

HIV/AIDS, Security and Conflict: New Realities, New Responses

AIDS, Security and Conflict Initiative



netherlands institute of international relations
clingendael

WRITTEN BY

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HIV/AIDS, SECURITY AND CONFLICT

NEW REALITIES, NEW RESPONSES

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ACKNOWLEDGEMENTS

As a witness to the devastating and deadly nexus linking HIV and conflict — and the yet unanswered opportunities for response — Alex de Waal saw the need for the AIDS, Security and Conflict Initiative (ASCI) while directing the Commission on HIV/AIDS and Governance in Africa. When he joined the Social Science Research Council (SSRC), there seemed no more appropriate institutional home from which to bring together intellectual, policy and practitioner perspectives to address the challenges of AIDS, security and conflict.

ASCI would not have been possible without a very committed and visionary collective effort extending across continents, communities of practice and academic disciplines. Three successive AIDS ambassadors from the Netherlands Ministry of Foreign Affairs provided leadership for ASCI's work as well as financial assistance. Between 2004 and 2005, Laetitia van den Assum, together with development cooperation expert Gerda Dommerholt, rallied support and interest within the Netherlands Ministry and among other AIDS ambassadors, including Swedish AIDS Ambassador Lennarth Hjelmåker and Australian AIDS Ambassador Annmaree O'Keefe, who was subsequently replaced by Ambassador Murray Proctor. Between 2005 and 2009, Netherlands AIDS Ambassador Paul Bekkers provided continued political leadership and principal financial support for ASCI's research and mobilization process. Appointed in 2009, Marijike Wijnroks, the current AIDS ambassador for the Netherlands, has committed her support to seeing ASCI through to a successful conclusion.

Clingendael, the Netherlands Institute of International Relations, was a co-convenor of the initiative's first phase. Suzanne Versteegen and Steven Schoofs were invaluable partners in launching the ASCI project and managing its many tentacles. They were ably assisted by Fadime Koç, Linda Timmer and Marco Blankestijn.

Support for ASCI came in many forms. Within the United Nations (UN), the Joint UN Programme on HIV/AIDS supported research and provided the Uniformed Services Task Force as a forum for discussing findings. ASCI extends its appreciation for the support and intellectual engagement provided by Peter Piot, Karl Dehne, Leo Kenny and Nertila Tavanxhi. UN Population Fund support for ASCI's field work and policy development global fieldwork was made possible by Pamela Delargy. Françoise Girard from the UN Office for the Coordination of Humanitarian Affairs organized early consultations within the humanitarian community.

Many research and non-governmental organization partners provided invaluable spaces for different constituencies to discuss and engage with ASCI findings. Dennis Altman and Michael O'Keefe organized a seminar at LaTrobe University, in Melbourne, Australia, on HIV and state fragility, bringing together scholars and policy-makers from across the Asia-Pacific region. Alastair Roderick, from Justice Africa, took the lead in organizing ASCI's international consultation on HIV/AIDS and policing and in coordinating supporting research. From the Center for Strategic and International Studies, ASCI thanks Stephen Morrison, Gene Bonaventure and Elizabeth Morehouse. For their collaboration in organizing a satellite session on gender issues at the International AIDS Society Conference in Capetown (2009), appreciation is also extended to Judy Auerbach, from the San Francisco AIDS Foundation, and Margaret Greene, from the International Center for Research on Women. We are grateful to Monica Juma, of the Africa Institute of South Africa, and her team for convening senior policy-makers and scholars from South Africa and the region to discuss ASCI findings on gender issues.

Heather Lord, at the Greentree Foundation, provided the most conducive environment for engaging in intellectual and policy debates about ASCI findings and recommendations. ASCI is indebted to all the project researchers, advisers and experts who participated in that meeting, including J. Peter Burgess, Katya Burns, Stefan Elbe, Keith Hansen, Megh Gurung, Colin McInnes and Robert Muggah.

ASCI extends its appreciation to Bill O'Neil, Tatiana Carayannis and Brittany Gleixner-Hayat, from the SSRC Conflict Prevention and Peace Forum, who organized consultations in Geneva and in New York with key UN constituencies to discuss ASCI findings on gender issues, humanitarian crises and post-conflict transitions.

For their thoughtful insights and suggestions, ASCI extends appreciation (but no responsibility) to: Tony Barnett, Gebretsadkan Gebretensae Bayru, Roxanne Bazergan, Gene Bonaventure, J. Peter Burgess, Pamela Delargy, Stefan Elbe, Paul Harvey, Leo Kenny, Priyah Marwah, Pia Peeters, Musumali Shindano, Steven Schoofs, J. W. M. Spreeuwenberg, Nertila Tavanxhi, Joseph Tumushabe, Hugo de Vries, Alan Whiteside and Marijike Wijnroks.

ASCI would not have been able to function without the institutional leadership and administrative support provided by the Social Science Research Council under the leadership of SSRC President Craig Calhoun. Alex de Waal, SSRC program director on HIV/AIDS and social transformation, served as ASCI's research director. Jennifer Klot, SSRC senior advisor on HIV/AIDS, gender and security, was the principal investigator for gender issues and cross-cutting themes and provided overall programme direction. Manjari Mahajan, SSRC research fellow, served as editorial adviser. Paul Price, SSRC editorial director, and Debra Yoo, SSRC production manager, managed ASCI's publication process. Joe Karaganis and Alton Philips created and managed ASCI's online research hub and information portal. Tanja Mrdja provided superb programme support, and Dana Huber provided seemingly unending research assistance and programme support for ASCI's mobilization phase. Selma Scheewe, SSRC programme coordinator, helped fill substantive, administrative, financial and programme management gaps wherever they arose. ASCI is grateful to Siovahn Walker for managing ASCI's publication launch and to Lisa Yanoti and John Koprowski for their extraordinary support in managing ASCI's financial and administrative arrangements.

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral treatment
ARV	antiretroviral
ASCI	AIDS, Security and Conflict Initiative
BCC	behaviour-change communication
CCA	command-centred approach
CHGA	Commission on HIV/AIDS and Governance in Africa
COPRECOS	Latin American and Caribbean Committee of STI/HIV/AIDS Prevention and Control of the Armed Forces and National Police
CPIA	Country Policy and Institutional Assessment
CPRD	Center for Policy Research and Dialogue
CT	care and treatment
DDR	disarmament, demobilization and reintegration
DFID	United Kingdom Department for International Development
DPKO	UN Department of Peacekeeping Operations
ECOMOG	Economic Community of West African States Monitoring Group
ECOWAS	Economic Community of West African States
GDP	gross domestic product
HIV	human immunodeficiency virus
ICES	International Centre for Ethnic Studies
ICMHD	International Centre for Migration, Health and Development
IDP	internally displaced person
IDU	injecting drug user
IGAD	Intergovernmental Authority on Development
JLICA	Joint Learning Initiative on Children and HIV/AIDS
KAP	knowledge, attitude and practice
MDRP	Multi-Country Demobilization and Reintegration Program
MPS	Malawi Police Service

MSM	men who have sex with men
MST	military sexual trauma
NCO	non-commissioned officer
NDF	Namibian Defence Force
NVF	new variant famine
OSCE	Organization for Security and Co-operation in Europe
PEP	post-exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PIH	Partners In Health
PTSD	post-traumatic stress disorder
R&R	rest and recreation
SANDF	South African National Defence Force
SAPS	South African Police Service
SEA	sexual exploitation and abuse
SGBV	sexual and gender-based violence
SSR	security sector reform
SSRC	Social Science Research Council
STI	sexually transmitted infection
SVE	sexual violence and exploitation
SW	sex worker
TB	tuberculosis
TCC	troop-contributing country
UN Action	UN Action Against Sexual Violence in Conflict
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women

UNODC	United Nations Office on Drugs and Crime
UNSC	United Nations Security Council
VCT	voluntary counselling and testing
VCT-CTP	voluntary counselling and testing–care and treatment plus
WHO	World Health Organization

PREFACE

A decade ago, the notion that an epidemic disease could be a security threat — of concern to superpowers and the United Nations Security Council — was a striking innovation. Today, the integration of human security issues, such as hunger, disease and the environment, into the international security agenda is part of common-place and mainstream discussion in foreign ministries and international agencies.

The AIDS, Security and Conflict Initiative (ASCI) is a pioneering exercise in developing the evidence base for the multifarious links between a particular disease and a variety of security concerns. This initiative provides new analysis of the reciprocal links between HIV and security and has helped identify new opportunities and strategies for HIV prevention and response. Although ASCI has been able to put to rest some of the earlier fears about soaring rates of infection among soldiers and the risks posed by HIV to the potential collapse of states, it has also identified very specific and alarming implications for the operational capacity of armies and police: about the role of sexual violence in increasing transmission risk, about the impacts of HIV and AIDS on local governance and community survival, and about the particular HIV and AIDS risks associated with post-conflict transitions. Epidemiological measures of impact — incidence and prevalence — have failed to capture these social and political implications. ASCI offers a new analytical framework for understanding these dimensions and proposes a new agenda for action across the security, humanitarian, human rights, development and health arenas.

Over a period of three years, ASCI brought together diverse communities of practice and supported 29 innovative and topical research studies addressing HIV and AIDS in relation to fragile states, uniformed services, humanitarian crises and post-conflict transitions. Throughout, gender has been a cross-cutting theme, informing ASCI's analyses and recommendations. This final report synthesizes and summarizes the conclusions and recommendations that can be drawn from this process. The studies commissioned by ASCI are diverse, creative and rigorous, and they have enabled a more precise and contextualized understanding of the dynamics at work and the measures that have proven successful, or not. And they also raise new and better questions to guide future policy research and action.

A global and multidisciplinary initiative such as ASCI could only have functioned with the efforts of many people and organizations. We would like to thank all the researchers involved in ASCI, the research director and the principal investigators, the members of ASCI's Advisory Committee, the staff of the Clingendael Institute and of the Social Science Research Council, the reviewers of our reports and all our donors, without whose generous support ASCI would not have been possible.

We sincerely hope that ASCI's work may make a modest contribution to the continuing efforts to prevent HIV and help inform more effective policies and programmes to mitigate its impacts and respond to challenges ahead.



Georg Frerks

ASCI Co-Chair



Souleymane M'Boup

ASCI Co-Chair

EXECUTIVE SUMMARY

Ten years after the HIV and AIDS epidemic was identified as a threat to international peace and security, the AIDS, Security and Conflict Initiative (ASCI) provides the evidence and analysis that demonstrate how the issue has evolved and the agenda has moved from the general to the specific. ASCI exemplifies how, with better data and increasingly refined analysis, the agenda of health and security is coming of age.

ASCI research shows that the mutually reinforcing dynamics linking HIV and AIDS, conflict and security cannot be analyzed as a single overwhelming threat. Rather, they must be understood as a composite of specific policy challenges, with a host of effective responses within reach. ASCI findings reveal that a number of earlier, more alarmist relationships that were assumed to exist between national-level state security and HIV and AIDS are not borne out by the evidence. But ASCI also identifies very specific threats posed by HIV and AIDS for the operational capacity of armies and across the uniformed services. It highlights under-examined HIV risks in humanitarian emergencies and post-conflict transition and in situations of fragility. ASCI's gender analysis exposes a number of flawed assumptions that have guided epidemiological and behavioural approaches to HIV and AIDS prevention and response both within and outside conflict situations.

ASCI analysis focuses upon an intermediary level between macro-level assumptions and micro-level behavioural and biomedical approaches. This level of analysis includes neglected areas and themes, potential new responses, and areas in which effective responses need to be recognized and sustained. It points to a number of policy and programmatic measures that have achieved important successes, sometimes unheralded.

Summary of Findings

ASCI results include a number of evidence-based findings with implications for HIV and AIDS research and policy development. These findings suggest the need for a new agenda for action across the security, humanitarian, human rights, health and development arenas.

- As a long-wave event, the non-linear and reciprocal impacts of HIV and AIDS and state fragility make it extremely difficult to discern any causal links between the epidemic and national-level fragility. Prevailing indicators of state fragility fail to capture the impact of HIV and AIDS on local governance, human resources, service delivery and community survival.
- HIV prevalence within the uniformed services is related to age, rank, time in service, maturity of the epidemic, repertoires of violence, military sexual trauma and the policies and activities of the command.
- HIV and AIDS can threaten the operational capability of armies, primarily at the tactical level, to maintain combat effectiveness, unit cohesion, morale and discipline, and human resource quality.
- Command-centred approaches to HIV prevention are likely to be more effective in reducing HIV risk among rank and file than solely relying upon education and training based on individual behavioral, medical, or human rights approaches.
- HIV prevention efforts have neglected police and other law enforcement and uniformed services, including customs, navy, immigration and corrections.
- The risks of HIV transmission, especially in epidemics concentrated among injecting drug users and sex workers, are influenced by law enforcement practices and, in turn, by the drugs trade and human trafficking and by the people who control sex work, including 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 is needed in post-conflict situations to respond to the complexities of context, increased population mobility, the demobilization of combatants, disruptions in humanitarian provision to displaced persons and refugees in camp settings, and the overload of health and social services in areas of population return.
- Disarmament, demobilization and reintegration 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 services.

Summary of Policy Recommendations

ASCI puts forward 10 HIV and AIDS, security and conflict policy recommendations. These priorities establish a wide scope for engagement and offer practical and immediate proposals for action.

(1) Align HIV and sexual violence prevention and response.

Urgent recognition must be given to violence, and especially sexual violence, as a physiological and social factor in risk transmission and in HIV, humanitarian, public health and security policies. There needs to be greater debate and consensus on what constitutes sexual violence, how to measure and model it, and what its patterns are in relation to conflict. The role of force or coercion should be made explicit in data linking HIV with social and behavioural factors. Sexual violence prevention and HIV prevention must be more closely aligned, and preventing sexual violence should be central to HIV and AIDS policies and strategies in conflict-affected environments.

(2) Develop command-centred approaches to HIV prevention and AIDS treatment and care in the uniformed services.

Success in responding to HIV and AIDS within the uniformed services will be enhanced by using integrated and mainstreamed approaches that emphasize military command responsibility for HIV policy development and implementation. ASCI recommends the elaboration and adoption of command-centred approaches (CCAs) to HIV prevention and AIDS treatment and care within uniformed services and United Nations (UN) peace operations. This type of approach requires systematic assessments of HIV and AIDS within a security institution and the development of lines of accountability and disciplinary and enforcement mechanisms to prevent sexual violence among the ranks, as well as sexual exploitation and abuse of local communities. Tools developed for ASCI, including the Military Institutional Audit and a Force Capabilities Framework assessment, can support a CCA. The African Union Common Security and Defence Policy should incorporate a CCA for HIV and AIDS. ASCI recommends that most aspects of national military HIV and AIDS programmes be harmonized with their civilian counterparts — in pursuit of equitable burden-sharing and common principles across the different sectors — while maintaining their specific relevance and application to the particular requirements of the uniformed services.

(3) Integrate HIV prevention and response into the design and command of peace support operations.

HIV and AIDS policies in peace operations, including issues of pre- and post-deployment testing, care and treatment, and the inclusion of HIV-positive people in the forces, should be more realistically aligned with operational demands and the capacities of troop-contributing countries. Building upon CCA operational tools, ASCI proposes the development of a tool specific to peace support missions: an HIV and AIDS security risk assessment to be undertaken prior to deployment or upon arrival at the mission area.

Practices of national, regional and UN peacekeeping missions should be aligned with the ultimate goal of a universal standard for HIV prevention, treatment and care across all troop-contributing countries. In line with achieving the global goal of universal access, HIV and AIDS treatment should be extended to UN peacekeepers as a matter of policy. On an interim basis, policy and practice should be aligned sufficient to the establishment

of a common treatment protocol among the different contingents making up a peacekeeping operation. ASCI recommends increased dialogue among bodies and institutions with complementary peacekeeping and peacebuilding mandates, namely, the UN Security Council, the African Union Peace and Security Council, the UN Peacebuilding Commission, and other regional mechanisms, to address the heightened risks of HIV and AIDS during post-conflict peacebuilding and to ensure the continuity of HIV prevention during post-conflict transitions and peacebuilding, including disarmament, demobilization and reintegration.

- (4) Integrate HIV and AIDS prevention and response into disarmament, demobilization and reintegration programmes.

Disarmament, demobilization and reintegration (DDR) programmes need to pay greater attention to HIV and AIDS, especially at the level of programme design and implementation. DDR provides important entry points for HIV prevention, testing, care and treatment. ASCI recommends a new approach to voluntary counselling and testing (VCT) that incorporates care and treatment (CT), not only of demobilizing soldiers, but also of partners and children: VCT-CTP (voluntary counselling and testing—care and treatment plus). HIV and AIDS policies for the uniformed services and peacekeeping personnel should be reflected in pension and retirement schemes, funeral and survival benefits, and compassionate leave, disability and medical discharge benefits as well as entitlements for children born out of wedlock and/or from rape. Consistent with UN Security Council Resolutions 1308, 1325 and 1820, the UN, the World Bank and bilateral donors are called on to support national governments in clarifying their policies and implementing more comprehensive VCT-CTP in the context of DDR and security sector reform.

- (5) Reframe the testing debate.

ASCI recommends a balanced dialogue on mandatory HIV testing and the establishment of health criteria for deployment. In different forms, mandatory testing is practiced by the majority of armies for reasons that are widely accepted among military commanders but have been inadequately justified in the context of human rights principles and national HIV and AIDS policies. Principled and practical arguments both for and against mandatory testing should be aired in public. Paradigms of international humanitarian law and the right of states to suspend certain human rights provisions during national security emergencies should be discussed as well as operational considerations for severely resource-constrained armed forces. Objections to testing are framed in terms of the violation of individual human rights. Some militaries link voluntary testing policies to incentives and preconditions for advancement and require seronegative test results as a basis for deployment and promotion. Others frame their policies in terms of medical fitness in general, leaving scope for discretion on how to utilize soldiers who test HIV-positive. A new debate needs to bring into direct conversation the divergent military, civilian and peacekeeping policies for HIV testing and deployment.

