

HIV/AIDS, security and conflict: new realities, new responses

Alex de Waal, Jennifer F Klot and Manjari Mahajan with Dana Huber, Georg Frerks and Souleymane M'Boup

Ten years after the HIV/AIDS epidemic itself was identified as a threat to international peace and security, findings from the three-year AIDS, Security and Conflict Initiative (ASCI)¹ present evidence of the mutually reinforcing dynamics linking HIV/AIDS, conflict and security.

ASCI's findings reveal that a number of earlier, more alarmist, relationships assumed to exist between national-level state security and the HIV/AIDS epidemic were not borne out. Under-examined risks in humanitarian emergencies and post-conflict transitions are highlighted, as well as threats posed by HIV/AIDS to the operational capacity of armies and across the uniformed services (such as police, prison and border authorities). ASCI's gender analysis exposes flawed assumptions that continue to guide epidemiological and behavioural approaches to HIV/AIDS prevention and response in conflict situations and fragile states. By focusing on intermediary levels of interaction – between macro-level assumptions and micro-level behavioural and biomedical approaches – ASCI offers a new agenda for action.

Summary of findings

- Prevailing indicators of state fragility fail to capture the impact of HIV/AIDS on local governance, human resources, service delivery and community survival.
- Prevalence of HIV within the uniformed services is related to age, rank, time in service, maturity of the epidemic, patterns of violence, military sexual trauma and command structures.
- HIV and AIDS can threaten the operational capability of armies primarily at the tactical level of operations. HIV/AIDS can affect combat effectiveness, unit cohesion, morale and discipline.
- Command-centred approaches to HIV prevention – i.e. that put responsibility for HIV policy and practice within the army command rather than on medical services alone – are likely to be more effective in reducing the risk of HIV infection and sexual violence among the rank and file than relying solely upon education and training based on individual behavioural, medical or human rights approaches.
- HIV prevention efforts have neglected police and other law enforcement and uniformed services, including the customs, naval, immigration and prison services.
- The risks of HIV transmission, especially in epidemics concentrated among injecting drug users and sex workers, are influenced by law enforcement practices and by the drugs trade, human trafficking and those who control sex work – pimps, 'protectors', traffickers and long-term clients.
- Post-conflict transitions are both a period of heightened vulnerability to HIV transmission and a neglected element in HIV and AIDS policy and programming.
- Greater policy attention and service continuity are needed in post-conflict situations to respond to increased population mobility, demobilisation of combatants, disruptions in humanitarian assistance to displaced persons in camp settings, and the excessive demands on health and social services in areas of return.
- Disarmament, demobilisation and reintegration (DDR) programmes are an important and consistently overlooked focus for HIV and AIDS prevention and response, especially among military and extended families, and women and children associated with armed forces.
- Forced sex may increase individual risk of HIV acquisition for different scenarios of coercion based on genital trauma, relative probabilities of HIV and other sexually transmitted infections, and inadequate access to health services.

Key recommendations

1. Sexual violence needs to be recognised as a physiological and social factor in HIV transmission. Consistent with UN Security Council Resolutions addressing women, sexual violence and HIV/AIDS (1308, 1325, 1820, 1882, 1888 and 1889), sexual violence and HIV

prevention efforts must be more closely aligned in conflict-affected environments, including through urgently needed consensus on definitions and measurement.

2. A command-centred approach (CCA) to HIV prevention and AIDS treatment and care within uniformed services and UN peace operations is needed. This should entail institutional and operational assessments of the potential impact of HIV/AIDS within security institutions and development of mechanisms of accountability, discipline and enforcement. Tools developed for ASCI, including a Military Institutional Audit and a Force Capabilities Framework², can support a CCA.

3. The integration of HIV/AIDS prevention and response in peace operations – including in relation to pre- and post-deployment testing, care and treatment, and inclusion of HIV-positive people within the uniformed forces – should fit more realistically with operational demands and the capacities of troop-contributing countries. Building on the operational tools of CCAs, ASCI proposes that HIV/AIDS and sexual violence security risk assessments be carried out in peacekeeping environments.

4. A universal standard for HIV/AIDS prevention, treatment and care should be developed across all troop-contributing countries and in alignment with regional and international approaches. In line with the global goal of universal access, HIV and AIDS treatment should be extended to UN peacekeepers as a matter of policy. ASCI recommends increased dialogue among bodies and institutions with complementary peacekeeping/peacemaking mandates (e.g. the UN Security Council, the African Union Peace and Security Council and other regional mechanisms, the Peacebuilding Commission and the UN Department of Peacekeeping Operations) to address the heightened risk of HIV exposure during post-conflict peacebuilding and to ensure the continuity of HIV prevention efforts during post-conflict transitions.

