited conduct for United Nations staff. Such conduct is prohibited by the United Nations Staff Regulations and Rules.

3.2 In order to further protect the most vulnerable populations, especially women and children, the following specific standards which reiterate existing general obligations under the United Nations Staff Regulations and Rules, are promulgated:

- Sexual exploitation and sexual abuse constitute acts of serious misconduct and are therefore grounds for disciplinary measures, including summary dismissal;
- Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defence;
- Exchange of money, employment, goods or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour, is prohibited. This includes any exchange of assistance that is due to beneficiaries of assistance;
- Sexual relationships between United Nations staff and beneficiaries of assistance, since they are based on inherently unequal power dynamics, undermine the credibility and integrity of the work of the United Nations and are strongly discouraged;
- Where a United Nations staff member develops concerns or suspicions regarding sexual exploitation or sexual abuse by a fellow worker, whether in the same agency or not and whether or not within the United Nations system, he or she must report such concerns via established reporting mechanisms;
- United Nations staff are obliged to create and maintain an environment that prevents sexual exploitation and sexual abuse. Managers at all levels have a particular responsibility to support and develop systems that maintain this environment.

3.3 The standards set out above are not intended to be an exhaustive list. Other types of sexually exploitive or sexually abusive behaviour may be grounds for administrative action or disciplinary measures, including summary dismissal, pursuant to the United Nations Staff Regulations and Rules.

4. DUTIES OF HEADS OF DEPARTMENTS, OFFICES AND MISSIONS

4.1 The Head of Department, Office or Mission, as appropriate, shall be responsible for creating and maintaining an environment that prevents sexual exploitation and sexual abuse, and shall take appropriate measures for this purpose. In particular, the Head of Department, Office or Mission shall inform his or her staff of the contents of the present bulletin and ascertain that each staff member receives a copy thereof.

4.2 The Head of Department, Office or Mission shall be responsible for taking appropriate action in cases where there is reason to believe that any of the standards listed in section 3.2 above have been violated or any behaviour referred to in section 3.3 above has occurred. This action shall be taken in accordance with established rules and procedures for dealing with cases of staff misconduct.

4.3 The Head of Department, Office or Mission shall appoint an official, at a sufficiently high level, to serve as a focal point for receiving reports on cases of sexual exploitation and sexual abuse. With respect to Missions, the staff of the Mission and the local population shall be properly informed of the existence and role of the focal point and of how to contact him or her. All reports of sexual exploitation and sexual abuse shall be handled in a confidential manner in order to protect the rights of all involved. However, such reports may be used, where necessary, for action taken pursuant to section 4.2 above.

4.4 The Head of Department, Office or Mission shall not apply the standard prescribed in section 3.2 (b), where a staff member is legally married to someone under the age of 18 but over the age of majority or consent in their country of citizenship.

4.5 The Head of Department, Office or Mission may use his or her discretion in applying the standard prescribed in section 3.2 (d), where beneficiaries of assistance are over the age of 18 and the circumstances of the case justify an exception.

4.6 The Head of Department, Office or Mission shall promptly inform the Department of Management of its investigations into cases of sexual exploitation and sexual abuse, and the actions it has taken as a result of such investigations.

5. REFERRAL TO NATIONAL AUTHORITIES

5.1 If, after proper investigation, there is evidence to support allegations of sexual exploitation or sexual abuse, these cases may, upon consultation with the Office of Legal Affairs, be referred to national authorities for criminal prosecution.

6. COOPERATIVE ARRANGEMENTS WITH NON-UNITED NATIONS ENTITIES OR INDIVIDUALS

6.1 When entering into cooperative arrangements with non-United Nations entities or individuals, relevant United Nations officials shall inform those entities or individuals of the standards of conduct listed in section 3, and shall receive a written undertaking from those entities or individuals that they accept these standards.

6.2 The failure of those entities or individuals to take preventive measures against sexual exploitation or sexual abuse, to investigate allegations thereof, or to take corrective action when sexual exploitation or sexual abuse has occurred, shall constitute grounds for termination of any cooperative arrangement with the United Nations.

7. ENTRY INTO FORCE

7.1 The present bulletin shall enter into force on 15 October 2003.

(*Signed*) Kofi A. Annan
Secretary-General

ANNEX 3: POTENTIAL LINKS BETWEEN HIV INTERVENTIONS & CONFLICT REDUCTION

GOAL 1 - REDUCING RISK		
Example of Objective	**Examples of Interventions**	**Could Contribute to Reducing Conflict by**
Promote safer sex	Sex education in and out of schools Mobile and static, affordable STI services provided through public and private sectors Social marketing of STI treatments Peer distribution of male and female condoms	Challenging gender and sexual stereotyping Promoting sexual responsibility (especially among boys and men) Fostering a sense of personal and social 'agency'
GOAL 2 - REDUCING VULNERABILITY		
Develop schools as more inclusive, protective and gender-sensitive, community based resources	Participatory review and re-orientation of schools in response to the impact of the epidemic	Facilitating community ownership of and investment in local schools, promoting their role as a community resource Promoting positive social cooperation
GOAL 3 - REDUCING THE IMPACT ON INDIVIDUALS AND FAMILIES		
Support livelihoods	Revolving grant schemes Vocational skills training Income generation for PLHA	Creating a social and financial safety net to mitigate the impact of the epidemic at household level Increasing opportunities for income generation Enhancing the dignity of PLHA and raising their profile and status within the community
GOAL 4 - NATIONAL ACTION TO REDUCE IMPACT		
Promote sustainable economic and social support in most heavily affected communities	Create realistic livelihood opportunities	Strengthening community coping mechanisms such as ability to absorb orphaned children and care for affected families