- (6) Integrate HIV Prevention and Response into Policing and Law Enforcement

In all aspects, the issues of HIV and law enforcement services have been neglected. One dimension is the impact of HIV and AIDS on police and other law enforcement institutions and the pressing need for HIV interventions at the law enforcement level. A second dimension is the way in which law enforcement practices, especially in relation to stigmatized and criminalized activities and groups, influence the trajectory of national and regional epidemics. Issues such as harm reduction for injecting drug use, the policing of sex work and trafficking, and the decriminalization of homosexuality are all central to this. A global programme of collaborative learning on law enforcement and HIV and AIDS is needed.

- (7) Increase focus on HIV and AIDS across borders, and in relation to traffic and trade.

Cross-border issues, including trafficking of women, the drug trade and sexual exploitation and abuse at border crossing points, are all related to risks of HIV transmission. The previously underestimated role of some groups of law enforcement personnel as core group transmitters or maintaining populations warrants further exploration. Bilateral, regional and multilateral exchange and cooperation is a prerequisite for addressing these questions, and borders should be a special focus for HIV efforts. The nexus between the international trade in illicit drugs, related sex trafficking activities, drug use and the emergence of narco-states in several parts of the world demands particular attention.

(8) Increase continuity of HIV and AIDS responses during post-conflict transitions.

A major policy gap in responding to HIV and AIDS occurs during post-conflict transitions, which can be simultaneously periods of heightened risk for HIV transmission and periods of programmatic weakness because of discontinuities between emergency assistance and reconstruction and development efforts. International policy frameworks and practices restrict HIV and AIDS-related assistance to post-conflict countries as they often fail to meet the funding criteria or conditions of stable governance.

More refined approaches are recommended, paying attention to a variety of gender-related factors that shape HIV risk during transitions. The linkages between psychosocial recovery and HIV risk are among the most underexplored. The psychosocial effects of war, conflict, displacement, torture and violence have repercussions for interpersonal relations, family and household arrangements, and socialization processes. Both conceptual and applied work are needed to better understand how notions of masculinity and femininity are shaped by conflict and its aftermath so that appropriate interventions can be designed for both men and women, boys and girls that take into account structural vulnerabilities and related HIV risks and consequences. In this context, existing policy successes need to be recognized and sustained, including best practices in responses to populations in refugee and displaced camps and the strengthening of health infrastructure in post-conflict settings.

(9) Address HIV and AIDS in fragile states: strengthen local government, community and family care arrangements.

The relationship between HIV/AIDS and state fragility is highly complex and non-linear. ASCI calls for a reassessment of existing measures of state fragility to take into account key elements of local government, including human resources, health sector delivery and community resilience. ASCI research points to the ways in which HIV and AIDS stress local government institutions, hindering effective representation and contributing to poor service delivery. In turn, these weaknesses undermine efforts towards achieving the goal of universal access to HIV and AIDS prevention, care and treatment. ASCI also documents the ways in which local government reforms can change social and economic contexts and alter patterns of HIV transmission. Obligations fall upon national governments to meet the needs of their citizens and ensure that the decentralization of governance and service delivery is adequately supported.

(10) Rethink the tools of measurement.

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. There is a need for more finely tuned indicators and approaches that are sensitive to these social and gender dimensions, especially in situations of protracted conflict, displacement and post-conflict transformation. Analytical frameworks and measurement tools need to consider local variations in sexuality and violence. Assessments of the drivers and impacts of HIV and AIDS should complement highly aggregated national-level indicators with more contextualized measures of dynamics at family, community, local and regional levels.

BACKGROUND

The AIDS, Security and Conflict Initiative (ASCI) is a global research initiative convened by the Netherlands Institute of International Relations “Clingendael” and the Social Science Research Council. The Netherlands Ministry of Foreign Affairs financed an inception phase from June to October 2005, which led to the development of a research agenda, an Advisory Committee and an international network of researchers, policy-makers and practitioners. Following meetings with the Advisory Committee and a variety of experts and scholars, ASCI issued a targeted call for expressions of interest in December 2006. In the ensuing months, ASCI’s research team (consisting of the secretariat, principal investigators, a research director and initiative co-chairs) engaged in an extensive process of identifying appropriate research partners across disciplines, continents and communities of practice. Considerable time and attention were given to selecting countries best suited for case-studies, locating knowledgeable and well-placed research partners and identifying opportunities to build on existing research initiatives. Between 2006 and 2008, a total of 29 research projects were commissioned, involving 26 research partners in 17 different countries (see Annex). From December 2008 to August 2009, ASCI’s research findings were presented in consultations across a range of academic and policy settings.

ASCI’s work was supported by Co-Chairs Georg Frerks and Souleymane M’Boup and ASCI Research Director Alex de Waal. Thematic research areas were led by Principal Investigators Tony Barnett, Manuel Carballo, Gebretsadkan Gebretensae Bayru and Jennifer Klot. The Advisory Committee consisted of Paul Bekkers, Judy El-Bushra, Winnie Byanyima, Pamela Delargy, Adele Dion, Stephen Heintz, Lennarth Hjelmåker, Annmaree O’Keefe, Peter Piot, Suebpong Sangkharomya, Margaret Vogt and Alan Whiteside. Over the course of the project, the Advisory Committee met three times.

Financial support for ASCI’s work was provided by the Netherlands Ministry of Foreign Affairs, the Australian Agency for International Development, the Canadian Department of Foreign Affairs and International Trade, the Rockefeller Brothers Fund, the Swedish Ministry for Foreign Affairs and the Joint United Nations Programme on HIV/AIDS. Funding for specific research projects and activities was also provided by the Health Economics and HIV/AIDS Research Division, University of KwaZulu Natal, Justice Africa, the United Nations Fund for Population Activities and the San Francisco AIDS Foundation.

Rationale

The rationale behind ASCI has been to achieve a more rigorous understanding of the links between HIV and AIDS, security and conflict. ASCI addresses growing concerns about the longer-term and structural impact of the HIV and AIDS pandemic. And it focuses attention on the impacts of HIV and AIDS on human security and national stability in the most affected countries, particularly those in conflict and post-conflict situations.

The point of departure for ASCI has been the need to crystallize much of the knowledge obtained by practitioners and researchers, to fill important gaps in understanding and to provide a sound foundation for evidence-based HIV and AIDS policy development and programming across four thematic areas:

- (1) Military and uniformed services;
- (2) Humanitarian crises and post-conflict transitions;
- (3) Fragile and crisis states;
- (4) Cross-cutting issues, including gender, data collection and measurement, and media representation.

Methodology

ASCI’s research portfolio includes 29 research projects across the four thematic areas. Individual projects embraced a wide variety of qualitative and quantitative research approaches, including field-based assessments,

literature reviews, macroeconomic and mathematical modelling, meta-policy analyses, statistical surveys and analyses, and case-studies. Each researcher established a study methodology appropriate to the specific research questions. This final ASCI report synthesizes the results that have been derived from across different disciplinary and methodological approaches.

Both the absence of extensive sector-specific research and the inherent methodological challenges impose some limitations on the findings presented by ASCI. ASCI, however, has tried to be reflexive about these limitations and the inevitable epistemic challenges. It has placed its findings in the context of an extensive literature review of policy and academic research. Moreover, it has strengthened its findings through numerous consultations and peer review with policy-makers, practitioners and scholars. This important effort to mobilize the social sciences and the biomedical and public health communities exposed significant gaps in understanding and in methodological approaches and helped build interdisciplinary collaboration. HIV/AIDS is a health challenge as well as a social, political and economic one. Much more interdisciplinary collaboration is needed to resolve the vexing and complicated issues raised by the HIV and AIDS epidemic, issues that will continue to unfold over generations.

Consultations and Peer Review Meetings

Mid-way through the research process, principal investigators convened ASCI commissioned researchers working on related thematic topics to share and critique their findings. A gender peer-group meeting was held at the London School of Economics; the International Centre on Migration and Health convened its researchers in Geneva. The fragile states research cluster was convened at LaTrobe University in Melbourne, Australia, and the Center for Policy Research and Dialogue convened researchers working on uniformed services in Addis Ababa.

In addition, ASCI brought together law enforcement officers and specialists from around the world for a September 2007 global consultation on the police and HIV that took place in The Hague. In September 2008, the Greentree Foundation hosted ASCI's cross-thematic peer review meeting that brought together all of its commissioned researchers.

During ASCI's final mobilization phase (December 2008–September 2009), research findings were also discussed within various policy and academic settings, including with the World Bank, the African Union, the National Institutes of Health Office of AIDS Research Advisory Council, Dalhousie University, and at the 15th International Conference on AIDS and STIs in Africa, held in Dakar in December 2008.

The Center for Strategic and International Studies coordinated briefings in Washington, DC on 23 June 2009, with international financial institutions, the United States foreign policy community and the United States Department of Defense. The SSRC Conflict Prevention and Peace Forum convened briefings with United Nations (UN) departments, funds and programmes in Geneva on 2 July 2009. Findings related to gender issues were presented at a satellite session organized in collaboration with the International Center for Research on Women and the San Francisco AIDS Foundation on 20 July 2009 at the International AIDS Society meeting in Cape Town. A seminar presenting South Africa and related regional findings was cosponsored by the Africa Institute of South Africa in Pretoria. Additional consultations have taken place at a meeting on HIV and trafficking in Eurasia coordinated by aids2031 and the UN Office on Drugs and Crime. The Joint UN Programme on HIV/AIDS (UNAIDS) hosted a number of opportunities to discuss ASCI findings with the Uniformed Services Task Force.

A draft version of this final ASCI report was reviewed by a number of experts across the fields of security, HIV and AIDS, reproductive health, humanitarianism and gender. For their thoughtful insights and suggestions, ASCI extends appreciation (but no responsibility) to: Tony Barnett, Gebretsadkan Gebretensae Bayru, Roxanne Bazergan, Gene Bonaventure, J. Peter Burgess, Pamela Delargy, Stefan Elbe, Paul Harvey, Leo Kenny, Priyah Marwah, Pia Peeters, Musumali Shindano, Steven Schoofs, J. W. M. Spreeuwenberg, Nertila Tavanhxi, Joseph Tumushabe, Hugo de Vries, Alan Whiteside and Marijike Wijnroks.

ASCI Research Hub and Information Portal

An online research hub and information portal (<http://asci.researchhub.ssrc.org>) played a central role in ASCI outreach activities. The ASCI research hub consists of a powerful set of online tools that enable a community of researchers, practitioners and policy-makers to discover and stay informed about relevant research, share knowledge and collaborate across ASCI's four thematic areas. The main portal provides general information about ASCI, an overview of its thematic priorities and access to all its working papers. It offers a word-searchable database of academic and policy research, organizations and key actors across the field of HIV and AIDS, conflict and security. The database, which is continually updated to reflect new publications and research materials, has over 700 entries that link users to articles, institutions and people thematically related to ASCI. The open-source design allows users to update their research profiles and add relevant materials to the growing collection of database resources.

1. INTRODUCTION

This is the final report of the AIDS, Security and Conflict Initiative (ASCI) that was convened by the Social Science Research Council (New York) and Clingendael Institute (The Hague) between 2005 and 2009. ASCI is a global research initiative aimed at informing policy and programming by strengthening the evidence base and addressing critical gaps in knowledge in the fields of HIV and AIDS and security. ASCI addresses four broadly defined thematic areas: military and uniformed services; humanitarian crises and post-conflict transitions; fragile states; and cross-cutting issues (gender was taken up as a cross-cutting issue for which research was specifically commissioned). In total, ASCI commissioned 29 studies (see Annex).

The central messages of ASCI's final report are that (1) HIV and AIDS pose diverse threats to human security and to international and national security; (2) security institutions and situations of insecurity and crisis influence patterns of HIV risk; (3) post-conflict transitions reshape and, in some cases, exacerbate HIV risks and impacts; and (4) HIV prevention and AIDS care and treatment are poorly integrated with security sector reforms, humanitarian assistance, peacekeeping and post-conflict peacebuilding.

ASCI research identifies ways in which these threats can be ameliorated through targeted policies, programmes and mobilization efforts. In conflict and post-conflict transitions, effective HIV and AIDS policies must adapt to evolving environments in which HIV risks are increased as a result of changing migration patterns, lapses in service provision and increased sexual violence. Key recommendations include an improved debate on HIV testing within the uniformed services and the adoption of command-centred approaches to HIV prevention and AIDS treatment and care to manage the impacts of HIV on the operational capacity of uniformed services. Recommendations also address the roles of law enforcement and trafficking in shaping the trajectory of epidemics nationally and regionally.

All these challenges require an explicit gender-sensitive, if not gender-transformative, approach. Gender analysis is integrated throughout this report and used to reconsider the efficacy of behavioural approaches to HIV and AIDS prevention and response among uniformed service members and their families. It also provides an empirical assessment of sexual and gender-based violence and exploitation as a physiological and social risk factor of HIV transmission, prevention and response. ASCI shows how gender is one among a number of significant factors associated with social, economic and cultural inequalities shaping HIV risk and vulnerability during conflict and in post-conflict transition and in the context of humanitarian service delivery, early recovery, and disarmament, demobilization and reintegration.

ASCI's findings challenge the efficacy of individual-behavioural approaches to HIV prevention that fail to recognize power hierarchies within social and sexual relations. They also require the rejection of macro-determinist paradigms that assign direct causation between the acceleration of HIV and conflict or state fragility. In between these extremes lies a complex array of factors, constraints and opportunities.

1.1 The Securitization of HIV and AIDS

AIDS in Africa basically takes generations out of play. And then you have refugee flows. And then you have economic disasters. And then you have civil wars that require exfiltration and some kind of involvement whether you choose to or not. And while we all believe we're immune from this, we're not. At some point somebody has to be responsible for it.

*George J. Tenet, director of the United States
Central Intelligence Agency, 7 February 2001
(United States Senate Select Committee on Intelligence, 2002)*

At the turn of the millennium, the United Nations Security Council (UNSC) held its first-ever discussion of a public health issue as a potential threat to international peace and security. This precedent-setting action was sparked by three different agendas, each with its own fears and aspirations. One motivation reflected traditional

state-centred security concerns and was driven by fears that high disease burdens and the attrition of human resources would lead to state crises. The second was a specific concern with peacekeeping, emphasizing the threats posed by HIV and AIDS to peacekeepers and peacekeeping operations and the fear that peacekeepers might contribute to HIV transmission. The third was a broader human security agenda — widening the scope of attention to the potential impacts of HIV and AIDS on the sociocultural, political and economic dimensions of human well-being.

The findings from ASCI-commissioned research have provided greater understanding about where and how the disaster has, and has not, unfolded. While earlier fears may have been alarmist, they were not entirely misplaced. Below the macro level of aggregation, ASCI finds an array of serious but largely tractable issues. Armies may not have imploded, but they are affected in several important ways. They face problems in absorbing the costs of providing treatment and care to service members and their families, retaining skilled and experienced staff, and managing legal and ethical issues over testing. Vital questions around law enforcement services and HIV and AIDS remain unaddressed.

Armed conflicts may not have unleashed uncontrollable HIV epidemics, but forced displacement and transitions from conflict to post-conflict situations pose major challenges for ensuring continuity of HIV prevention and AIDS treatment and care and adapting to rapidly changing socioeconomic and political environments. National governments may appear resilient in the face of these challenges, but ASCI research identifies measurable, though not yet catastrophic, impacts on local government structures. While existing indices of “state fragility” show no direct correlation and certainly no causation between HIV/AIDS and state fragility, there is much evidence indicating that state capacity is an important determinant of effective HIV and AIDS responses. These are all manifestations of traditional national security challenges, albeit in a new form, at an intermediate level and with a differentiated impact.

1.1.1 Threats to international security

Among security realists, especially in the United States, the rapid growth of the HIV pandemic in parts of the world caused some analysts to predict that entire societies were in peril. A seminal United States national intelligence report (NIC, 2000) outlined a dire scenario in which the HIV pandemic, left unchecked, brings about catastrophic social and political collapse in affected countries, causes armies to become unmanageable, exacerbates armed conflict and makes humanitarian emergencies immeasurably worse. This anticipated scenario, considered imminent in southern and parts of eastern Africa, was viewed as a threat to American national security. A second scenario (NIC, 2002) expanded the fear to a “second wave” of countries — China, India, the Russian Federation, Ethiopia and Nigeria. It predicted a trajectory, similar to that foreseen for southern Africa, of generalized epidemics and potential sociopolitical crises that, in turn, would pose a major national security challenge to the United States.

These scenarios did not unfold as predicted. The dire consequences of HIV and AIDS have not threatened the state security of the United States or that of any other power. Rather, the catastrophe wrought by HIV has predictably and disproportionately threatened human security in those regions where the epidemic is most advanced. These threats are concentrated in southern Africa, the global epicentre of the pandemic and a subregion in which the fall in life expectancy is itself a demographic disaster. Although there have been important impacts of HIV and AIDS on health, society and politics in the Russian Federation, India and China, these countries have not constituted a second wave of infection comparable to the one devastating southern Africa. As ASCI research shows, the South-East Asian and Pacific epidemics have also not followed the “Africanization” trajectory (O’Keefe, 2008).

Efforts to contain the pandemic and especially to provide treatment have been more substantial than could have been predicted, although they continue to face enormous sociocultural and political obstacles and enduring stigma and discrimination. On present trends, HIV remains a current threat to the life chances of millions. Future scenarios, African and global, must take account of expanded risks, such as new, adaptive and more virulent strains of HIV. The proclivity of HIV to mutate and develop resistance to current treatment regimens should be cause for continuing vigilance.

