

Disarmament, demobilisation and reintegration: opportunities in post-conflict settings

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The international community has learned much over recent years about the need and potential for integration of HIV awareness into the disarmament, demobilisation and reintegration process.

A number of converging factors can make post-conflict settings high-risk environments for the spread of HIV. The loss of access to basic health care, education and information during an armed conflict can leave communities without adequate knowledge or means of HIV prevention when warfare ends. A number of welcome developments in terms of national recovery – the opening up of trade and transport, the return of displaced populations and ex-combatants to their communities, and improved access for humanitarian and development programmes – also bring new patterns of population interaction (including possible exploitation) and new HIV risks.

Although armed violence may have ended, shattered economies are slow to recover, leaving many communities in deep poverty. In post-conflict settings, the new hopes for peace and recovery may exist side by side with unemployment, destitution and despair, with people turning all too often to alcohol or drug abuse and other risky behaviours. Where women have assumed new decision-making roles while men were off fighting, the return of men to civilian life (and often to unemployment) is sometimes associated with increased domestic violence. All of these factors can drive an HIV epidemic, adding to the already daunting challenges of peacebuilding and reconstruction.

Yet there are also unique opportunities in post-conflict environments to mitigate such an epidemic. Ex-combatants (either in formal militaries or non-state armed groups) and women and children associated with armed groups are considered especially at-risk groups for HIV due to their age range, their

mobility patterns and their conflict experiences. The risk-taking attitudes of members of armed forces and groups are also known to increase their probability of exposure. If sexual violence or other forms of sexual exploitation have been factors in the conflict, then female ex-combatants, women associated with armed forces and groups, dependants and abductees are also frequently at high risk of HIV and other sexually transmitted infections (STIs). Disarmament, demobilisation and reintegration (DDR) processes, which help reintegrate ex-combatants to civilian life, can be designed such that they both help identify and diminish HIV risks and also reinforce national and local prevention and care programmes.

A disarmament, demobilisation and reintegration (DDR) programme is designed to help ex-combatants return to civilian life and to help prevent security problems which could arise when combatants are left without livelihoods and support networks during the transition from war to peace. Disarmament includes the collection and disposal of arms, ammunitions, explosives and light and heavy weapons. Demobilisation entails the formal and controlled discharge of armed forces and groups. Reintegration is the socio-economic process by which ex-combatants gain sustainable employment and income back in their communities.

HIV awareness in DDR programmes

Two decades of national demobilisation experiences in HIV-affected countries have helped to inform the establishment of norms and standards for HIV prevention in today's DDR programmes. The

Ethiopian military health authorities, for example, believed that the return of HIV-infected conscripts/ combatants to their communities after the end of the Eritrean war of independence war in 1991 was an important transmission factor in the epidemic in Ethiopia. Based on that experience, during the 1998-2001 border war with Eritrea they adopted an intense HIV prevention campaign within the military. Then, prior to post-war demobilisation, they trained demobilising troops to serve as HIV educators and change agents in their communities upon return. In Mozambique, it was found that giving vouchers for food, shelter and training to ex-combatants provided a better basis for their reintegration into civilian life than giving cash payments. Cash is often quickly spent by ex-combatants, and sometimes on things directly increasing HIV risks such as drinking or commercial sex – as was seen in the badly managed early days of the Liberian DDR process.¹ In Timor Leste, where ex-combatants initially had few employment opportunities, their frustration with their lot contributed to alcohol and drug use as well as increased levels of domestic violence – all risk factors for HIV. When livelihood and credit programmes were introduced, the situation improved.

By 2000, when the Security Council passed Resolution 1308 on HIV and Security², it was widely recognised that post-conflict periods were critical points for HIV interventions. The Resolution emphasised the importance of HIV awareness and prevention within both peacekeeping and demobilisation processes. In the same year, Security Council Resolution 1325 on Women, Peace and Security³ emphasised the specific HIV risks faced by women and girls in conflict situations and brought attention to the previous neglect of women, girls and children in

demobilisation processes. Over the next few years, as the UN became involved in an ever larger number of peacebuilding and recovery situations, the importance of integrating both gender and HIV awareness within DDR programmes became clear. A number of health screening and training programmes sprang up, with different agencies involved in different countries, but these were not evidence-based and the quality (or even availability) was highly variable.