		Reducing dependence on high-risk survival strategies
GOAL 5 - SUPPORTIVE LEGAL AND SOCIAL NORMS		
Promote gender equity in sexual relationships	Social mobilisation for legal recognition of and action against rape in marriage Human rights education campaigns Provision of legal rights services	Increasing status of girls and women Challenging gender stereotyping and violence Building social relations on the basis of cooperation rather than competition and exclusion Challenging the acceptability of male sexual violence Enhancing community sense of rights and social participation
GOAL 6 – COMMUNITY ACTION TO REDUCE IMPACT		
Empowering communities to respond to issues at local level	'Stepping Stones' – use of intensive, focused process of community-based group work Increased community and external investments in essential infrastructure in key sectors including health, education, social services and agriculture	Identifying and addressing locally relevant conflicts Being explicitly gender and 'difference'-sensitive Promoting 'community ownership' of problems relating to HIV, sexuality and conflict

ANNEX 4: POSSIBLE GOALS & MEANS OF WORKING WITH COMMUNITIES TO REDUCE VULNERABILITY TO CONFLICT AND HIV[57]

HIV prevention activities intended to:

- *Improve relationships*, empathy, caring, sharing and communication between people;
- *Reduce stigma*, discrimination, conflict and violence
- *mediate and increase understanding* between individuals or groups;
- *Mobilise communities to work collectively for the common good,* help each other, build social capital, fight for rights and plan democratically;
- *Advocate and build movements for change* and joint action beyond the community level;
- *Reduce conflict at different levels*: e.g. between partners, within families, across groups and communities.

Examples of specific interventions include:

- 'Stepping Stones',
- participatory assessments and planning work with community groups which brings them together for dialogue;
- transformative learning approaches that engage groups in reflecting critically on their lives and culture, building on knowledge, values and skills in communication, relationships etc;
- skills-building in relation to anger and conflict management, mediation and community strategies for reducing violence and conflict (e.g. LEAP 'Playing with Fire' programme);
- involving people living with HIV and their families, building their capacity and reducing stigma;
- linking prevention and care, making ARV drugs available, increasing the resources available for poor communities and families struggling to cope with the impact of HIV;
- linking prevention and existing development interventions in order to reduce pressure on resources and stress, as people struggle to cope and survive.

[57] From Gill Gordon, personal communication January 2004.

ANNEX 5: HIV/AIDS, TRAFFICKING & SEX WORK IN MILITARY & CONFLICT AFFECTED REGIONS

SECTION A: HIV/AIDS IN THE MILITARY

UNOMOZ (Mozambique): 1992-1994[58].

During this period, Italian p/k troops were stationed in the provincial capital of Nampula. Mozambican women's organisations and international NGOs (such as the British-based Save the Children Fund) became concerned at the increase of prostitution in the vicinity of the UN barracks. Many of those involved were unmistakeably minors, including girls observed visiting the barracks en route from their schools. There was no systematic use of condoms. Complaints to the local commander did not produce the desired results and it was only when they went public in the Mozambican press that there began to be concern at higher levels of the UN mission. Investigation by the Mozambican authorities confirmed the reports that the troops were actually breaking Mozambican law with regard to sexual minors; however, the response was only to withdraw that contingent and return them to their home countries, not to carry out any of the sanctions available under military regulations.

There has been no epidemiological study of the outcome of the period. At this point, knowledge about and levels of HIV/AIDS among Mozambicans were very low; however, the UNDP and other researchers were researching the risks posed by the immaturity of the female genital tract and of the anus of young boys.(Peter Gordon, personal communication. This knowledge was presumably available to the military authorities if they had been motivated to seek it out.

UNTAC (Cambodia)

It has been estimated that the number of women working in prostitution in Cambodia grew from 6,000 in 1992 to more than 25,000 in 1994 (Soeprapto W 1995). It was known that girls as young as twelve were being recruited from rural areas. The military authorities were themselves highly concerned about the implications and cited HIV/AIDS as constituting the most serious threat to the lives of the peacekeepers (Soeprapto W 1995).