Although the predictions of HIV-induced state disaster may have been overestimated, the immense political force unleashed by those predictions should not be minimized. The politics of HIV and AIDS, including the coalition behind the creation of PEPFAR (US President's Emergency Plan for AIDS Relief) and the unpublicized but expedited responses of many armed forces, were strongly influenced by this mobilization. There is no agreement about why the global HIV pandemic did not continue to escalate in the manner that had been predicted. One contributing factor is likely the unprecedented global response. Another is the early mischaracterization of HIV and AIDS as a short-term "emergency" infectious disease outbreak. The uniquely long-term characteristics of the human immunodeficiency virus mean that its consequences — health, social, economic and political — will unfold over the medium and long term for generations to come. This presents new challenges for measuring its impacts as they become intertwined with other demographic crises and stressors, from famine and natural disasters to conflict and insecurity.

1.1.2 International peace support operations

The second agenda bringing HIV and AIDS to the attention of the UN Security Council was a focused concern about potential threats to peacekeeping, including the risks to peacekeepers, the strains on peacekeeping operations and the risk that peacekeepers could themselves become vectors of transmission, both to host populations and from host populations to troop-contributing nations. UNSC Resolution 1308 (2000) restricted itself to the most immediate problem, namely, UN peacekeeping operations, and led to a growing consensus on the potentially constructive role that UN peace operations could play in strengthening HIV prevention.

Nearly 10 years after this historic resolution, a number of important policy challenges remain unresolved, including the controversial issue of pre-deployment testing and the provision of in-service and post-deployment treatment and care. As international and regional engagements in peacekeeping and peacebuilding continue to expand, the need for coherent HIV policies within and across diverse troop-contributing countries becomes ever more important. Policy needs and responses will vary according to the specific needs of contingents, their functional and operational requirements and the application of the UN's policy of zero tolerance for sexual exploitation and abuse in peacekeeping operations. Ensuring the continuity of HIV prevention and AIDS treatment and care during post-conflict transitions and peacebuilding is another persistent challenge. Disarmament, demobilization and reintegration programmes have been a consistently overlooked focus for HIV prevention and response, including their near exclusionary approach to military families and women and children associated with armed forces and groups. This neglect is being remedied, for example, in Côte d'Ivoire and Sudan, but much more needs to be done.

1.1.3 Human security

The UN Security Council's third concern about HIV and AIDS was about human security. The human security concept points to the interlinkages across a variety of security threats beyond the traditional strategic and military domain, including economic, environmental, health and political security. This trend emerged in the wake of the United Nations Development Programme (UNDP) report on human security (UNDP, 1994), which gradually came to influence multilateral and national debates and made the protection of civilians more central to the international peace and security agenda. This was followed by international action on behalf of conflict-affected children and women against the use of sexual violence in war and in support of the role of women in peacebuilding. Also recognized was the potential contribution of non-governmental actors in achieving a broader notion of security. It was pointed out that many more people die from threats to human security, such as preventable illnesses and food scarcity, than from war. If "hard" security issues were a matter of concern because they might affect human beings, a lethal epidemic that was already killing millions of people every year and threatening to kill many more should be a security concern just as much as a war. This framing of HIV as a threat to human security represented a significant step forward. It helped mobilize the resources and commitment of the international community and also of diverse constituencies in the United States, from former Vice President Al Gore's supporters to conservative Christian groups, in support of a project of common benefit — overcoming the pandemic (Burkhalter, 2004).

Yet, hard evidence establishing HIV as a security threat was lacking, and plausible conjecture took the place of data in much of the discussion. Despite the securitizing scenarios, mainstream media coverage of HIV and AIDS remained nearly exclusively focused on medical and humanitarian aspects while almost entirely neglecting the gender, political and security dimensions (Campbell, 2008). One of the principal rationales for ASCI has been to provide the empirical basis for assertions about the links between security and HIV, with the aim of injecting new rigor into the debate and providing concrete suggestions for action. ASCI did not deal with non-conflict-related humanitarian emergencies, except in passing. This subject has been covered by Samuels, Harvey & Bergmann (2008) and in *World Disasters Report: Focus on HIV and AIDS* (IFRC, 2008).

1.2 The Gender Dimensions of HIV and AIDS, Security and Conflict

The gender dimensions of HIV and AIDS, security and conflict provide a central focus for ASCI's analysis and recommendations. ASCI research offers new insights about how gender shapes HIV risk and response in crisis. Drawing from literature spanning different disciplines and fields of practice, ASCI uses gender analysis to question dominant epidemiological models of HIV risk that have yet to incorporate the physiology of women's susceptibility in situations of forced sex.

ASCI commissioned research provides new evidence about the role of force and coercion in HIV transmission. It shows how force is underestimated in the context of early marriage and commercial, transactional or survival sex. In the face of imminent threats to physical safety, HIV risks are also associated with the oxymoronic phenomenon of "protection sex", which exposes the most vulnerable to additional risks of abuse, exploitation and HIV infection because the immediate alternatives appear worse.

Within official HIV and security discourse and practice, the term "gender" is typically understood to mean "women". This limited and inaccurate understanding of the concept fails to capture both the biological and social factors that shape gender relations and, accordingly, HIV risk and access to prevention, care and treatment. In conflict situations, this one-dimensional conceptualization of "gender" is often translated into HIV responses that define risk according to single sex "risk groups" defined by a single social variable — such as "the military" or "sex workers".

These approaches fail to recognize the rich and complex relational map of interactions and variation within these groups. Simplifying HIV prevention to reach "the military", for example, doesn't consider the multiple and changing social and sexual identities that a person has over a lifetime, or even over the duration of a conflict. Before, during and after conflicts, members of the military become civilians, and civilians may enlist or be forcibly recruited into service. HIV risks will differ accordingly. For example, soldiers serving in peace operations may have better access to HIV prevention than those in private military companies. Men in uniform may have sex with both men and women and therefore face additional risks that are not likely to be considered within military HIV programmes. Inadvertently, these generalized approaches often overlook sub-populations within these social categories who may be most at risk — e.g., female military, male sex workers, or men who have sex with men but consider themselves heterosexual. In other words, one dimension of a person's sexual and social identity is an insufficient basis for targeting HIV interventions.

Access to HIV prevention and AIDS care and treatment will also be determined by social position, rank, economic status, ethnicity, location, age, disability, religion, marital status, cultural practices, drug use and family structure. HIV risk will be determined by a range of inequalities associated with a combination of variables that take different expressions according to the interpersonal, sociocultural and political contexts in which relationships, including sexual relationships, are played out.

El-Bushra (2008) contends that the capacity to deliver effective HIV responses in conflict situations is hindered because gender and social analysis of HIV risk is often secondary to epidemiological assessments of transmission risk. Behavioural paradigms of HIV transmission risk have yet to explain — let alone reduce — the disproportionate rates of infection among young women as compared to men in sub-Saharan Africa. "Empowerment" approaches to HIV prevention typically focus on individual agency and assume that the ability to "negotiate" "safer sex" is something that can be taught. They underestimate the deeply entrenched and socially underwritten power relations based upon systems of patriarchy, ethnic and power relations that have developed over centuries

In sum, the shortcomings of HIV prevention and response in conflict reflect the neglect of gender analysis in analyses of HIV risk and response. ASCI offers a framework for understanding gender in HIV and conflict that can improve HIV and AIDS policies and programmes, with specific recommendations.

1.3 New Realities, New Responses

ASCI research suggests that existing frameworks for assessing and responding to HIV have not sufficiently reflected the risks associated with conflict, post-conflict transitions and state fragility. Findings from across ASCI research projects help specify the factors that explain how HIV risk is shaped by the important, widely acknowledged but poorly specified social processes that fall under the general rubric of civil-military relations, sexual violence, conflict, post-conflict reconstruction and state fragility.

ASCI findings about the relationship between HIV and state fragility are in line with a more sanguine reappraisal of the severity of threats posed by the epidemic at the macro level of analysis. ASCI research shows how national assessments often fail to capture impacts seen at local government and community levels, within families and across generations. They also fail to capture the related and adverse impacts of the twin epidemic of tuberculosis (TB). In developing countries, TB is typically the first manifestation of AIDS, and it kills up to half of all AIDS patients worldwide (WHO, 2009), with implications for service delivery and human resources that have yet to be reflected in the fragile states agenda and international poverty reduction strategies. ASCI's research points to the need to move beyond existing state fragility paradigms to approaches better attuned to complex and varied local realities.

Current approaches to conflict, humanitarian crisis and post-conflict reconstruction have yet to consider the impacts of HIV and AIDS in anything other than a passing manner. Similarly, high-level generalizations about the relationships between state fragility and HIV/AIDS tell us little about the contours of impact and resilience. But we should not be surprised that HIV and AIDS has not led to state collapse. Throughout history, states have shown a remarkable capacity to remain robust even while presiding over far-reaching social changes and calamities, and there is no reason to expect the case of the HIV epidemic to be any different.

Within the security sector's response to HIV and AIDS, the focus on national armies has led to a neglect of other uniformed services (most notably, the police, immigration and corrections), irregular forces, private military companies and former combatants. This final ASCI report therefore uses the term "uniformed services" to encompass the entirety of the security sector. Usage of this term also puts a new focus on police services, which play especially important and complex roles in HIV epidemics.

While a state security approach is too narrow, a human security focus can become so broad that it encompasses everything of concern and therefore can be of limited use for policy. Each of the existing frameworks offers both value and limitation, as well as opportunities for intermediate or hybrid concepts, such as "sustainable security" (Brigety & Dewan, 2009). Therefore, ASCI has sought to combine these levels of analysis, shifting lenses when appropriate for understanding the issues at stake. The approach followed, comprising multi-level empirical data collection and analysis, has enabled ASCI to overcome the limitations of both security frameworks while benefiting from their respective strengths.

2. STATE FRAGILITY AND HIV/AIDS

According to existing indices of state fragility, those countries with the highest HIV prevalence are not ranked among the most fragile, and those considered most fragile do not report the highest rates of HIV. ASCI's research helps explain this finding, both methodologically and substantively, with three principal explanations. The first is that current measures of state fragility tend to focus on macroeconomic indicators of state capacity to govern and manage development funds, while the most acute impacts of HIV and AIDS will be felt at household and community levels. The consequent pressures on human capacity and increased demand for services are most apparent at local government levels and particularly in the health sector. Absent indicators that reflect these local constraints, both the direct and indirect impacts of HIV and AIDS at state levels will continue to be underestimated, if not rendered completely invisible. The second reason points to the yet unmeasured costs and consequences of the unpaid-labour burdens that women and girls disproportionately assume in providing HIV and AIDS-related care, including for orphans.

The third explanation recognizes the remarkable resilience of states in the face of human calamities, including epidemic diseases, and the ways in which national and international responses to HIV and AIDS have served to strengthen aspects of government capacity and democracy. In addition, current indicators of state fragility tend to measure changes in capacity over the short or medium term, whereas the impacts of HIV and AIDS are most visible over the long term. As a long-wave event, the non-linearities and feedback loops in the relationship between HIV and AIDS and state fragility make it extremely difficult to discern any causal links.

2.1 What is Fragility?

It has become commonplace to observe that HIV hastens state collapse, which in turn helps to create the conditions for further transmission of HIV. The reality is probably more complex: the states with highest HIV incidence in Africa are not the most fragile, and some that are — Liberia or Somalia, for example — are not among those with the highest HIV prevalence.

Dennis Altman (Altman, 2007)

A decade ago, it was widely feared that entire states might collapse under the onslaught of HIV and AIDS. Garrett's predictions (2005) of the possible emergence of terrorist groups in a fight for resources and "Lord of the Flies" scenarios of unsocialized orphans with Kalashnikovs have clearly not come to pass (de Waal, 2006a). Instead, experience and data suggest the opposite: states with the highest rates of HIV are not the most fragile, and conversely, some of the most fragile states have among the lowest prevalence of HIV, with state responses to HIV and AIDS having generally strengthened governance. ASCI research helps isolate the reasons for these unexpected outcomes by examining the prevailing concepts of state fragility and the indicators used to measure it, as well as by investigating the pathways of impact and resilience in relation to both HIV and state fragility.

ASCI commissioned two studies that make quantitative comparisons across countries using standard indices for state fragility, including those developed by the World Bank. The results show no overall positive correlations between HIV prevalence and state fragility. On the contrary, an increase in HIV is (insignificantly) associated with decreased fragility. However, tuberculosis (TB) prevalence is associated with state fragility indicators (the study does not differentiate TB associated with HIV from other TB infections). Barnett & Dutta (2008) used indices of state fragility constructed from indicators of conflict, corruption and other correlates of state fragility and from measures of HIV prevalence. In a second study, Sato (2008) focused on those countries already classified as fragile. A number of different regression models were run on these data to identify significant associations. None were found. Other studies (e.g. Menon-Johansson, 2005) have used comparable quantitative approaches and come to the converse conclusion, namely, that HIV is negatively associated with governance quality, while analyses using time-series data (Paxton, 2009) show that the links are diverse for different forms of state fragility. Cumulatively, what is striking about these studies is that the effects they identify are all at the margin. The dramatic medium-term impacts of HIV on state survival that were hypothesized a decade ago have been discounted.

The studies of state fragility highlight the influence of underlying conceptual and ideological models of statehood, state fragility and governance. Such models are often rooted in modernity and modernization theory and adopt Weberian or Westphalian notions of the state in the European tradition, which focus on sovereignty and state monopoly over organized violence. These models are ill suited to realities in developing countries and, in addition, are unable to capture prevalent hybrid models of governance, such as neo-patrimonial systems that are common in sub-Saharan Africa. Barnett (2009) argues that an alternative tradition of state analysis might have saved us from the development of a misleading, homogenizing and apparently “technical” discourse about state fragility and governance. Instead, what might be required is careful analysis of the diversity within and between states, of the relations between classes and other significant social groups, and of the role of various inequalities (including gender inequality) in relation to state structures and ideologies. Analyses that consider the distinctions between different kinds of states are likely to provide more illuminating insights than the highly generalized analyses by proxy that are being used to inform intelligence assessments of state security.

Measures of state fragility used by financial and aid institutions are even narrower than those used in academic and policy analyses, primarily because they are intended as a basis for establishing aid allocation criteria and funding mechanisms. Torres & Anderson (2004, p. 28) characterize these approaches along three broad lines.

- (1) Fragile, failed or crisis states — These approaches are based on the assessment of a state’s strength around issues of capabilities, sovereignty and conflict.
- (2) Poor-performing countries — Most of the international financial institutions focus their approaches to difficult environments on how well a country performs in terms of development outcomes, taking into account the quality of governance and policy choices.
- (3) Difficult aid partners — In this approach the emphasis is placed on the poor aid relationships between donors and recipient states, which are due to a combination of, first, a lack of political interest in poverty reduction and, second, weak state and non-state institutional capacity to implement policy.

The World Bank’s measure of state fragility is based on its own diagnostic tool, the Country Policy and Institutional Assessment (CPIA). CPIA scores determine the relative size of grants and the terms of concessional lending by the World Bank’s International Development Association (i.e. grace periods, repayment schedules and interest rates). The CPIA has a single purpose: to determine a country’s ability to effectively use development assistance. This is evaluated by assessing the quality of a country’s policy and institutional frameworks — factors the World Bank considers to be “within the country’s control”, as compared to outcomes (such as growth rates) that are “influenced by elements outside of the country’s control” (World Bank, 2009). It is therefore not surprising that the CPIA’s principal indicators of performance pertain to economic management, structural policies and public-sector management and institutions, as well as policies for social inclusion and equity (Figure 2.1). Partly as a result of these measurement approaches, most fragile states receive only a fraction of the aid to which they would be entitled if, for example, equity criteria of equitable distribution of assistance among countries were employed, a discrepancy that helps explain and even amplifies the poor performance scored for many fragile states.

The linkage between HIV and state capabilities, including the absorptive capacity for aid, is an important issue in the HIV-fragility discussion. Of the 39 countries that received World Bank funding for fragile and conflict situations, only 7 were among the 20 countries with the highest HIV prevalence (World Bank, 2008).

The different indices have strikingly divergent rankings of the most fragile states, a reflection of how difficult it is to agree on a common definition and measurement of the concept. Regarding the CPIA, the principal criticism is the absence of indicators that reflect security issues or actual outcomes. Other international indices on state fragility, such as the Fund for Peace/*Foreign Policy* “Failed States Index”, the Brookings Institution Center for Global Development “Index of State Weakness in the Developing World” and the George Mason University Center for Global Policy “State Fragility Index”, include more expansive indicators of sociocultural, political, economic and security issues. However, there is a common result across indices: no correlation with HIV prevalence in 2007 (Table 2.1). This confirms the robustness of the negative finding.

Drawing upon this evolving literature, ASCI research explored various ways in which HIV does negatively affect governance and a country’s ability to utilize aid at national and local levels. The following pages discuss how these impacts can be considered in developing more effective national policies and institutional arrangements within fragile states in order to contribute positively to development and poverty reduction.

Figure 2.1
World Bank CPIA criteria

A. Economic Management
1. Macroeconomic Management
2. Fiscal Policy
3. Debt Policy
B. Structural Policies
4. Trade
5. Financial Sector
6. Business Regulatory Environment
C. Policies for Social Inclusion/Equity
7. Gender Equality
8. Equity of Public Resource Use
9. Building Human Resources
10. Social Protection and Labor
11. Policies and Institutions for Environmental Sustainability
D. Public Sector Management and Institutions
12. Property Rights and Rule-based Governance
13. Quality of Budgetary and Financial Management
14. Efficiency of Revenue Mobilization
15. Quality of Public Administration
16. Transparency, Accountability, and Corruption in the Public Sector

From World Bank (2009).

2.2 The Reciprocal Impacts of HIV and Governance

The potential impacts of HIV and AIDS on state capacity depend on the demographic and governance context in which a national epidemic unfolds. In sub-Saharan Africa, impacts can be seen in the loss of skilled human resources and the additional drains on health systems. These impacts are most pronounced at local levels. It seems that in populations with hyperendemic HIV — i.e. sustained prevalence above 15% — such as in southern Africa, the impacts depend on the intersection of other factors, including poverty, skilled labour emigration and governance crisis. They may be less visible in countries that have the economic capacity to fill specific gaps by importing skilled personnel. In the health sector, the outmigration of doctors, nurses and midwives has been devastating.