Integrated DDR Standards

In an effort to consolidate lessons about DDR and to establish basic standards, the UN Inter-Agency Working Group (IAWG) on DDR was established in 2005 to develop an integrated approach to DDR across the UN system. The IAWG worked for over a year to collect and analyse lessons and then launched the Integrated DDR Standards (IDDRS)⁴ in December 2006. The IDDRS are a set of comprehensive guidelines covering all aspects, both operational and technical, of a DDR process. They include modules for a number of 'cross-cutting' aspects, including gender, human rights and HIV. The HIV policy guidance reinforces the idea that DDR programmes are a critical entry point for addressing HIV, and shares key lessons from initiatives in various countries.

Since the adoption of the standards, the Gender, HIV and DDR Sub-Working Group⁵ has been working with a number of UN missions to address gender and HIV within DDR processes. Funding was secured from UNAIDS, the British and Irish governments and the European Commission to implement HIV-DDR programmes in several countries, including Sudan, Côte d'Ivoire, Nepal, Colombia, Liberia, Sierra Leone and DRC. While political and operational factors heavily determine the progress of DDR overall and impede its smooth progress, there has been significant progress in use of the guidelines and in 'mainstreaming' HIV considerations into many DDR processes.

Experience thus far also indicates that the reduction of HIV risks requires coordination with even more sectors than previously thought and that linkages to other areas

such as reproductive health, gender, gender-based violence, community security and livelihoods must be strengthened in order to ensure a comprehensive multi-sectoral approach at the national and local levels. To build the knowledge base for such programming, UNDP, UNFPA and DPKO, in partnership with the Sonke Gender Justice Network and the International Center for Research on Women, are currently conducting operational field studies/reviews in four or five countries. This research initiative (June 2010 to December 2011) is supported by the European Commission, among others, which is a good sign that donors are beginning to appreciate the importance of the HIV linkages with security sector initiatives.

Lessons, achievements and challenges

Many of the lessons learned thus far are not surprising. Experience has shown that 'cantonment' periods (when ex-combatants are gathered together after disarmament and before return to civilian life) can provide time and space for critical health screening and education efforts, including awareness raising about HIV and provision of basic prevention packages. Community reintegration policies work best if they incorporate HIV prevention as a priority not only for ex-combatants but also for host communities and returning refugees; such programmes can even create some common ground among groups with widely differing wartime experiences. It is also becoming ever clearer that training and employment programmes which ensure livelihoods are not only critical for national economic recovery but are also a key to HIV prevention since they offer alternatives to sex work and lessen the prevalence of other high-risk behaviours.

Experience also shows that responding to HIV during the DDR process has a catalytic effect and can be an entry point for addressing several other sensitive issues such as gender-based violence and gender inequality among armed forces and groups. Including HIV activities in reintegration programmes has also had the collateral benefit of raising awareness of the needs of female combatants and women and

children associated with armed forces as in the case of Sudan.

Successful interventions in Sierra Leone, Liberia, Niger, Nepal, Sudan and Côte d'Ivoire have shown that having dedicated staff capacity within a coordinated national DDR response greatly improves the successful integration of HIV concerns.

While there has been progress in integrating HIV into the demobilisation phase, the reintegration phase of DDR remains the most challenging. Why? Barriers include a lack of dedicated technical expertise on the ground; lack of HIV awareness among key policymakers; limited financial resources; and poorly articulated linkages between DDR-HIV programmes and national HIV strategies. It is critical to mainstream the needs of demobilised personnel and their dependants within national HIV frameworks. All too often, newly established national HIV/AIDS commissions completely neglect the security sector.

The DDR process provides an opportunity to reach out to vulnerable groups, contributing to effective recovery and strengthening long-term development. Integrating HIV/AIDS within DDR processes is vital for the well-being of male and female ex-combatants, women and girls associated with armed groups, and their receiving communities. With the right engagement and training on HIV issues, ex-combatants do have the potential to become 'change agents', assisting their communities to prevent infections.

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1. <http://tinyurl.com/UN-LiberiaDDR>

2. <http://tinyurl.com/SCR1308>

3. <http://tinyurl.com/SCR1325>

4. <http://www.unddr.org>

5. chaired by UNDP and UNFPA and including DPKO, UNIFEM, UNICEF, UNAIDS, WHO and ILO