As in Mozambique, it took an alliance of relief agencies, NGOs and Cambodian women's association to make this an issue of public concern rather than a military affair; in their open letter to the head of the UN mission, they stated "There has been a dramatic increase in prostitution since UNTAC's arrival and a noticeable absence of condoms and education about their use. It is not surprising that HIV has reached an "emergency" level of at least 75% among blood donors."(Enloe, 2000: 99).

Botswana

Botswana has been involved in peacekeeping operation in Somalia, Mozambique and Lesotho. The National Aids Co-ordinating Agency estimates that HIV infection is between 35% and 40%. The official policy is "no stigma and no discrimination"; access to treatment care and support for "all those who are eligible" (It is not stated whether this includes partners and children.)

[58] This material is based on my own field notes and interviews in 1994. See Jacobson, 2004 for details

"The military are very young and very mobile people… we have the cash power that would have influence … our soldiers can afford to go out and entertain themselves." Major General Bakwena Mutile, head of Botswana Defence Force Aids Programme. (From BBC World Service News, 20 November 2003).

Cameroon

HIV infection rates in troops returning from ECOWAS intervention in Sierra Leone, 1993: 6.2%

Civilian rate, 1993: 2.0%

Recent studies have found that in Tanzania, Uganda, Zambia, and Zimbabwe, 75% of soldiers were dying within one year of discharge from AIDS. AIDS is now the leading cause of death in the military and police forces in these countries, some accounting for more than half of in-service and post-service mortality. In some countries, AIDS patients occupy three-quarters of military hospital beds and account for more military hospital admissions than battlefield injuries.

SECTION B: HIV/AIDS IN CONFLICT ZONES [adapted from UNAIDS Fact Sheet 2, UNICEF AND UNHCR publications]

Cambodia, 1990s	Military: 8% Police: 8%	Civilian rate 4%

Burundi: effects of civil war 1993-2003

Population	**HIV infection rates (estimated)**
Urban (approx 10%)	11%
Countryside	Less than 1%
Urban	11-12%
Countryside	2-4%

"Of the 17 countries which each have over 100,000 children orphaned by AIDS, 13 are in conflict or on the brink of emergency and 13 are heavily indebted poor countries. In addition, the spread of HIV infection during conflict is accelerated by the involvement of young people with military forces, who are themselves typically young and sexually active."

Ethiopia and Eritrea

In 1998, at the beginning of the conflict with Eritrea, the limited data available shows the HIV rates in the border regions of conflict (Tigray and Afar regions) seemed to be quite low in rural areas but significant in some of the small urban centres and near trucking lines.

In 1999, 15-20% of civilian hospital beds were occupied by patients with HIV-related diseases.

Statistics provided by regional authorities in Tigray indicate:

1992 - 70% of CSWs in Mekele HIV+
1992 - 70% of CSWs in Adigrat were HIV+
1992 - 0% of rural dwellers in Endamariam Korado were HIV+
1998 - 12.5% blood donors HIV+
1998 - 6% ANC users HIV+
1998 - 54% of TB cases in Mekele hospital tested positive

SECTION C: TRAFFICKING & SEX WORK IN CONFLICT-AFFECTED REGIONS

"Twelve naval officers who failed to stop the sexual abuse of a teenage girl on their base have been dismissed from the service. Eight marines and four civilians were arrested earlier this week for the sexual abuse of a 16-year-old girl who was kidnapped at a naval base and ended up in forced prostitution in neighbouring Kosovo. Authorities said the 12 officers should have prevented any criminal behaviour. The teenage victim was abducted in June [2003] at the Bisht Palle naval base in Durres district, 30 miles west of the capital, Tirana, and sexually abused by marines for about two months, before being sold to motel owners in Durres, Korce and Pogradec." (The Independent, 13 December 2003).

UNHCR SURVEY 2000 (Data from rural areas in host country among low risk groups: pregnant women, blood donors)

L= low-level epidemic (HIV prevalence not consistently exceeded 5% in any defined subpopulation
G= generalised epidemic (consistently >1 % in pregnant women)
C= concentrated epidemic (consistently >5% in at least one defined subpopulation and is <1% in pregnant women in urban areas)

Cluster/Sites	**Situation**	**Est. Pop. in Camps** (except S Africa)	**Est. Prevalence***
East Africa			
Ethiopia	East	140,000	G
Ethiopia	West	80,000	G
Kenya	Dadaab	130,000	G
Kenya	Kakuma	75,000	G
Tanzania	Ngara	120,000	G
Tanzania	Kibondo	100,000	G
Tanzania	Kasulu	150,000	G
Sudan	El Showak	70,000	Unknown
Uganda	Arua	80,000	G
Central Africa			
Rwanda		28,000	G
West Africa			
Guinea		100,000	C/G
Liberia	Sinje	25,000	Unknown
Southern Africa			
Namibia	Osiere	20,000	G
South Africa	Urban refugees	50,000	G
Zambia		115,000	G
Asia			
Nepal		95,000	L
Pakistan	Punjab	50,000	L
Pakistan	Balochistan	150,000	L
Pakistan	NWFP	1,000,000	L
Thailand	North	110,000	C/G

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