Post-conflict transition and HIV

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Research in Bosnia, the Democratic Republic of Congo, Haiti and Liberia has highlighted worrying neglect of HIV issues in the aftermath of conflict and displacement.


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The last half century has seen a dramatic increase in the number of conflicts and complex emergencies. Most have occurred in settings where conflict further weakened already inadequate national health, educational and other public services. The growth in frequency of conflicts and the number of people affected by them has prompted a strong commitment to emergency relief in the acute phase of crises but, by comparison, interest in post-conflict transition to recovery and reconstruction has been much more limited in both vision and scope.

Bosnia, Haiti and Liberia have all gone through protracted conflicts, and hostilities continue in eastern DRC. A research project undertaken by the International Centre for Migration Health and Development (ICMHD)[1] and its research collaborators as part of the AIDS, Security and Conflict Initiative (ASCI) focused on how the transition from conflict is experienced by different groups of people and the effect it has on their attitudes to HIV and sexual and gender-based violence (SGBV). In DRC, Haiti and Liberia HIV remains a large and still growing problem. In Bosnia, where the epidemic has been far less evident, the growth in the number of reported cases of TB may be indicative of underlying, poorly diagnosed and unreported HIV. All four countries saw conflict produce extensive, repeated displacement of people and extensive sexual and gender-based violence, and in DRC and Liberia there was also widespread mutilation associated with that violence.

Post-conflict donor neglect

Our research suggests that in general the international community has given relatively little attention, either conceptually or programmatically, to the transition from conflict to recovery. In three of the countries surveyed where there was a clear end to open hostilities, there were no large-scale interventions designed to ensure the long-term human security of the populations concerned. Nor was there much evidence of any targeting of population groups whose vulnerability was due to or had been exacerbated by the conflict. Whatever recovery and social reconstruction have occurred or are now occurring in all four countries appear to have been coincidental and have largely bypassed many of the people who bore the brunt of the conflicts.

This neglect of people whose reinsertion into society is essential for recovery and reconstruction is creating a new marginalisation (real and perceived) from health and social services, including much-needed HIV initiatives. As well as placing lives at risk, this neglect could have serious implications for public health and future social and political stability.

The prevalence of HIV among people aged 15-49 in Bosnia, DRC, Haiti and Liberia in 2007 was estimated to be 0.1%, 1.5%, 2.2% and 1.7% respectively but the lack of good data makes accurate estimation very difficult and in the three latter countries the situation may have been significantly worse. To what extent patterns of incidence and prevalence of HIV were influenced by conflict is not clear for the same reason.

What is clear is that displaced and sexually abused women conspicuously failed to benefit from post-conflict HIV and other health interventions. In none of the four countries did cessation of or reduction in hostilities bring much improvement to their lives. Indeed, displaced women in DRC, Haiti and Liberia reported that their situation worsened and they felt more at risk of being exposed to HIV after conflict than during conflict. This was particularly evident in Haiti and DRC where displaced women said they were living in constant fear that they or their daughters would become infected with HIV and they complained that whatever HIV interventions had been mounted had not taken them or their needs into account.

In all four countries concern about HIV among displaced women was linked to what they saw as their continued, if not increased, vulnerability to rape. In DRC, Haiti and Liberia, displaced women said they felt the risk of being raped had increased with the decreased presence of outside relief groups and there was a general perception that little if anything was being done to provide them with the assistance (physical and psychosocial) needed to deal with the aftermath of rape. There was a consensus that not only did they not know where to go to report rape but they did not believe anything would be done about it because there was no real interest in them or their welfare. They mentioned that having been raped, knowing someone who had been raped, or fearing rape has become a major psychological barrier to going back to their families and communities of origin. In all the countries displaced women said they felt more socially isolated after the conflict because of the social stigma associated with rape.