In 2003, the UN Secretary-General spoke about the “triple threat” of HIV, food insecurity and lack of state capacity, with particular reference to southern Africa (Nelson, 2003). Recent research illuminates the contours of this crisis. Whiteside & Whalley (2007) and Naysmith, de Waal & Whiteside (2009) describe how this combination of stresses is generating a long-wave “emergency” in Swaziland. Price-Smith’s (2007) discussion of Zimbabwe makes a similar argument for that country and assembles data to assert that HIV exerts moderate to significant negative effects upon Zimbabwe’s economy, social stability and structures of governance and, ultimately, its national security. However, Barnett cautions against generalizing from extreme cases, such as Swaziland and Zimbabwe, to draw wider conclusions about likely impacts on bigger and better-governed states (Barnett, 2009, p. 10).

In the Manipur and Nagaland states in northeast India, Jacob (2008) shows the epidemic to have very modest but measurable impacts on some elements of governance, the largest impact owing to poor education from irregular teaching practices and premature retirement. The health sector appears less affected, but the evidence is mixed, and virtually no impacts were seen in the electoral sector. Jacob points to other more significant factors, such as the insurgency. He concludes that it would take many years of a higher level of HIV prevalence for impacts to become a significant impediment to governance in the states, with any adverse impacts mitigated by the fact that the two states are part of the much larger Indian republic, which has the capacity to absorb governance shocks in its smaller states without a threat to its overall stability.

Table 2.1
Rankings of State Fragility and HIV Prevalence

	Brookings Fragility Rank (2008) ¹	Fund for Peace Fragility Rank (2009) ²	CPIA Rank (2008) ³	HIV Prevalence (2007) ⁴
1	Somalia (0.5%)	Somalia (0.5%)	Zimbabwe (15.3%)	Swaziland (26.1%)
2	Afghanistan (<0.2%)*	Zimbabwe (15.3%)	Eritrea (1.3%)	Botswana (23.9%)
3	Democratic Republic of the Congo (1.5%)*	Sudan (1.4%)	Comoros (<0.1%)	Lesotho (23.2%)
4	Iraq (<0.2%)*	Chad (3.5%)	Sudan (1.4%)	South Africa (18.1%)
5	Burundi (2.0%)	Democratic Republic of the Congo (1.5%)*	Central African Republic (6.3%)	Namibia (15.3%)
6	Sudan (1.4%)	Iraq (<0.2%)*	Chad (3.5%)	Zimbabwe (15.3%)
7	Central African Republic (6.3%)	Afghanistan (<0.2%)*	Guinea-Bissau (1.8%)	Zambia (15.2%)
8	Zimbabwe (15.3%)	Central African Republic (6.3%)	Afghanistan (<0.2%)*	Mozambique (12.5%)
9	Liberia (1.7%)	Guinea (1.6%)	Cote d'Ivoire (3.9%)	Malawi (11.9%)
10	Cote d'Ivoire (3.9%)	Pakistan (0.1%)	Togo (3.3%)	Kenya (8.5%)*
11	Angola (2.1%)	Cote d'Ivoire (3.9%)	Democratic Republic of the Congo (1.5%)	Central African Republic (6.3%)
12	Haiti (2.2%)	Haiti (2.2%)	Angola (2.1%)	United Republic of Tanzania (6.2%)
13	Sierra Leone (1.7%)	Myanmar (0.7%)	Congo (3.5%)	Gabon (5.9%)
14	Eritrea (1.3%)	Kenya (8.5%)*	Solomon Islands (N/A)	Uganda (5.4%)
15	Democratic People's Republic of Korea (<0.1%)	Nigeria (3.1%)	Timor-Leste (N/A)	Cameroon (5.1%)
16	Chad (3.5%)	Ethiopia (2.1%)	Haiti (2.2%)	Cote d'Ivoire (3.9%)
17	Myanmar (0.7%)	Democratic People's Republic of Korea (<0.1%)	Sao Tome and Principe (N/A)	Congo (3.5%)
18	Guinea-Bissau (1.8%)	Yemen (<0.2%)*	Guinea (1.6%)	Chad (3.5%)
19	Ethiopia (2.1%)	Bangladesh (<0.1%)*	Kiribati (N/A)	Equatorial Guinea (3.4%)
20	Congo (3.5%)	Timor-Leste (N/A)	Burundi (2.0%)	Togo (3.3%)

*Estimated value – data not available; **Light gray denotes that the country is in the top 20 for HIV prevalence.

1. Source: Rice SE, Patrick S. *Index of State Weakness in the Developing World*. Washington, DC, Brookings Institution, 2008 (http://www.brookings.edu/reports/2008/02_weak_states_index.aspx).
2. Source: Fund for Peace, *Foreign Policy. Failed States Index 2009*. Washington, DC, Fund for Peace/*Foreign Policy*, 2009 (http://www.foreignpolicy.com/articles/2009/06/22/the_2009_failed_states_index).
3. Source: International Development Association. *IDA Resource Allocation Index – 2008*. Washington, DC, World Bank, 2009 (<http://go.worldbank.org/S2THWI1X60>).
4. Source: Joint United Nations Programme on HIV/AIDS (UNAIDS). *A global view of HIV infection, 2007 [wall chart]. 2008 Report on the Global AIDS Epidemic*. Geneva, UNAIDS, 2009. (http://data.unaids.org/pub/GlobalReport/2008/GR08_2007_HIVPrevWallMap_GR08_en.jpg).

In the Russian Federation, where the population is declining and its health status is poor and deteriorating, relatively low levels of HIV and AIDS are likely to have a significantly deleterious impact on the human resource pool available for key institutions, such as the military. In southern and eastern Africa, where fertility levels are high and populations are still expanding, the impacts are different, and the crucial demographic intermediaries are other factors, such as the emigration of skilled personnel.

Concern with the former Soviet Union and analysis of Soviet data was the starting point for the health–state failure paradigm. Murray Feshbach, one of those who sounded the alarm on Soviet infant mortality rates more than a quarter century ago, updated his analysis for ASCI. Feshbach (2008) evaluates the interdependence between demography, health and the military in the Russian Federation. Taking data from 1987 onwards, he shows that dramatic changes in the health of the Russian population have adversely affected the military and therefore have had grave impacts on governance. In particular, the fall in births has meant a reduced cohort of labour supply for recruitment into the military services. Both the quality and the quantity of recruits are argued to be dwindling, but at this moment, there is no danger of the Russian Federation becoming unstable. Alongside HIV, Feshbach explores TB, mental health problems, drug addiction and alcoholism as burdens on the population. Feshbach's projection and evaluation suggest that while HIV is a worrying problem, there are many other health concerns to combat in order to re-strengthen the military and general populations. His analysis implies that although the Russian Federation is unlikely to face any form of state crisis on account of HIV — or indeed other diseases — these will be major constraints on the ambitions of the Russian government as it strives to reassert itself on the global stage.

2.2.1 Local governance and HIV/AIDS

ASCI research found significant impacts of HIV and AIDS at the level of local government and communities. In focusing entirely on national-level phenomena, there is a danger of overlooking the damaging impact of the epidemic on local government's ability to both represent its constituencies and deliver services to meet growing demands. As international financial and development institutions continue to promote decentralization processes, the implications become more alarming. Smith's study in Papua (2008) attributes the exacerbation of public service delivery problems, in part, to the devolution of responsibility for HIV and AIDS programming to local government. Despite increased funding for HIV/AIDS channelled from the central level, Smith shows a decline in local HIV and AIDS expenditures due to competing spending priorities and corruption. Smith also reveals how reforms to the local government system are shaping the trajectory of the epidemic at the provincial level. Meanwhile, rapid economic changes, such as the growth of new urban centres, associated with government administration, mining ventures and transport hubs are changing the profiles of livelihoods and communities. HIV risks are now being associated with the rapid influx of male migrant labour and related increases in transactional and commercial sex. Smith also associates increased HIV risk with alarming rates of domestic violence against women, the highest in the region, and widespread incidence of men who have sex with men (MSM) and women, but do not identify themselves as homosexual or bisexual. ASCI-commissioned research in South Africa reveals that hyperendemic HIV creates stress and attrition for local government institutions, which in turn contributes to poor-quality services and less responsive and effective local government (Chirambo & Steyn, 2008). Comparable stresses on service provision in different sectors, including education, health and agriculture, have been noted elsewhere in sub-Saharan Africa (CHGA, 2008). Chirambo & Steyn (2008) found that local government in South Africa was showing definite "cracks", which contribute to the problem of poor service delivery to the general public. In a sample of 12 municipalities throughout the country, most councillors surveyed thought that disclosing HIV status would be ruinous for a political career. The study also found a consistent pattern of elevated death rates among councillors aged 29–42 and increased sick leave and lower productivity among councillors at low pay grades. Despite the availability of employee assistance programmes and voluntary counselling and testing, uptake was limited.

Chirambo & Steyn conclude that fear of stigmatization and discrimination has influenced wider social attitudes towards HIV and AIDS and may account for the underutilization of HIV services, including treatment, and the unexplained withdrawal of councillors from public duties. Practically, it has affected the representation of some communities in local government, thereby limiting the potential for the effective decentralization of service delivery. Chirambo & Steyn suggest that HIV is one of many factors eroding the skills and leadership capabilities necessary for local government to function and to meet the aspirations of its constituencies. Increased cost burdens, staff turnover and representational ruptures may not in the short term cause acute crises in local

government. But they are severe enough to warrant intervention and targeted support to ensure that local government can function more efficiently under the impacts of the epidemic.

2.2.2 Rethinking democracy and HIV/AIDS

Recognizing the reciprocal linkages between HIV/AIDS and governance, ASCI also assessed the influence of governance on HIV/AIDS and found differential impacts between national and local levels of governance and across sectors. Study findings suggest that some aspects of state functioning can remain robust even while communities are plunged into protracted crises. South Africa, Botswana, Lesotho and Swaziland illustrate this point. State capacity and governance are the strongest indicators of good performance in adopting best practices in HIV and AIDS policies (Strand, Kinney & Mattes, 2008), despite important outliers, such as South Africa. Case-studies of effective and ineffective national responses come to the same conclusion, notably, the Joint Learning Initiative on Children and HIV/AIDS (JLICA) case-studies of Cambodia, South Africa and Tanzania (2009). They illustrate the necessity of capacity-constrained governments doing a few simple things and doing them well. For such states, the priority is to implement policies that have clear goals, ideally bring universal benefit and command popular support.

The challenges of antiretroviral (ARV) rollout in situations of weak governance were researched in detail in Mozambique (Høg, 2008) and Haiti (Weigel, 2008). Mozambique's ARV rollout must be seen in the context of the country's unique liberation history and the strong national attachment to a socialist health system. Høg's study shows how the elected government of Mozambique seeks to strengthen and sustain its legitimacy by opting for the provision of public rather than privatized health services as a way of delivering on its pledges. He notes that "Frelimo seems to apply these strategies to gain legitimacy throughout the country" and that "political commitment to free public health has become a social contract and solemn promise between the State and the Mozambican people ..." (2008, p. 35). Seventeen years after the end of its civil war, Mozambique can no longer be counted as a state in transition, and it is not considered fragile. But Mozambique is an extremely poor country in which policy choices and outcomes are shaped overwhelmingly by resource constraints. Høg's study suggests that the Mozambican government accords primacy to its sovereignty over national (health) policies and development process. This seems to correspond with the Organisation for Economic Co-operation and Development's professed wisdom that service delivery can be a source of legitimacy (OECD, 2008). Arguing that state capacity remains limited and other service providers are also needed in the health sector, Høg poses the intriguing question of whether the government's political avoidance of private health care, in the context of weak state capacity to fill the resulting service gaps, should be regarded as contributing to a particular form of fragility.

Meanwhile it is also true that states considered less democratic in their approach to human rights may have lower prevalence of HIV. For example, Cuba's approach to HIV and AIDS has been praised for its results but highly criticized for its methods. Parameswaran (2004) attributes Cuba's achievement — one of the lowest rates of HIV in the world, one thirtieth of that in the United States — to strict enforcement of quarantines and a sanatorium system. During the 1990 recession, however, this approach became popular for free provisions provided by the government, including food and salary. In 1993, people were allowed to leave, but most did not because of the impeccable care they received. Cuba now manufactures its own ARVs and is likely to become a production hub for other developing countries.

The key finding from a Justice Africa project on HIV/AIDS and democracy in Africa (de Waal, 2006b) is that, contrary to the expectation that the spread of HIV would coincide with regression away from democracy and an increase in disrespect for human rights, the epidemic years have witnessed an increase in democracy and civil society activity in sub-Saharan Africa. On most human rights and good governance indicators, the region has been improving, despite significant setbacks in some countries, such as Zimbabwe, and a stalling in democratization after 2005. The principal reason for this is that the international response to the epidemic has centred upon human rights and civil society. The efficacy of this response in terms of controlling the epidemic can be disputed, but its pressures to promote a particular vision of good governance cannot be dismissed. It would, however, be wrong to see the response as simply being one of international promotion of the forces of democracy against the repressive instincts of states, resulting in the extension of civil liberties. Rather, international assistance serves as a form of patronage, encouraging domestic activist-entrepreneurs to seek livelihoods and protection from foreign sponsors. International donors thereby become domestic political players, creating hybrid forms of national governance (Englund, 2006).

In Myanmar, where the Global Fund to Fight AIDS, Tuberculosis and Malaria has (uniquely) decided that it cannot operate due to governance concerns, ASCI research indicates that limited initiatives are possible. Khin's (2008) study of HIV and AIDS policies in Myanmar shows the stratagems used by local non-governmental organizations and government officials to negotiate with a repressive government that is unwilling to allow any manifestation of civil society, especially one with international connections or a human rights agenda. Even in such contexts, there is scope for modest action.

Altman (2008) questions whether community pressure or government pressure matters more in reducing HIV prevalence. In most countries in South-East Asia that he studied, Altman found that leadership arose among community-level organizations and support from external agencies was important. Altman warns, however, that governments may provide perverse incentives for supporting HIV programmes as it is a "fashionable" topic that is sure to attract funds. His research summarizes four elements that affect national responses to HIV and AIDS: (1) the size, or the perceived size, of the epidemic; (2) the operation of the bureaucracy; (3) external pressures, including from international organizations and donors, civil society and the media; and (4) social and sexual cultures. Altman argues that these factors must be analyzed — bearing in mind intercountry variations — in order to gain a full picture of political responses in South-East Asia.

Haiti is a state apparently lacking both the will and the capacity to implement HIV and AIDS programmes. State health services are almost non-existent. Weigel's (2008) study for ASCI reviewed the ambitious programme of Partners In Health (PIH), which aims to provide high-quality health care to some of the most destitute and deprived communities. The PIH model invests in both government health infrastructure and the development of community-based health service accompagnateurs (community health promoters). Critiques of the PIH model focus on the potential for replicating a relatively small-scale project at national scale. Haiti's HIV prevalence has fallen in recent years, from 4% in 2002 to 2.2% in 2007. This success cannot be attributed to either national programmes or to PIH, neither of which have the reach or capacity to effect this kind of change. Haiti's reduction in HIV prevalence parallels that of Zimbabwe, which brought down its HIV rate at a time when most observers were predicting precisely the opposite as its economic implosion and governance regression set the country into reverse on almost every other indicator.

2.3 Fragile Communities and HIV/AIDS

A consistent finding across a large body of research is that the intersection of HIV/AIDS and other sources of stress creates acute crises for communities. These crises are locally contoured and variable, without any single pattern. Former UN Secretary-General Kofi Annan's triple threat of HIV, food insecurity and lack of state capacity remains a good framework for understanding the crisis in the southern Africa subregion. Similarly, in South-East Asia and the Pacific, researchers prefer to focus on the impacts of HIV on communities rather than states. The central argument of the "new variant famine" hypothesis (de Waal & Whiteside, 2003) is that mechanisms for resilience and coping depend upon the labour and skills of productive adults, especially women, and if HIV causes these people to fall sick, households' and communities' capacities for withstanding stress can no longer be relied upon. Naysmith, de Waal & Whiteside (2009) argue that this is occurring over a long time period in Swaziland.

The recent JLICA (2009) findings illuminate the extent to which family and kinship structures have absorbed the socioeconomic burdens of HIV and AIDS. This has happened through remarkable adjustments in family structure, such that household sizes have actually increased during the epidemic years, leaving extremely few child-headed or skip-generation households, contrary to stereotype. The yet unmeasured burdens of this response have been borne disproportionately by women.

Among the most significant of burdens is HIV-related caregiving. Akintola (2008) reports that governments are encouraging home care as a way to save money on institutionalized care in public hospitals and to free up bed space for those with other illnesses. UNAIDS estimates that up to 90% of illness care is provided in the home, with the principal givers of physical and psychosocial support women and girls (UNAIDS Global Coalition on Women and AIDS, 2005). It is often taken for granted that women provide, and will continue to provide, unremunerated care and support to infected and affected family and community members. In many cases, family and kinship structures are being pushed beyond capacity. The term "resilience" is fast becoming a euphemism for the absence of state provision of care and treatment.

In South Africa, Seekings (2009) points to the decline of the conjugal household and evident limits of extended family and community support, especially on the paternal side. A clear majority of African women aged 20–59 live in households supported by grants, and up to one fourth of African women depend entirely on kin. Support from family is in the form of housing, food and care, or from pensions. However, Seekings states that these ties to kin are principally on the maternal side and not always reliable as care for non-extended-family members may take priority.

As families and communities adapt to these challenges, little is known about the impact of these additional pressures on the well-being of individuals, their educational achievements, entry into the labour market or experiences of sexual violence. How these impacts may differ for women and girls, men and boys has not garnered significant attention in policy discussions. In conflict-affected settings, there are a growing number of accounts of families selling children or forcing children to bring income into the household by whatever means possible, including through begging, selling on the street or prostitution, and of young women being compelled from positions of extreme powerlessness to enter partnerships with members of armed groups (D'Awol, 2008; Seckinelgin, Bigirimwami & Morris, 2008).