5. DDR provides important entry points for HIV/AIDS prevention, testing, care and treatment. A new approach to voluntary counselling and testing, before and after deployment, should incorporate care and treatment not only for demobilising soldiers but also for their families. The UN, the World Bank and bilateral donors should support national governments to clarify policies and include Voluntary Counselling and Testing/Care and Treatment Plus (VCT-CTP) in the context of DDR and security sector reform.

6. HIV/AIDS policies for the uniformed services should be reflected in pension and retirement schemes, funeral and survival benefits, compassionate leave, disability and medical discharge benefits as well as entitlements for children born out of wedlock and/or as a result of rape.

7. ASCI recommends greater dialogue on mandatory HIV/AIDS testing and the establishment of health criteria for deployment. Mandatory testing is practised by most armies but has been inadequately justified in the context of national HIV/AIDS policies and human rights principles. Some militaries provide incentives to encourage voluntary testing and require sero-negative test results as a prerequisite for deployment and promotion. Others frame their policies in terms of medical fitness in general, leaving scope for discretion on how to utilise soldiers who test HIV-positive. Both principled and practical arguments for and against mandatory testing should be aired. International humanitarian law and the right of states to suspend certain human rights provisions during national security emergencies should be discussed alongside the resource constraints of armed forces.

8. ASCI identified the pressing need for HIV/AIDS interventions within the police and other law enforcement institutions. Law enforcement practices, especially in relation to stigmatised and criminalised activities and groups, influence the trajectory of national and regional epidemics. Issues such as harm reduction

for injecting drug users, policing sex work and trafficking, and decriminalising homosexuality are all central to this. A global programme of collaborative learning on law enforcement and HIV/AIDS is recommended.

9. Borders should be a special focus for HIV prevention efforts. Cross-border issues, including trafficking of women and drugs, and sexual exploitation and abuse at border crossing points are all related to risks of HIV transmission. The role of some groups of law enforcement personnel as core-group transmitters needs examination. Bilateral, regional and multilateral exchange and cooperation are vital. Linkages across the international trade in illegal drugs, related sex-trafficking activities, drug use and the emergence of narco-states in several parts of the world demand attention.

10. There is a major response gap during post-conflict transitions, a time when transmission risks can be heightened due to discontinuities between emergency and reconstruction and development efforts. International policy frameworks and practices put limits on HIV/AIDS-related assistance to post-conflict countries, as these often fail to meet funding criteria which may require conditions of stable governance. More refined approaches are recommended, paying particular attention to a variety of gender-related factors that shape HIV risk during transitions.

11. The linkages between psychosocial recovery and HIV risk are among the most under-explored. The psychosocial effects of war, conflict, displacement, torture and violence have repercussions for interpersonal, family and household relationships.

12. We also need to better understand how notions of masculinity and femininity are shaped by conflict and its aftermath, so that appropriate interventions can be designed for men and women, boys and girls. Policy successes need to be recognised and sustained, including best practices in HIV/AIDS response

to populations in refugee and IDP camps and the strengthening of health infrastructure in post-conflict settings.

Conclusion

The relationship between HIV/AIDS and state fragility is highly complex and non-linear. ASCI's findings lead to a call for a reassessment of current measures of state fragility to take into account key elements of local government, including human resources, health sector delivery and community resilience. ASCI's research highlights the many ways in which the HIV/AIDS epidemic puts stress on local government institutions, hindering effective representation and contributing to poor service delivery. Such weaknesses undermine efforts to achieve universal access to HIV/AIDS prevention care and treatment. Local government reforms and national-level commitment to genuine

decentralisation can alter patterns of HIV transmission for the better.

Conventional indicators of conflict and epidemiological and behavioural models of HIV transmission fail to capture the relevant dimensions of social disruption and related trauma for gender relations, family structures, local government and social services. We need more finely tuned indicators that are sensitive to these social and gender dimensions. Analytical frameworks and measurement tools need to consider local variations in sexuality and violence, and assessments of the drivers and impacts of HIV/AIDS should complement aggregated national-level indicators with more contextualised measures of family, community and social dynamics.

Alex de Waal (alex_dewaal@harvard.edu) is the Social Science Research Council's HIV/AIDS Programme

Director and Jennifer F Klot (klot@ssrc.org) its Senior Advisor for HIV/AIDS, gender and security. Manjari Mahajan (mahajan@ssrc.org) is an SSRC research fellow. Dana Huber (dhuber@ssrc.org) is a Research Assistant at the Social Science Research Council.

Georg Frerks, Professor of Conflict Prevention and Conflict Management and Director of the Centre for Conflict Studies, Utrecht University, and Souleymane M'Boup, Professeur, Laboratoire de Bactériologie Virologie, Université Cheikh Anta Diop, Dakar, Senegal, are co-chairs of ASCI.

The full report of which this is a summary is available at:
<http://tinyurl.com/ASCI-Summary>

1. ASCI is a research partnership between the Social Science Research Council (New York) and the Clingendael Institute for International Relations (The Hague).

2. See <http://tinyurl.com/ASCIreport4>