Feelings of social isolation were also associated with the knowledge that they had lost their homes and that housing was not a part of any reintegration initiatives they had heard about (and which in any event

they did not see as applying to them). Fear of being left without a roof and means of income generation in DRC and Liberia led many of the interviewees still living in camps to say that no matter how poor these camps were, they offered far more security than what they thought awaited them outside. Many women said they would prefer to be given building materials to construct their own shelters and stay "in the bush".

DDR interventions of limited benefit

Disarmament, demobilisation and reintegration (DDR) processes typically follow conflicts everywhere in the world. Governments and the international community see DDR as a way of decreasing the risk of new outbreaks of armed violence. Our study suggests that DDR interventions have failed to incorporate HIV issues in any meaningful way. This was especially the case in Liberia but in all four countries ex-combatants felt that not enough had been or was being done for them and that they had seen little benefit from HIV programmes.

There was a general sentiment among ex-combatants in DRC and Liberia that conflict had 'allowed' – and in some cases encouraged – them to abuse women and in doing so possibly to expose them to HIV. Most perceived HIV as a condition for which there was no cure and many ex-combatants in these two countries had a fatalistic approach to HIV, saying that dying from HIV was ultimately the same as dying from a bullet, and that as ex-combatants they had little or no control over the outcome.

Female ex-combatants felt that the end of conflict had presented a number of additional problems including resistance to their return by families and communities of origin. In Haiti, women who identified themselves as ex-combatants also talked about the hostility of local police and the danger they sensed from law enforcement personnel who still saw and treated them as combatants and criminals.

Rape in the post-conflict phase also emerged as an important theme and there was widespread agreement among ex-combatants that the risk of rape in post-conflict settings remained high. In DRC many ex-combatants said they thought that women often "got themselves into" vulnerable situations, by virtue of their lifestyles and their willingness to sell sex in order to satisfy non-essential needs. Despite this, ex-combatants in all four countries agreed on the importance of women to society and the need to protect them. In this regard they frequently mentioned the need for more efficient prosecution of perpetrators of rape and the need for greater discipline in civil society as well as in the military.

Conclusion

Donors and humanitarian and development agencies have tended to neglect the post-conflict phase. Several explanatory factors can be identified including the fact that:

- many donor governments make a conceptual and organisational distinction between humanitarian relief and development assistance that is simplistic and not based on evidence
- there is a common but ill-founded belief that the end of conflict signals a time of social reconciliation, reinvestment in social development by national governments and an economic recovery that automatically benefits the general population
- there is an equally non-evidence-based assumption by donor agencies that national governments facilitate the return of trained, knowledgeable personnel or have the capacity to train new ones
- assumptions about post-conflict recovery seem to have built on inappropriate analogies with the rapid post-conflict reconstruction of Japan, Germany and other industrialised countries
- donors seem to overlook the reality that developing countries typically go into conflicts with already weak infrastructures that then became even weaker and see their vital agricultural, educational and health systems fundamentally disrupted
- donor fatigue and frustration have come to typify the international response to the frequency of conflicts and the seemingly slow capacity for countries to reconstruct and move on to a development trajectory.

The post-conflict process often sees displaced women, especially those who have been raped and otherwise violated, socially isolated and unable to benefit from whatever HIV prevention and treatment initiatives are put in place. Their re-entry into society and the reconstruction process is hindered by this isolation and the fact that the stigma attached to rape (or suspected rape) assumes even greater importance than during conflict.

Ex-combatants are also being neglected and by-passed by HIV programmes and there is a sense that DDR initiatives have not paid sufficient attention to the issue of HIV or not had the time or the vision to use the DDR process as an opportunity for consolidated and targeted HIV interventions.

Displaced women and ex-combatants constitute a significant proportion of post-conflict societies. They come with a burden of traumatic experiences but they also represent a vital and potentially crucial part of the recovery and reconstruction process. HIV can be a window of opportunity for strengthening the larger health development process and facilitating recovery. Indifference to the needs of these two groups of people does not bode well for post-conflict reconstruction.

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