While explicitly rejecting the apocalyptic scenarios predicted 10 years ago, Barnett (2006; 2009) raises important questions about longer-term consequences of HIV and AIDS for social cohesion. His focus is on issues that will be clarified over many years by ethnographic research. For example, while the fear that large numbers of children orphaned by AIDS will grow up outside a family environment is not materializing (JLICA, 2009), the nature of parenting and family relationships for adopted children and those in extended families — and the psychosocial consequences — is not well understood. The longer-term impacts of behaviour-change messages on social mores and values also warrant study. Mabala (2008) describes how young women in Tanzania, unable to “say no” to the environment in which they are continually exposed to sexual advances and harassment, often decide it is better to have the patronage and protection of a single “sugar daddy” rather than be exposed to the perils of youth gangs in the street, school and market. But abstinence-focused HIV prevention messages contribute to the internalizing of an individual responsibility for being “lustful”. The young women may also stigmatize their parents’ generation for having acted “sinfully” and having breached taboos. Subtle and longer-term value changes such as these may have significant effects over a generation or more.

2.4 The Gender Dimensions of State Fragility and HIV Risk

Baryanyi & Powell’s (2005) review of donor perspectives on fragile states concludes that none of the donors systematically incorporate gender into their considerations. They further suggest that this failure may undermine the effectiveness of strategies to address state fragility. Feminist economists concur. Johnston (2008) concludes that macroeconomic models of HIV and AIDS understate the impact of the epidemic on growth and development because they fail to distinguish between the community impacts of high mortality rates for women and men, ignore gender segmentation within labour markets and fail to consider the impact of increased demand for care work on both market and non-market production.

Drawing on a growing body of social science research, ASCI re-emphasizes the unmeasured toll that AIDS places on family care arrangements. The cost and value of caregiving in HIV-affected settings has not been considered as a factor in macroeconomic and sector-specific planning, employment programmes, workplace and social protection policies, or health system reforms and expenditures. Nor have the longer-term development impacts of increased care burdens been assessed in terms of lost educational opportunities and changes in women’s economic, political and social status. Although women are largely responsible for sustaining their families and communities under stress, women’s labour in the domestic sphere is almost entirely unmeasured in official statistics. Critical increases in this labour burden may pass unrecognized until a breaking point is reached.

Chapter 4 of this report calls for the urgent recognition of violence, and especially sexual violence, as a physiological and social factor of HIV risk. Researchers have also called attention to the fact that women’s risk of HIV may be shaped more dramatically by health-sector reforms and transportation, education and macroeconomic policies than by any single HIV intervention. Without governmental policies and support for women’s property rights, education, livelihoods and access to health care, unsafe transactional sex can become one of the few alternatives for survival (Klot & Nguyen, 2009).

2.5 State Fragility Conclusions

AIDS is clearly a long-wave event with impacts taking various forms and unfolding over generations. Barnett (2006) distinguishes HIV from short-wave events, such as other infectious disease outbreaks:

The distinction is subtle but important. Take an infectious disease with a short incubation period and a high rate of mortality — for example, cholera. This has long-term effects, inasmuch as people die and leave others bereft, but the event itself has a short-wave form. We know that it is happening soon after it begins; we respond to it as best we can through public health measures and vaccination and treatment of infected and sick people. The same is true of a natural event such as a volcanic eruption or the 2004 Asian tsunami. Again, the effects were immediate and the need to respond was instantly apparent. (p. 302)

Both ASCI research and experience worldwide over the last decade indicate that the HIV and AIDS pandemic is not in the process of tearing down the pillars of national security in large or medium-sized countries. The global trajectory of the pandemic has also altered. Infection rates have stopped their appalling rates of increase, globally and in most countries. The threats posed to states by HIV and AIDS are different.

The sheer diversity of the world's HIV epidemics, of the states that are considered to be fragile and of the relationships between these factors points to the importance of tracing context-specific links between HIV and weak governance — in both directions. Generalization is difficult. UNAIDS (2008) has adopted the mantra “know your epidemic”, but it is equally important to know your social, economic and political context (Buse, Dickinson & Sidibé, 2008). Local levels of government and specific government sectors may be hard hit by HIV and AIDS, and the kind and quality of governance can influence the direction of an HIV epidemic. These dimensions are not captured in the preferred categorization of HIV epidemics, which is based on individual behaviours as generic categories rather than sociopolitical contexts (Barnett, 2009, p. 23–24). As a result, entire possible arenas for intervention are largely neglected.

3. THE SECURITY SECTOR AND HIV/AIDS

In the security sector, ASCI's research assesses the particular risks that HIV and AIDS pose for the operational capability of armies, with impacts on combat effectiveness, unit cohesion, morale and discipline, and human resource quality. The evidence indicates that HIV prevalence within the military is related to a constellation of factors, including age, rank and time in service, maturity of the epidemic, prevalence in deployment locales, command structures, institutional repertoires of violence, and sexual violence within the ranks. The research shows that there are also very important gaps in existing knowledge about the security sector, notably, concerning irregular forces and other uniformed services, including law enforcement, customs, navy, immigration and corrections. Moreover, disarmament, demobilization and reintegration (DDR) programmes are an important and long-neglected focus for HIV prevention and response, especially among military and extended families, and women and children associated with armed forces. ASCI research challenges conventional "core group" theories and shows how, in some situations, elements of the security sector actually sustain and shape the epidemic.

ASCI findings point to several main policy directions. One is the important concept of the "command-centred approach" to HIV prevention and AIDS treatment, which shifts the locus of responsibility for HIV policy from the medical services to the military command. A second is the need for a balanced dialogue on mandatory testing, which is practiced by the majority of armies for reasons that appear self-evident to military commanders but are inadequately justified in the context of human rights principles and national HIV policies. A third is the importance of law enforcement services in the trajectory of epidemics, especially among injecting drug users and sex workers.

3.1 HIV and AIDS and the Military

Both HIV/AIDS among soldiers and military responses to HIV/AIDS have been little understood. Militaries have been reluctant to share data and have often not given full information about their policies, and the issue has been prone to misunderstandings. ASCI research focused on filling in some critical gaps in the evidence and analysis.

3.1.1 HIV rates among soldiers

It is no longer an accepted truth that soldiers have rates of sexually transmitted infections (STIs), including HIV, two to five times higher than the general population and even greater ratios in times of conflict, as was thought some 10 years ago (UNAIDS, 1998). These alarmist generalizations focused mainly on African armed forces and led to warnings of the dissolution of command structures, the loss of experienced officers and the potential accelerated spread of infection throughout the general population and among peacekeeping personnel (Yeager, 2000; Singer, 2002). In light of a growing body of evidence and research (Whiteside, de Waal & Gebre-Tensae, 2006; Lowicki-Zucca, Karmin & Dehne, 2009), many of these original presumptions about the reciprocal and mutually reinforcing aspects of HIV and insecurity have been reopened.

At earlier stages of the African epidemic, when general population prevalence was very low, it may have been the case that uniformed personnel had much higher HIV rates (cf. UNAIDS, 1998). However, analysis commissioned by ASCI indicates that the picture in general is more complex and less alarming than previously presumed. For instance, among new recruits to infantry armies, mostly young men from disadvantaged and rural backgrounds, HIV rates may be lower than in the general population, but among longer-serving soldiers, including the officer corps, rates may be higher than among their civilian peers (Whiteside, de Waal & Gebre-Tensae, 2006; CPRD, 2008). The prevalence differentials within armies, among armies and between armies and the civilian population depend upon a host of factors, including the stage and nature of the HIV epidemic, the demographic composition of armed forces, alcohol and drug use, military deployments and ethos, and military HIV policies and practices, including in some cases the exclusion of those found to be HIV-positive (Elbe, 2003). Furthermore, HIV risk depends on the availability of condoms and STI treatment. Ward (2008) also points to the importance of appropriate screening of blood supplies for emergency treatment of serious injuries among active military. In their recent statistical analysis of data for 21 African militaries, Ba et al. (2008) confirm that HIV prevalence is highly variable, sometimes comparable and sometimes significantly elevated compared to the general population.

This and other research indicate that all conclusions on HIV rates among the military must be treated with care. The reliability of data remains a serious concern. The sensitivity, secrecy and stigma associated with HIV among the uniformed services have created significant gaps in knowledge about infection rates. Moreover, there is frequent reluctance to share those data that are available. An ASCI-commissioned study on five Central American countries that show fairly low official prevalence figures argues that serious underreporting is occurring at national levels (Kruijt & Balconi, 2008). Moreover, without systematic testing, reliable figures regarding the military (and police) are lacking. Cases are revealed only when HIV-positive individuals themselves choose to disclose their serostatus (Kruijt & Balconi, 2008). There is also an almost total data vacuum relating to HIV among demobilized soldiers and their partners and similarly among soldiers who have served in peacekeeping missions after their military deployment.

Comparing HIV rates among serving soldiers with rates in the civilian population is a distraction from the most important questions. In purely quantitative demographic terms, the comparisons are not like-with-like: the rates need to be adjusted for age specificity, and there are also arguments for adjusting for location and socioeconomic status. Comparisons between serving soldiers and, say, migrant workers or public sector employees might yield more interesting results. However, more useful research and analysis will focus on specific circumstances and the reasons why some armies have been so much more successful than others in keeping HIV rates low.

A host of reasons have been posited for relatively higher HIV rates among soldiers. In some countries (for example, the Russian Federation) the increased risk factors include the declining health status of those population segments from which soldiers are recruited and a growth in injecting drug use (Feshbach, 2008). Once in the force, soldiers are posted away from home, in locations that may provide higher HIV risk than their district or country of origin. They are often relatively well paid, and sometimes lonely and bored, in areas where the surrounding civilian population is comparatively deprived, a situation that in many instances leads to higher levels of transactional sex (CPRD, 2008).

Absent a strong chain of command that orders the required policies and transmits the right messages, the behaviour of young, sexually active soldiers may be governed mostly by peer pressure and small-unit norms. In some cases, soldiers are inducted into hyper-masculine cultures that reward risk-taking and perceptions of invincibility, in which sex, and perhaps especially unprotected sex, is considered a sign of virility and compensation for the emotional aridity of professional military life (Elbe, 2003; Patel & Tripodi, 2007). Okulate, Jones & Olorunda (2008) find that HIV-positive military personnel are more likely than HIV-negative personnel to use condoms inconsistently with sex workers and casual partners. In other cases, HIV risk is associated with alcohol, marijuana and injecting drug use. In a large cohort study among Nigerian military personnel, Essien et al. (2007) find a direct correlation between alcohol and marijuana use with HIV risk, and no association between HIV risk perception and frequency of casual sex. In ASCI studies, it was indeed found that social rather than purely physical conditions put militaries and police at risk (ICES, 2009). Soldiers may abuse their authority over the distribution of resources, security, food and safe passage and engage in sexual exploitation and abuse. In desperate situations, garrisons may attract impoverished women and girls (also men and boys) as well as sex workers.

Stigma and denial around homosexuality contributes to HIV risks in most armies. This is a neglected and mostly invisible topic (Wade et al., 2005). It includes the risks among men who have sex with men and women. In many armed forces, sexual relations between men are forbidden or illegal. Many men who have sex with men identify as heterosexual but may engage sexually with men during periods of isolation from women, for example, or as an alternative to engaging in commercial or transactional sex (Hankins et al., 2002). An instructive parallel is migrant labourers in South Africa, where men having sex with men in all-male compounds was seen as a way of preserving their heterosexual fidelity to female partners they lived with only a few months of the year.

There are two clusters of explanations for why these above-mentioned factors do not necessarily lead to higher HIV rates among the military. The first concerns the demographic composition of armies and the social epidemiology of their interactions with the civilian population. Some factors predispose soldiers to higher HIV rates; others do not. The most important risk-reducing factor in some countries is the preference for infantry armies to recruit from poorer, rural young men, who have a lower rate of HIV than their more affluent or urban peers and a lower rate than women and older men (Abebe et al., 2003; CPRD, 2008).

The second cluster of explanations relates to HIV policies within the armed forces. Evidence is incomplete, but it is likely that most armies have a practice of mandatory testing of recruits for HIV and have pre-deployment,

contract and promotion practices that make employment conditional on HIV status; they also have internal HIV prevention programmes. Ten of the fifteen major troop contributors to United Nations peacekeeping operations have mandatory testing policies (Lowicki-Zucca, Karmin & Dehne, 2009). Even where mandatory testing is prohibited and positive cases cannot be dismissed, such as in Central America, there is in practice a strong pressure to agree to voluntary testing. Due to the stigma attached to HIV, those who test positive tend to leave the institutions of their own volition (Kruijt & Balconi, 2008).

Some armies with formal mandatory testing policies may not implement them consistently or completely. And the counselling element may be absent. Testing is expensive and complicated, and if an army is recruiting on an emergency basis, it may decide to suspend the practice. If there is mandatory testing on enlistment, those who pass may be considered “HIV-free”, and an opportunity for counselling and HIV education may be missed.

According to Lom (2001), early mobilization and political commitment kept HIV infections low in Senegal. Some 10 years ago, Senegal began training military officers and providing treatment for soldiers while on mission. As of 2007, Senegal reports lower prevalence in the army as compared to the general population. Reasons cited include effective leadership, peer education training programmes, mass sensitization campaigns accompanied by small group discussions, condom distribution (92% of soldiers report using condoms with sex workers), health worker and laboratory assistance training, regular testing, and family outreach. The highest rates of infection were identified in the oldest age group, which was 40–49 years. Interestingly, prevalence was higher among married as compared to single soldiers (Dieng, 2008). Lower prevalence in the Royal Thai Army as compared to the general population is attributed to effective HIV surveillance, a 100% condom use policy and support programs for those living with HIV. Additional factors include public acknowledgement of HIV and commitment to prevention, management of all levels of organization, and sufficient resource allocation (UNAIDS, 2004).

3.1.2 The operational impacts of HIV and AIDS

ASCI research commissioned from the Centre for Security Sector Management at Cranfield University (Kershaw, 2008) reveals concern within armies about the potential impacts of HIV and AIDS on operational capacity, even at low prevalence levels. The concerns are specifically about the adverse impacts of HIV and AIDS on combat effectiveness, morale and discipline and on the quality of human resources (cf. Heineken, 2001; Rupiya, 2006). The Kershaw study argues that HIV-infected soldiers are less able to withstand the rigours of training, combat and living under hard circumstances. Furthermore, training, operations and career planning are affected by absence, compromising vital bonding processes among soldiers and placing additional burdens on fit soldiers, which contributes to problems of morale. The most affected group includes middle-ranking officers between 25 and 30 years of age, leading to significant human resource deficiencies in the armies concerned (Kershaw, 2008, p. 10). The study also argues that in some cases strenuous military operating and training conditions may accelerate the transition from HIV infection to symptomatic AIDS, with serious health consequences.

A similar set of concerns informs the United States Army’s policy on HIV (Tasker, 2008), which includes pre-recruitment testing and exclusion of those who test positive, as well as periodic mandatory in-service testing. This places HIV within policies that are framed by health care and physical performance variables: medical readiness concerns, neuropsychiatric concerns, the stress of training, the risk of exposure to other infections, the risk of infected blood exposure to other service members, the risk of tuberculosis (TB) transmission, difficulties in providing medical care in remote locations, the cost-inefficiency of investment in training, and medical liability concerns.

On the other hand, armies are accustomed to personnel losses and are generally structured with built-in redundancy. Usually, there are multiple qualified candidates for promotion to every vacant position. Also, the length of time between a soldier becoming symptomatic with AIDS and becoming unable to perform his duties may be sufficient for a replacement to be identified and trained. This means that in an army that suffers high HIV rates, any accelerated attrition due to AIDS is unlikely to be a major threat to the army’s human resources. The impact of HIV and AIDS on an army will depend on factors that include the military’s budget, educational and development levels in the country, and whether it is primarily an infantry army or a mechanized force dependent on specialists. Most developing-country armies are primarily infantry forces. While infantry with low levels of training and even non-commissioned officers can be replaced relatively easily, the specialists and high-ranking officers in a developing-country army are scarce and difficult to replace. Although few in number,

these individuals form the backbone of the force. In a developed nation, where educated personnel are readily available and health care is better, the institutional impacts of HIV and AIDS on the armed forces can be more easily managed.

An additional set of concerns among militaries, especially in poor countries, involves the financial implications of enlisting HIV-positive soldiers. The costs are measured in terms of the expenditures not just on treatment but also on specialist training that may have limited or no return. For example, many air forces have a “no-fly policy” for pilots found to be HIV-positive. The cost of training a pilot can be extremely high.

3.1.3 Military sexual trauma

An important and neglected issue in HIV military policy concerns the risks to male and female service members of sexual and gender-based violence and exploitation within the ranks, which is known as military sexual trauma (MST). MST refers to sexual harassment, assault, rape and other acts of sexual and gender-based violence experienced by service members. While both male and female service members are victims, women are disproportionately affected (United States Department of Veterans Affairs, 2009). The link to HIV risk follows directly.

The best documentation of MST has been done by the United States military. Between 71% and 90% of women who leave the United States military report having been sexually harassed, and almost one third report having been sexually assaulted or raped. Between 2002 and 2007, 59 345 male veterans and 57 637 female veterans screened positive for some sexual trauma during military service (Claiming Justice, 2009). According to a 2009 Pentagon report, reports of sexual assault among United States troops stationed in Iraq and Afghanistan rose 26% from the previous year. Overall, some 71% of victims are between 16 and 24 years old and in the lowest ranks, while 59.5% of assailants are between 20 and 34 years old and in higher ranks (Benedict, 2009).

A number of factors lead to underreporting of harassment and assault and a very low level of prosecutions, and in the rare cases in which a conviction is obtained, most punishments are mild and non-judicial — little more than a “slap on the wrist” (Benedict, 2009). A 2004 United States Department of Defense review of its sexual assault policies and programs found incomplete and poorly integrated data systems and records; significant gaps in the documentation of victim treatment and case disposition; inconsistent policies and procedures aimed at preventing sexual assault; and many barriers to reporting, including junior personnel who were not aware of reporting options and a real lack of victim privacy and confidentiality (United States Department of Defense, 2004). Victims are reluctant to come forward, fearing inaction or worse. It is extremely difficult for individuals to challenge a powerful institution to which they have sworn their loyalty and life. Accusing a colleague also betrays the most sacred tenet of the military: the team.

In the United States, with the aim of increasing the rate of investigations, prosecutions and convictions, steps have been taken to promote protection for every victim who reports by putting the burden of proof on investigators, not on the victim, and by no longer making victims face their assailants or pay for their own rape evidence kits. Although very little data is collected on military sexual trauma outside the United States, anecdotal accounts suggest the phenomenon is widespread.

3.1.4 Supporting military families

Military HIV policies should consider the needs of soldiers, their families and dependants, and other women and children with whom they may have been associated during different periods of deployment. Donohoe (2005) states, “Military families face unique stresses, including relocations, long work tours, frequent family separations, soldiers’ opportunities for developing extra-marital relationships, and dangerous assignments”. These stresses increase the risk for family violence and, therefore, HIV.

Families of HIV-positive soldiers have particular needs for HIV prevention, care and support. While some militaries shift the burden of the epidemic to families by discharging HIV-positive soldiers, others absorb these costs and provide health and social services. In Central America, military medical services are considered to be

superior to civilian ones, which are moreover beyond reach for the majority of the population (Kruijt & Balconi, 2008). Ideally, these services should include psychosocial support, biomedical prevention and treatment of opportunistic infections, clinical care for those requiring antiretrovirals, and extension services, such as home care and family support. These services should be available to military families, including widows, orphans and other dependants, not excluding children born out of wedlock and their mothers.

Military HIV policies need to embrace pension and other retirement schemes; funeral and survival benefits, including for orphaned children; and compassionate leave, disability and medical discharge benefits. The amount and structure of military salaries and allowances can also impact family relations — in the case of South Africa, payments are made to the spouse rather than to the soldier on tour. Operational practices of posting personnel far from their partners for long periods of time need to be reconsidered or ameliorated by providing additional resources for family housing, particularly outside the national capital.

The impact of combat stress on HIV risk within military families is an issue rarely considered in the context of HIV policies. Donohoe (2005) claims that “combat stress after entry into the service increases the likelihood of men abusing their spouses and may therefore increase HIV risk behaviors. In the US, veterans with combat exposure have more marital problems, as do veterans with PTSD [post-traumatic stress disorder]. In a study conducted during the first Gulf War, the probability of severe spousal aggression by US Army soldiers was significantly greater for those who were returning from deployment than among those not deployed.” An estimated one third of male veterans with PTSD engage in partner violence, contributing to a domestic violence rate that is three to five times higher among military couples than civilian ones (Lutz, 2004). Between 1997 and 2001, more than 10 000 cases of spouse abuse per year occurred in the armed forces, including 114 homicides. These numbers are likely a significant underestimate, as the military does not usually count intimate partners, such as girlfriends, as domestic abuse victims.

3.2 HIV and AIDS Policy and Planning in the Uniformed Services

Military HIV/AIDS policies vary considerably. National military policies usually draw from the country’s national HIV and AIDS policy, but military authorities are rarely explicit about how they deviate from civilian principles. Army policies address issues ranging from mandatory screening to treatment, care and support. Implementation strategies emphasize HIV awareness and education, typically through sensitization, behaviour change and training programmes. Although standard HIV prevention in the military emphasizes information and education campaigns among the lower ranks, behaviour-change communication (BCC) approaches are not universally considered effective or suitable to uniformed services (Bratt, 2002). BCC approaches often rely on participatory processes and peer communication strategies, which work only if there is buy-in from ranking officers so that the process and message are endorsed by the hierarchy. Knowledge, attitude, behaviour and practice (KABP) surveys are a common tool for designing and measuring HIV prevention efforts, despite mixed reports of efficacy. Bing et al. (2008) report an increase in HIV risk perception and condom use among Angolan military and find a significant increase in the use of condoms during vaginal sex at the three-month point following HIV prevention education. But according to another study, a survey of 3 141 Nigerian military personnel reported only a 38.6% rate of condom usage despite 95% awareness about HIV risks and 86.4% familiarity with the symptoms of sexually transmitted infections (Kershaw, 2008, p. 9). A study by the International Centre for Ethnic Studies (ICES, 2008) found that although three quarters of Sri Lankan soldiers surveyed were aware that condoms helped prevent HIV, the actual use in practice was much lower, in recent both heterosexual and homosexual contacts.

3.2.1 Command-centred approaches to HIV prevention and AIDS treatment and care

ASCI research and analysis points towards approaches to HIV and AIDS in armed forces that are designed with the functional requirements of the institutions in mind, a departure from the individual-centred approach that has long been the norm for civilian HIV and AIDS policies and programmes. This new type of response involves three key elements: a Force Capabilities Framework analysis, the adoption of a command-centred approach to HIV prevention and AIDS treatment and care, and a civil-military dialogue on testing. It consists of much more than simply involving the command or making HIV management one of the responsibilities of a senior officer.

Any military policy for HIV must be based upon a sound analysis of the needs of the army as an institution, which will depend on the state's national security requirements. Kershaw's study (2008) argues that the impact of HIV and AIDS needs to be assessed at tactical, operational and strategic levels as they all determine successful military functioning. Because most analytical and policy frameworks for HIV are derived from civilian models and developed without consideration for military priorities, their application to the situation of armies is limited. The study, therefore, suggests adopting a Force Capabilities Framework to assess the potential impact of HIV on force procurement, preparation, employment and sustainability. Each of these elements may be affected. Recruitment has to provide for a higher redundancy factor since the disease affects training effectiveness (creating a "skills plateau") and combat readiness and leads to lower overall sustainability due to high deficiency rates, especially among the higher ranks. Kershaw's study suggests that the Force Capabilities Framework assessment should then be followed up with a six-stage Military Institutional Audit to determine remedial action to mitigate the effects (Kershaw, 2008, pp. 24–34). These approaches suggested by Kershaw for the military reflect the earlier UNAIDS work on the "business response", which is useful as a practical instrument to assess institutional consequences of HIV (UNAIDS, PWBLF & GBC, 2000).

In most of the militaries for which ASCI researchers obtained evidence, HIV policies are led by a senior military medical officer and confined to medical departments. Medical officers rarely possess high rank in the military hierarchy and are unable to ensure the integration of HIV policies into the standard procedures of the army. ASCI finds that some of the most notable successes in HIV control in militaries have been achieved through approaches that put responsibility for HIV policy and practice within the army command rather than on the medical services alone (CPRD, 2008). This is consonant with experience that suggests the highest success rates for addressing most health issues in military forces have been achieved through command-centred approaches. Armies that fail to use this type of approach have lost battles and entire wars (Grau & Jorgensen, 1997).

A command-centred approach (CCA) to HIV has the following characteristics and benefits.

- Placing leadership for HIV and AIDS programmes at the highest level of command ensures that the programmes extend effectively beyond medical corps structures and reflect the priority given to HIV prevention (cf. UNAIDS, 2003).
- Interest shown by the command provides a more favourable situation for medical corps than if the medical officers are taking exclusive responsibility, giving them greater status with fellow officers and greater access to all parts of the army as an institution.
- HIV programming can be coordinated with other activities in the army, including human resource management and training.
- The integration of HIV activities into other army activities provides opportunities for synergies that bring benefits across the board in terms of health, training, civil-military relations, etc.
- A CCA enables the integration of HIV risk-reducing behaviour into clear standards of conduct, incentives, and disciplinary and enforcement procedures.
- A CCA requires regular and reliable information about the health status of soldiers, including their HIV status, for the purposes of monitoring the programme and making decisions on fitness to serve, especially on specialist missions or peacekeeping operations, notwithstanding the fact that certain elements of the programme may require confidentiality in the relationship between soldier and physician.

The efficacy of command-centred approaches has been demonstrated by military HIV programmes in the Senegalese and Ethiopian armies, among others (CPRD, 2008). In both these cases, utilizing the army's own established mechanisms for controlling the behaviour of individual soldiers has yielded greater results than individually oriented HIV prevention efforts by medical staff. There is also a trend among southern African militaries for HIV committees to be chaired by a member of the command. However, no army has yet taken the approach to its logical conclusion — systematic integration of HIV activities, standards and personnel into all aspects of the army's functioning.

The core principle of the command-centred approach — that primary responsibility for the health of military units lies with the military command, not the individual soldier or the military medical service — is compatible with either mandatory or voluntary testing for HIV. According to circumstance, the approach may require comprehensive health assessment of individuals in order to ascertain fitness to perform specific duties, which in turn may require proof of HIV-negative status. It may also require regular monitoring of HIV prevalence at unit level in order to measure the efficacy of unit commanders' HIV prevention activities.

Command-centred approaches to HIV prevention and AIDS treatment and care pose particular challenges for armies and armed groups where command, control and discipline are lacking. The formalization of these armies, including instituting systems of discipline and remuneration, is a prerequisite for effective HIV programming, quite apart from other considerations, such as respect for human rights.

3.2.2 The mandatory testing controversy

In ASCI-commissioned research, CPRD (2008) studied HIV intervention packages in the militaries of five African countries: Ethiopia, Kenya, Botswana, Zimbabwe and Zambia. It also drew upon comparative research elsewhere (cf. Lowicki-Zucca et al. 2009). The study finds variability in testing procedures across countries. Most militaries with the requisite capacity and national legal authority screen soldiers on enlistment and screen candidates for peacekeeping missions prior to deployment. The others aspire to do so. A large majority of countries reject candidates who test positive during pre-recruitment and impose restricted duties on those in service, generally prohibiting foreign deployment. Many armies argue that testing is justified by operational needs and therefore should be recognized as a policy option, if not a requirement, and consider HIV as one of many disqualifying medical conditions for military enlistment. Testing is also considered a necessity for ensuring the capacity of the military institution to provide the requisite treatment and care. Some countries that host peacekeeping missions have also indicated that they may demand pre-deployment screening of peacekeepers.

Lowicki-Zucca et al. (2009) note that of the 15 largest countries contributing troops to peacekeeping operations, 10 have mandatory HIV testing policies, of which only one (Uruguay) deploys soldiers known to be HIV-positive on peacekeeping operations. These policies contradict the human rights principles that inform the UN's approach to national HIV and AIDS policies. The workable compromise found by the UN Department of Peacekeeping Operations is to shift the focus to an overall health assessment and to national policies. The UN's HIV testing policy for uniformed peacekeepers (DPKO, 2004) is that the sole medical criterion for deployment and retention is "fitness for duty". The UN requires that individual peacekeepers undergo pre-deployment medical tests carried out by the troop-contributing country (TCC) and refers to World Health Organization clinical criteria rather than HIV serostatus as guidelines for eligibility for deployment. It does not require that individuals at any time be tested for HIV in relation to their deployment, but its criteria exclude individuals showing signs of active disease. The UN requires that all uniformed peacekeepers be offered voluntary confidential counselling and testing prior to deployment but notes that this should not be interpreted as a requirement for mandatory testing. The DPKO also recognizes that many TCCs have a mandatory HIV testing policy and do not deploy HIV-positive personnel and respects this national requirement.

The United States armed forces conduct pre-recruitment testing and exclude those found to be HIV-positive, followed by periodic mandatory in-service testing (Tasker, 2008). They defend this policy on operational, medical and cost grounds. The army squares this policy with human rights concerns by ensuring that testing is accompanied by appropriate counselling and referral to medical and psychosocial services for those who test positive.

The ethical implications of testing — voluntary or mandatory — without the corollary commitment to (or even the possibility of) the provision of appropriate treatment, care and support must also be considered. This implies a need for policies on post-deployment testing and regarding the provision of testing, treatment, care and support for military families and for women and children associated with armed forces.

There is no doubt that most military commanders prefer mandatory testing and screening and that there are sound operational and institutional reasons in support of this policy. There are, however, serious human rights considerations and related objections to mandatory testing. These arguments are based on the International Labour Organization Code of Practice for non-discrimination in employment on the basis of HIV status and include the privacy and individual rights of the soldier, the fear of stigma and discrimination, and the fact that

HIV-positive individuals can in fact be healthy and capable of fulfilling their duties (ILO, 2001). Also, many practices of mandatory testing are not accompanied by sufficient counselling or follow-up care and treatment for those who test positive.

In May 2008, the South African constitutional court resolved that mandatory testing was illegal and required the South African National Defence Force (SANDF) to cease the practice. Following on a similar precedent in Namibia, this is a significant legal challenge to military preferences for mandatory testing and raises critical questions about international policies and practices. It is important to note that the SANDF chose not to mount a legal defence of the principles of testing and conditional employment and deployment but rather to ignore the court's decision, at least for the time being. In doing so, the SANDF passed over the opportunity to develop a set of principles based on international humanitarian law that is founded upon principles of military necessity and proportionality allowing that military officers may be compelled by circumstance to undertake actions that would be considered contrary to individual rights in other civilian circumstances. Military service itself usually entails surrendering some individual rights. For example, soldiers do not have the same guarantees of confidentiality in health examinations and treatment, and they are told to expect discrimination on the basis of disabilities and health conditions, including non-infectious and less-debilitating conditions, such as flat feet, hypertension and diabetes. Human rights legislation also allows for exceptions in circumstances, such as states of emergency, involving severe threats to national security. Military commanders are puzzled why HIV should be considered a special case.

A similar challenge mounted in Namibian courts had a different resolution. After the courts found it unlawful for the Namibian Defence Force (NDF) to impose mandatory testing and discriminate against HIV-positive individuals, a compromise mechanism was found to ensure that the army's policy of deploying only HIV-negative individuals on peacekeeping missions could be sustained. This policy was drawn up after discussions with UN advisors. The exclusionary policy was adopted as part of a comprehensive process whereby the NDF provided its personnel an opportunity to attend VCT (voluntary counselling and testing) at independent centres in Namibia as an alternative to mandatory testing, whereupon, having received their HIV test results, personnel are permitted to apply for peacekeeping operations, with prior knowledge that only those with seronegative results would qualify.

The Namibian model provides an alternative that maintains the principle of voluntary testing while at the same time meeting an army's demand for HIV-negative soldiers on certain deployments, including peacekeeping. As applied, this CCA variant allows armies to provide employment to all soldiers irrespective of HIV status, but with duties selected on the basis of a comprehensive health assessment, which may include a requirement to produce an HIV-negative test result.

3.2.3 Harmonization of civilian and military policies

The previous section highlighted the need for a civilian-military dialogue on testing. There are other elements of HIV and AIDS policy and programming in the military that may also be poorly aligned with national or civilian policies. Actual or potential non-alignment can occur in a number of areas, including testing, discrimination in employment or advancement, and treatment. In some countries military HIV and AIDS policies and programmes are based on national frameworks, while in others the military establishment has developed its own policies and programmes. Often, medical facilities available to the uniformed services are better resourced and otherwise superior to those available to the general population. Nonetheless, practices of screening military recruits for HIV or discharging personnel found to be HIV-positive may simply shift the burden of care and treatment to the under-resourced civilian sector. In many countries, the army is a "total institution" that not only employs personnel but also provides housing, schooling, health care and other benefits for their families. Meeting the needs of the widows and orphans of soldiers can be an institutional and budgetary challenge.

A particular harmonization challenge is the counselling, care and treatment of those who are discharged from the army after having tested HIV-positive. A government whose armed forces practice mandatory testing and exclusion has a powerful obligation to ensure that these services are provided adequately, whether by the military or by civilian health services. In all cases, some coordination and/or harmonization of military and civilian HIV and AIDS policies is desirable. However, the specific demands made on uniformed services will require that they continue to maintain distinct policies and practices in some areas.

3.2.4 HIV/AIDS and other uniformed services

Other groups within the security sector include paramilitary organizations, irregular forces, and private military and security companies, as well as groups who are undergoing disarmament, demobilization and reintegration into civilian life (law enforcement services will be discussed later in this report). The diversity of these groups and their circumstances militates against any one-size-fits-all approach to dealing with their needs for HIV and AIDS policies and practices.

These groups pose particular challenges for HIV policy-making. Because they are often not subject to consistent command and control, command-centred approaches may be impossible to apply. They may not readily fall under a coherent institutional framework, at either the national or the international level. Remarkably strong interagency coordination at both these levels would be needed for an effective policy response. Additional research regarding the impact of HIV in these neglected groups is needed.

Militaries and other security services are the focus of reform efforts in many countries, especially those in post-conflict transitions. Security sector reform (SSR) and disarmament, demobilization and reintegration (DDR) comprise an additional focus for ASCI research. D'Awol (2008) demonstrates how the post-conflict context in south Sudan encompasses many adverse factors that contribute to risk of a generalized epidemic. Many of these are the consequence of war, prevailing sexual and gender-based violence, customs and cultural barriers, and the troublesome environment subsequent to the signing of the country's Comprehensive Peace Agreement. Whereas DDR and SSR programmes are in principle ideal entry points for addressing HIV and AIDS concerns, there are many shortcomings in terms of institutional policy, the set-up of programmes, resources, focused approaches for special-needs groups and a fully gendered approach (D'Awol, 2008).

Several pieces of research commissioned by ASCI indicate that HIV concerns are neglected in SSR and DDR more widely. These processes of reform are often formulaic and rushed, without clear objectives other than meeting somewhat arbitrary targets. Sufficient time and resources are rarely devoted to HIV education, VCT and other related activities. The consequence is that demobilized men and women are not given the basic tools for HIV prevention, much less used as peer educators or messengers for HIV and AIDS policies and programmes. Similarly, the restructuring of security services proceeds without attention to the multiple personal, institutional and social requirements for handling HIV noted in this chapter. This is an obvious missed opportunity, demanding engagement between international organizations, such as the United Nations Population Fund (UNFPA), UNAIDS, the DPKO and the United Nations Development Programme, and national DDR commissions and similar institutions.

Not only is the neglect of HIV interventions a missed opportunity, it is also symptomatic of an approach to SSR and DDR that focuses on immediate security symptoms rather than grappling with the issues of social exclusion, livelihood vulnerability and gender relations that underpin the drivers of the epidemic. If DDR processes fail to address the underlying causes of violence, and especially gender violence, DDR itself may well become a potential source of gender violence (D'Awol, 2008, p. 66). The policy response must go well beyond increasing resources and time allocated to HIV interventions. Rather, SSR and DDR programmes need greater clarity on their strategic goals, and these goals and the mechanisms used to attain them need to be designed with attention to many different aspects of HIV.

In all uniformed services the issue of HIV in all its aspects — transmission, context and interventions within the institution or vis-à-vis the outside world — is highly gendered. ASCI studies indicate a range of problematic issues in this domain before, during and after conflict. In a number of cases uniformed services had been engaged in gender-related HIV programmes; in others they were either insufficiently prepared or predisposed to act according to prevailing gender standards. The studies also point to serious flaws in intervention packages, in which gender frequently was an almost completely neglected issue. Despite all critical observations made above, the field of HIV and the security services provides a number of opportunities for policy engagement and programmatic activity. Chapter 5 discusses the policy implications and recommendations arising from ASCI research in this field.

3.3 HIV and AIDS and Peace Support Operations

Security Council Resolution 1308 of July 2000 called for international and national action to respond to two distinct concerns regarding HIV in peacekeeping environments. The first was to protect peacekeepers from HIV, and the second to prevent them from transmitting HIV. Subsequently, the role of peacekeepers in promoting HIV prevention among host communities has also been expanded. Significant attention and resources were mobilized in support of these aims within the UN system, through bilateral and military-to-military cooperation and among troop-contributing countries nationally.

Now, on the threshold of the tenth anniversary of the adoption of Resolution 1308, much has been learned about the specific threats posed by HIV to peacekeepers and peacekeeping operations. The investigation by Lowicki-Zucca, Karmin & Dehne (2009) into HIV rates among peacekeepers and their hosts, extrapolating from country-level data, finds no evidence that peacekeepers contribute to HIV epidemics in the populations that they are stationed among. Data indicate that while peacekeeping troops often come from populations with higher HIV prevalence than host societies, most TCCs exclude HIV-positive soldiers from peacekeeping deployment, and even if they were not to do so, the absolute numbers of peacekeepers living with HIV would be very small compared to the domestic infected population. However, this does not detract from individual risks, the specific dangers associated with sexual exploitation and abuse by peacekeepers, and the perception among host communities that peacekeepers might be vectors of HIV.

Previously identified risks must be reassessed in light of new evidence and new realities. The changing nature of contemporary conflicts, the maturity and varied trajectories of HIV epidemics, increased access to treatment, and changing international and regional arrangements for peace missions all present new opportunities for HIV prevention and response. ASCI research identifies five such priorities in relation to HIV and peacekeeping and peacebuilding agendas: (1) strengthen command-centred approaches to HIV; (2) strengthen regional networks and cooperation in support of HIV policy development within uniformed services; (3) align HIV and sexual violence prevention efforts; (4) expand the focus on militaries to include other uniformed services, particularly the police; and (5) ensure continuity of HIV prevention during post-conflict transitions and peacebuilding, including through DDR and SSR programmes. The fifth priority will be addressed in Chapter 4.

3.3.1 *Command-centred approaches to HIV and AIDS in peace support operations*

A command-centred approach to HIV prevention and AIDS treatment and care builds upon the observation that armies operate on the basis of command and results follow accordingly. Based on its research with national militaries, ASCI advocates a command-centred approach to HIV prevention and AIDS treatment and care. For this to be effectively implemented in a peacekeeping environment, it will be necessary to specify command responsibilities, expected results and budgetary and human resource implications across military and civilian medical services. Force commanders and other senior staff also need to be sensitized to HIV and AIDS and the range of related issues, including stigma and discrimination. Pre-deployment cooperation among troop-contributing countries will be needed. Many of these steps require only the implementation of existing recommendations by the DPKO, UNFPA and UNAIDS. Given the onerous demands on current peace-support operations, the requisite human and financial resources will need to be secured, especially for TCCs that face high-prevalence HIV epidemics at home.

A coherent approach to HIV prevention in a peace mission does not require the adoption of unified treatment regimes and policies among different national contingents, though the convergence of treatment approaches is highly desirable. At minimum, each TCC should have an HIV policy that takes into account the specific needs of the contingent that it deploys, and the mission itself should be fully informed of and able to coordinate among the policies followed by its different contingents. Mission-level HIV policies should consider the specific functional and operational requirements of the mission as a whole (e.g. human rights verification, election monitoring, peace enforcement) and of each contingent's specific contribution. They should also incorporate the UN policy of zero tolerance for sexual exploitation and abuse (SEA) in UN peacekeeping operations, which urges troop- and police-contributing countries to ensure that their personnel are trained and that disciplinary action is taken upon incidents of SEA, as outlined in the UN General Assembly Report of the Special Committee on Peacekeeping Operations and its Working Group (2007). Meanwhile, TCCs face the challenge of harmonizing their national policies and programmes with those of the missions in which their soldiers participate. The

situation is further complicated by the presence of civilian mission staff, who have different terms of service (including medical benefits) and tours of duty and who are subject to different HIV and AIDS policies and programmes.

The command-centred approach is not an alternative to behaviour-change initiatives and medically run programmes. On the contrary, it represents a strengthening of these approaches by ensuring that they are under the command of senior officers, with results reported to the command and decisions made accordingly. The CCA aims to make behavioural norms and unit-based enforcement mechanisms part of the regular military chain of command, not an optional extra. This holds for both national armies and police services (of TCCs) and peace-keeping missions.

Command-centred approaches tend to include policies of mandatory testing and the selective deployment of those who can demonstrate HIV-negative status. As mentioned, the majority of TCCs have such policies, although the quality (especially with regard to counselling) and consistency of implementation is not fully documented. More important, there is a danger that if a commander believes that his troops are all seronegative, he will downplay the importance of ongoing programmes to ensure that they stay seronegative, such as behaviour-change communication.

In a peacekeeping operation the command-centred approach requires that the leadership of each national contingent be held accountable for policy design and implementation. Prior to deployment, the necessary command structure, standards of conduct and enforcement mechanisms must be established. During deployment, the policy measures must be enforced. Preferably, all TCCs that contribute a contingent to a mission will coordinate and align their policies, providing a coherent basis upon which the mission can build its programmes and standards. Command responsibilities during deployment then include ensuring programme continuity.

3.3.2 Treatment policies among peacekeepers

The provision of treatment and other policies for serving personnel living with HIV and AIDS is another area of controversy that requires urgent attention. The UN has formally adopted universal access to HIV prevention, treatment, care and support as a goal but is not at present providing treatment to those peacekeepers actually engaged by the UN itself. To date, the UN has established nine HIV/AIDS Units and a further nine HIV Focal Points in peacekeeping operations. Their functions include providing VCT, male and female condoms, and post-exposure prophylaxis; training and maintaining peer educators; working on DDR programmes; running HIV awareness in local prisons; working with local non-governmental organizations to build national capacity; and data collection. These are onerous tasks and taking on responsibility for AIDS treatment and care would be more challenging still. Current DPKO policy is that treatment is a matter for national militaries, noting that personnel deployed on UN missions come from those national armed services and will return to them after their peacekeeping duties conclude. It would be administratively and medically impracticable to maintain different treatment regimens for a country's military personnel who had served in UN missions in parallel to their national colleagues who had not done so. But at the same time the coexistence of different treatment policies for different national contingents serving in the same UN mission can also create problems, for example, when there are different criteria used to determine whether an individual soldier or police officer is fit for duty or should be repatriated.

Given the difficulties already faced by the UN in raising sufficient troops for peacekeeping missions, the organization is understandably reluctant to impose additional barriers to TCCs pledging their personnel. The ideal global solution to this conundrum lies in adopting an international goal of standardization of treatment practices among all TCCs, in line with global commitments to universal access. However, it is more practicable to begin by specifying an international norm and then identify mission-specific policies based on the troop contributors, the nature of the local epidemic and the health infrastructure available.

International disagreement over policies for serving personnel living with HIV and AIDS has the potential to inhibit the good faith and cooperation required to ensure the smooth functioning of a peacekeeping mission. The solution to this challenge lies in the UN providing necessary technical support for TCCs to provide appropriate prevention, treatment and care, backed by donor commitments to provide the resources necessary. This is a specific field in which the goal of universal access can be made meaningful and achievable.

3.3.3 Regional cooperation in HIV/AIDS response in the context of peace support operations

The challenges of developing coherent HIV strategies across national militaries are being dealt with, in part, through the establishment of regional HIV networks of military and uniformed services. One result of this will be to reduce the variability in HIV policies among the different national contingents contributing to a peacekeeping mission. The study by CPRD (2008) highlights the challenge of standardizing policies among various contingents in African Union or UN peacekeeping missions, particularly policies on HIV and AIDS, because treatment remains the responsibility of each contributing country, while overall education and prevention are also the responsibility of the UN. Since national military policies and strategies concerning HIV are derived from national circumstances rather than international principles or the requirements of peacekeeping operations, regional cooperation is a logical step towards adopting common policies among troop contributors at a regional level.

COPRECOS LAC is the Latin American and Caribbean Committee of STI/HIV/AIDS Prevention and Control of the Armed Forces and National Police. Founded in 1995, the 22-country network carries out training, develops monitoring and evaluation plans and promotes the standardization of policies, women's leadership and pre- and post-deployment HIV programmes. COPRECOS takes a family and community approach and integrates uniformed service personnel living with HIV in developing responses. COPRECOS is supported by a number of UN organizations, including UNAIDS, UNFPA, UNDP and UNICEF (the United Nations Children's Fund). Thailand's successful AIDS military programme established a vast network of "alumni" through its regional training centre in Bangkok and is now in the process of establishing an Asian regional network. In July 2009, military forces from 20 countries in west and central Africa launched a regional HIV network to share information on responding to HIV within their ranks and communities. Their aim is to improve policy coherence, provide technical assistance, share information about models of HIV prevention and response and improve collaboration with the United Nations system. Africa's continental engagement with HIV and AIDS issues among peacekeepers predated that of the UN (CPRD, 2008), but it has since progressed more slowly. Subsequent to the transformation of the Organisation of African Unity into the African Union (AU) in 2002, the AU has set up an embryonic African Standby Force for peace-support operations and is creating a common security and defence policy, which is slated to take HIV into account as a security concern. The Southern African Development Community has been proactive in this area and is working on guidelines for harmonizing HIV, TB and malaria policies among the armed forces of the subregion. This promises to be an important step forward.

Military-to-military assistance and bilateral and multilateral cooperation provide important resources — financial and technical — for strengthening HIV prevention nationally and regionally. The United States Department of Defense HIV/AIDS Prevention Program, for example, supports activities in a total of 70 countries. Programmes are based on host nation needs and encourage comprehensive strategy development and training in prevention and care among uniformed services. UNFPA is the largest provider of reproductive health commodities (HIV test kits, post-exposure prophylaxis kits, condoms) for uniformed services programmes and supports national programmes in several countries. The UNAIDS Secretariat also contributes to the overall UN efforts in HIV responses among all cadres of uniformed services and coordinates a global Uniformed Services Task Force on HIV and AIDS, with the aim of strengthening and expanding effective and comprehensive HIV prevention and AIDS care, treatment and support for uniformed services personnel and their families and communities, in both developed and developing countries.

It is increasingly clear that the mandate and purpose of peacekeeping and peacebuilding missions may require training and operational strategies different from those taught in national military academies. The recent proliferation of peacekeeping training programmes and institutes all over the world — national, regional and international — reflects the distinct and qualitatively different demands and skills required for participation in peace missions as compared to other combat or national settings. These relate to the differences both in military culture and deployment settings and in mission objectives that often require civilian-military interactions and confidence-building measures with local communities. Command-centred approaches to HIV prevention and AIDS treatment and care should be integrated into relevant curricula and training programmes.

3.3.4 Preventing sexual violence and HIV risk in peacekeeping and peacebuilding

In Resolution 1325, the UN Security Council recognized the centrality of women and gender issues for international peace and security. Resolution 1820 (2008) recognized that sexual violence in war further exacerbates conflict and impedes the restoration of peace and security. The associated risk of HIV creates an even more devastating and potentially deadly threat, with impacts unfolding over decades, through impaired physical and psychosocial recovery, orphaned children and fractured communities. Although political will, policy commitments and rhetorical outrage have never been clearer, the realities on the ground have yet to change. Too little has been done in operational terms to better utilize peacekeepers to improve the protection of those vulnerable to sexual violence and reduce HIV risk.

Although HIV prevention has always been a first-line response for those working with survivors of sexual violence, sexual violence itself has yet to be a first-line entry point for HIV prevention. The UNAIDS decision that sexual violence is one of nine priorities for 2009–2011 signals a heartening though belated recognition of the urgent need for intensified action (UNAIDS, 2009). International efforts to stop sexual violence in war should also include increased attention to HIV. One example, UN Action (UN Action Against Sexual Violence in Conflict), is a concerted effort by the UN system to improve coordination and accountability, amplify programming and advocacy, and support national efforts to prevent sexual violence and respond effectively to the needs of survivors. To prevent wartime rape from becoming a peacetime norm, UN Action has begun to highlight the linkages between Security Council Resolutions 1820 and 1308 to address HIV and sexual violence in peace processes, ceasefire monitoring and DDR (Stop Rape Now, 2009). It has recommended training to sensitize uniformed servicemen and women on prevention of sexual violence and HIV prior to deployment on peacekeeping missions. It has also called for improved data quality on the extent, intent and impact of war-related sexual violence and the need for armed/security forces to vet for sexual violence perpetrators.

Effective coordination between military, police and other protection stakeholders is needed. UN Action and the UN Development Fund for Women together with the United Kingdom Department for International Development are developing strategies for utilizing military and civilian assets to increase women's protection from violence. They are developing guidelines on mandate interpretation to clarify responsibilities for sexual violence response and are addressing pre-deployment and mission-specific training, gender-sensitive security assessments and the deployment of more women as uniformed and civilian peacekeepers. As a matter of priority, HIV prevention and response strategies should be aligned closely with these efforts.

3.4 HIV and Law Enforcement

HIV among law enforcement services, and especially the police, remains a remarkably neglected subject, despite the numerous risk factors that are uniquely associated with this sector (ASCI, 2007). Although research suggests that the prevalence rate among police officers is higher than among the general population in some African countries (Kershaw, 2008, p. 21), this finding cannot be generalized due to a lack of reliable data. Pearce (2007) observes that many assumptions about high prevalence rates among the police were based on unproven, often alarmist, statements and incorrect stereotypes that may have added to a climate of fear and denial. And Roderick further warns against the danger of assuming homogeneity of risk and prevalence within police forces (2007). Prevalence rates among the police vary according to ethnicity, age, rank and deployment patterns. Similar to the military, impacts are felt especially in higher ranks that require specialist and longer trainings. Pearce was unable to find any specific research about HIV and women in the police forces, let alone sex-disaggregated data.

Issues concerning the police and HIV fall into two main areas. The first is how police institutions respond to HIV within their services, and the second is how policing practices influence national HIV epidemics and responses.

3.4.1 HIV within police services

Within police services, issues of testing on recruitment and in-service training, privacy, stigma and discrimination, health benefits and promotion policies, and operational exposure to HIV all arise. Though police may be

exposed to high-risk individuals or violence, especially in prisons, these physical and operational risks can be more than offset by training and precautions (Masuku, 2007). This does not, however, apply in the same degree to social risks, an area in which police officers appear to be more vulnerable.

The negative impacts of HIV and AIDS in police services include the loss of productive time, overburdening, the lowering of morale and increased costs for health care, sick leave and funerals. These internal issues are all broadly similar to the HIV-related issues in other security institutions, including the military. Masuku (2007) examined the impact of HIV on the South African Police Service, focusing on the Johannesburg area. He found that in-service deaths of police personnel (from all causes) increased by a factor of 50% between 2002/03 and 2004/05, and there was a significant increase in the number of police officials taking sick leave. The data do not indicate that policemen and women are falling sick or dying at a rate substantially greater than the general population, but they clearly imply that the police service needs to attend to the impact that the disease is having on its ranks and on its institutional effectiveness.

Evidence from several case-studies indicates that the police still trail considerably behind the military in dealing with HIV challenges, institutionally and medically. Relative shortcomings included policy, awareness and infrastructure as well as access to medical care. These could all be attributed to a relative lack of coordination, interest and institutionalization (Kruijt & Balconi, 2008, p. 32). Similarly, Pearce refers to a study by Pharoah (2005) reporting that management structures of the Malawi Police Service (MPS) continued to view HIV as either an external or an individual problem rather than an organizational one. Moreover, the government's National Strategic Framework was not tailored to the specific requirements of the MPS and showed serious flaws in dissemination and implementation.

In South Africa and Myanmar, buy-in by higher management and openness in discussing the issue remained problematic (Pearce, 2008, pp. 8, 24–25). Masuku actually found increased risk-taking behaviour among police officers who had received HIV training. These challenges partly reflect the exclusion of police within nationwide prioritization of HIV and AIDS policies. Similar shortcomings also apply to police roles in post-conflict DDR programmes. On a more positive note, Kruijt & Balconi concluded that technical assistance by organizations such as UNAIDS and UNFPA had been able to improve performance in the Central American region. Hence, their study concluded that the situation was in principle susceptible to positive policy and programmatic interventions (Kruijt & Balconi, 2008, p. 33). In general, however, there remains limited interaction between the police and the HIV policy and research communities.

3.4.2 Policing HIV

“Policing the epidemic” is an expression that refers to the way law enforcement practices shape the risk environment for HIV and, in turn, influence the trajectory of the epidemic. Civilian police forces that participate in international peacekeeping operations face the same problems and constraints as their military counterparts in such missions; indeed they may even be less prepared and more exposed to risk by virtue of their direct engagement with local populations. Law enforcement officers have direct and continuous “front-line” contact with an array of groups at special risk of HIV, including injecting drug users, users of other unlawful drugs, sex workers, street children, trafficked women, illegal migrants, survivors of sexual abuse and rape, gay men, transgendered individuals and others, such as detainees and prisoners. Where HIV and AIDS are concentrated among such groups, policing practices can play a primary role in either preventing or accelerating HIV risks. Practices relating to needle exchange can therefore also become a key driver of the epidemic as can laws on needle exchange, prostitution, homosexuality and the provision of health services to immigrants. Special attention is also warranted for populations in prisons, who are at high risk.

Public perception of the police and their relationship with communities most at risk are important in determining whether they play an exemplary role or further inflame prevailing discrimination and stigma. Protection of sex workers and the promotion of harm-reduction projects can dampen or reverse epidemic trajectories. In generalized epidemics, these groups are also important, so law enforcement practices remain a significant factor determining epidemic pattern.

The second dimension to law enforcement and HIV concerns the link between organized crime and HIV. Three examples can be provided: trafficking in women and children, the drugs trade, and the criminalization of states.

Trafficking

Reliable data on trafficking are scarce, but the scale and implications of the problem are becoming more evident. In his compelling journalistic journey through the global criminal underworld, Glenny (2008) describes the tragic story of a young woman (under the pseudonym Ludmila Balbinova) from the Republic of Moldova who travelled to Israel on the promise of a job as a waitress. It was a lure: she was trapped by a trafficking ring and forced to work as a prostitute. Although Ludmila escaped and made it back to her country, destitute and traumatized for life, she could not return home for fear of being found by her traffickers and from shame. She also tested HIV-positive.

Ludmila's story is a window on a far wider phenomenon of the international criminal underworld. Even UN peacekeepers in Bosnia and Herzegovina have been implicated (Allred, 2006). All sex workers are vulnerable to sexual violence and exploitation, but trafficked women and children are vastly more vulnerable than those who retain links with their communities or at least remain within national borders. Recent evidence from Cambodia, Indonesia and Thailand provides strong empirical support for increased HIV vulnerability among trafficked women and girls in comparison to other sex workers (UNDP, 2009).

In "regulating" sex traffic and prostitution, police and law enforcement frequently undermine or prevent drug users and sex workers from seeking HIV support. They may also create no-go areas and underground ghettos and further stigmatize the groups concerned. The policing of brothels in Thailand is said to have been associated with increased violence against sex workers, including by the police, and may also have contributed to the growth of an informal sex economy in which young, mostly indigenous girls trafficked from rural areas or across borders have even less access to services or protection. In Central America, police officers have "drawing rights" on the services of neighbourhood sex workers (Kruijt & Balconi, 2008, p. 15) and themselves commit acts of sexual and gender-based violence (Pearce 2007, p. 27).

Powerful evidence in support of the significance of policing for the trajectory of the epidemic comes from the modelling of epidemic "core groups" undertaken by Watts et al. (2009). This modelling exercise, commissioned by ASCI, questions the long-held assumption that sex workers form a "core group" of HIV transmitters — i.e. those who, when infected, are most likely to spread HIV multiple times — which then leads to infection among a wider "bridge" population of male clients who in turn pass the virus to their partners. The core group is generally the basis for targeted HIV prevention and, as such, more likely to be stigmatized.

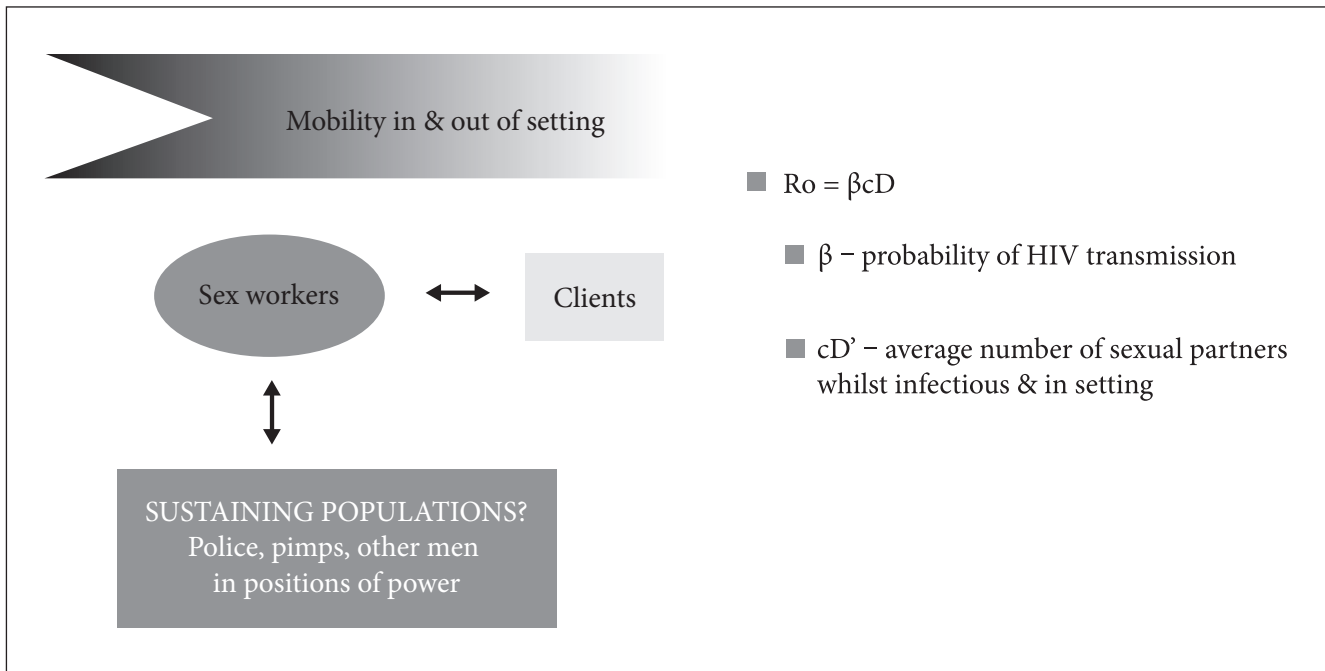
When considering priorities for HIV prevention, concepts from epidemiological theory are important in helping identify priorities for HIV response. Core group theory stands out as one such concept. However, in its simplicity, it may miss important elements. The Watts et al. model exposes three such factors. First is the assumption that sex workers are a homogeneous group with equal potential to transmit infection. Social science research points to numerous distinguishing variables, including age, stage of disease progression, access to services and protection, experiences of violence, and work environment (e.g. regulated brothels as compared to informal industries or need-based transactional and survival sex). Second, although core group theories generally account for the number of clients, they have yet to consider the men who are non-commercial users. These are often men in positions of power — be they pimps, partners, police or soldiers — whose prevalence is often unknown. Third, conventional core group theories fail to consider how the factor of mobility will influence transmission risk.

Traditional core group theory (as reflected in the standard version of the R_0 equation in Figure 3.1) estimates the total number of people that an HIV-positive person will infect in a susceptible population as determined by the rate of partner change. It does not consider how mobility between different settings, and the length of time in the different locations, can influence transmission patterns. Watts et al. introduce a new equation to reflect both the number of sexual partners and the average duration that an individual is infectious in a particular setting. This reconfiguration is especially important in commercial sex situations, which often have high levels of both sexual activity and mobility. Conflict-related sex trafficking further increases the mobility of sex workers while decreasing their time in any one setting. The vast and sophisticated network of criminal, drug and sex trafficking has made it possible to traffic women very quickly to avoid detection. Under these circumstances, they are less likely to form a stable reservoir for the virus.

Rather, the Watts et al. model points to the role of men — especially regular sex clients and men who control the sex trade, including pimps and those who provide "protection" for brothels and sex workers on the street (a

Figure 3.1

Could men who remain in the sex work setting be a neglected group helping to sustain HIV infection?



From Watts et al. (2009).

group that often includes policemen) — in transmitting the virus to newly recruited sex workers. Watts et al. identify scenarios in which this group constitutes the “maintaining population” insofar as they provide a more stable long-term reservoir for the virus than do the more transient sex workers whom they infect.

Although quantitative data are lacking on which to build verified epidemiological models that provide the appropriate roles for populations of sex workers and the men who control them, the Watts et al. model provides a powerful theoretical basis on which to revise assumptions. It demonstrates that potential contribution to sustained HIV transmission by the controlling group may be more significant than that of the sex workers. It follows that HIV control policies and programmes should count the groups that control the sex trade, including their risk-taking behaviour and their economic and coercive power over women and girls, as a priority entry point for HIV prevention.

Drug trade

Injecting drug use, illegal in most countries, is a major source of HIV transmission worldwide. It is also well established that drug use follows the drug trade, so that the opening up of new trafficking routes (in the recent past, the Caribbean, and more recently west Africa and central Asia) leads to an increase in the consumption of the trafficked drug along the new routes, displacing older favoured recreational drugs (e.g. marijuana in the Caribbean).

Beyrer et al. (2000) show how HIV transmission has followed heroin trafficking routes in South-East Asia. Using virological analysis of the different subtypes of HIV found throughout the region, they were able to identify four trafficking routes, each associated with a distinct strain of the virus. For central Asia, Ancker (2007) warns that the combination of drug trafficking and people trafficking creates the threat of an HIV epidemic largely driven by injecting drug users, rendered more likely by state incapacity alongside poverty and inequality. The trafficking and use of injecting drugs, such as heroin, are also commonly associated with increased sex work.

Non-injecting drug use, such as the trend towards synthetic recreational drugs, including crystal meth, is also associated with HIV risk. One route for this is lowered inhibition and higher risk-taking behaviour, including unprotected sex.

The third link between crime and HIV is the phenomenon of criminal syndicates who contest state authority or even take control of governments, in part or whole. Versions of narco-states have existed in the South-East Asian “golden triangle”, Afghanistan, the Andean republics and countries on the transit routes to the United States, such as Panama. This phenomenon is now spreading to west Africa, where drug money and violence have become major factors in countries such as Guinea Bissau, some of which were already “criminalized states” and vulnerable to such penetration (Bayart, Ellis & Hibou, 1999).

The rise of narco-states is becoming a major international policy concern. Drug use is likely to increase in a narco-state, with consequent HIV risks, which is a particular hazard should this occur in a country that already has hyperendemic HIV. Equally important is the risk that essential government services, including health, will be adversely affected or collapse. As shown by Strand, Kinney & Mattes (2008), state capacity and governance are the strongest indicators of a government’s likelihood to adopt best practices in HIV and AIDS policies.

3.5 Security Sector Conclusions

ASCI research and analysis underlines the need for HIV and AIDS policies in the military that are sensitive to the operational and institutional requirements of the armed forces, which in turn depend on an individual state’s security needs. ASCI recommends first a command-centred approach to HIV prevention and AIDS treatment in the military. This approach puts the responsibility of HIV policies and practices on the command structure within the military rather than on the medical services. Placing the leadership of HIV programmes with the highest level of command is likely to increase the priority of integrating HIV and AIDS policies into standard procedures of the army.

Second, there is a need to reframe the debate on testing for HIV within the military. Mandatory testing is common in militaries and justified on grounds of operational requirements. However, it is often seen as opposed to human rights concerns about confidentiality and individual rights. Both militaries and human rights advocates tend to have inflexible positions on testing and fail to understand the other’s position or see the possibilities for alternative approaches. ASCI’s findings indicate the need for a new debate that straddles military deployment requirements with wider concerns for individual rights. While the operational demands for testing within the military should be kept in mind, they should be accompanied by considerations for adequate counselling and follow-up care and treatment for those who test positive.

ASCI findings point to new priorities and challenges regarding HIV in peacekeeping missions. They reveal the need for command-centred HIV management strategies that align HIV and sexual violence prevention approaches. The UN should ideally move towards the goal of providing technical guidance to troop-contributing countries for HIV prevention, treatment and care for all troops who may be deployed as UN peacekeepers.

A final issue concerns the much neglected subject of HIV-related policy within the police and other law enforcement services. Evidence from several countries indicates that the police significantly trail the military in dealing with challenges related to HIV. Their infrastructure, training, policies and awareness programmes are relatively inadequate in dealing with HIV risks to their forces, which in turn calls for greater interaction between the police and HIV policy communities to increase positive programmatic interventions. Moreover, there needs to be a greater awareness of how police and law enforcement services shape the trajectory of the epidemic through their interactions with high-risk groups, such as sex workers, gay men, drug users and illegal migrant labourers. The role of law enforcement in the context of drug and sex trafficking as well as criminal syndicates creates further risks. ASCI calls for the establishment of a global programme of collaborative learning on effective HIV and AIDS policies in law enforcement services.

4. HIV/AIDS IN CONFLICT, CRISIS AND POST-CONFLICT TRANSITION

ASCI's approach to HIV and emergencies is framed by the analytical starting point that armed conflict should be seen not as a category of environment but as a broader context that is unpredictable and fluid and in which varied micro-environments exist — providing stability and stasis, insecurity and volatility. ASCI's principal finding on the nexus linking HIV, emergencies and transitions is that HIV risks are more likely associated with post-conflict transitions than with armed conflict itself. This does not mean that all post-conflict transitions are moments of increased risk, but rather that, in some cases, this may be so. Indeed, conflict may in some instances be a protective factor against HIV when low prevalence populations are less mobile and have increased access to humanitarian support and HIV prevention, care and treatment. Factors contributing to increased risks include population mixing between high and low prevalence populations during migration, return and reintegration processes; more limited access to health services and gaps in provisioning; and increased sexual violence and exploitation. ASCI research presents new evidence on the association of sexual violence — particularly in conflict situations — with heightened HIV risk. ASCI findings highlight processes of disarmament, demobilization and reintegration as highly under-utilized for HIV prevention as well as the need for attention to links between HIV and intensified psychosocial challenges facing soldiers, their families and survivors of violence. ASCI's central conclusion is that snapshot indicators — whether measurements of conflict "severity" or HIV prevalence — fail to capture the dynamic and complex nature of the social and epidemiological changes taking place and evolving over time.

4.1 Recontextualizing HIV Risk

Conflict can affect the epidemiology of HIV/AIDS. Conflict is generally understood to accelerate HIV transmission, but this view is simplistic and disregards complex interrelations between factors that can inhibit and accelerate the spread of HIV in conflict and postconflict settings, respectively.

Mock et al. (2004)

At the end of the 1990s, a part of the general alarm about the implications of the HIV and AIDS pandemic for security and governance included concern about the mutually reinforcing interlinkages between HIV and humanitarian crises. These concerns were further compounded by the apparent "vicious interaction" between HIV and food insecurity in southern Africa in 2002–2003 (Nelson, 2003; CHGA, 2008). Over the last few years, better data and new research have revealed a more complex and multidimensional map of interactions and exposed the stark limitations and limited explanatory power of standard categories of "risk groups" and "risk behaviours".

A report by the Overseas Development Institute assesses HIV risks across three types of crises: emergencies, rapid-onset natural disasters and slow-onset natural disasters (Samuels, Harvey & Bergmann, 2008). The authors call attention to increased risks of sexual violence and transactional sex during *all* kinds of emergencies and show that access to HIV prevention, treatment and care is extremely limited in conflict and post-conflict settings. Different kinds of emergencies possess different dynamics and patterns of vulnerabilities and coping mechanisms, pointing to the need for a contextual analysis of HIV risk and responses rather than the application of a standard set of interventions.

ASCI reached similar conclusions in its assessment of HIV risk over a different continuum, namely, during and after conflict. When conflicts are declared "over", it is rare for anything resembling the pre-emergency norm to be reconstituted. Almost invariably, the affected population becomes much more urbanized and stratified, with new power relations and authority structures, an extension of market relations and a decline in customary forms of social exchange. HIV risk will vary accordingly, while access to services in camp settings during conflict may be greater than during a resettlement or return phase. ASCI research reveals increased risk during the stage of post-conflict "peacebuilding" and calls attention to the importance of continuity of services between situations and phases.

ASCI points to five key factors that impact HIV prevalence during conflict and its aftermath (see also Mock et al., 2004). One pertains to the individual characteristics of each HIV epidemic, including HIV prevalence prior to the conflict. The second concerns population movements and disassortative mixing. Conflict can be protective against HIV when it isolates risk groups. But risk can also increase as a result of the mixing of high and low prevalence populations, either through displacement — voluntary or forced — or through the movements of military and peacekeeping forces (cf. Elbe, 2002). The third factor is health infrastructure, including access to HIV prevention, care and treatment. HIV risk increases when services are disrupted or inaccessible, particularly the provision of safe blood, sexually transmitted infection (STI) treatment and prevention, male and female condoms, post-exposure prophylaxis (PEP) and emergency reproductive health care. Gaps in provisioning antiretrovirals through cold-chain systems are a particular concern and may result in drug resistance. On the other hand, certain groups, such as refugees, may find themselves in special circumstances in which they enjoy increased access to basic services. The fourth factor relates to the cumulative and overlapping impacts of other stresses, including natural disasters and famine. The final factor is the nature of the armed conflict itself, noting that conflicts vary in intensity and in the conduct of the combatants. In particular the incidence and nature of sexual violence and exploitation associated with the conflict, perpetrated by combatants and others, will be important.

4.1.1 HIV and emergencies: The macro- and micro-environments

The ASCI approach to HIV and emergencies is framed by the analytical starting point that armed conflict should be seen as a context that is unpredictable and prone to change in ways beyond the control of civilians. Within this fluid environment, there may be micro-environments, such as a refugee camp, that may sometimes provide stability. The diverse nature of conflicts and of the conflict experiences of individuals and groups, even within a single conflict, demands analysis that focuses on contextual factors. Moreover, a single “risk group” can have changing and differing risk profiles as the environment evolves during conflict and its aftermath.

Most important, analysis must move beyond the aggregate population level. For much of the last decade, the debate on HIV and conflict became stuck on the single question of whether armed conflict caused an increase in HIV rates. Intuitively there were many reasons to suppose that it should. However, data demonstrate that the reality is more complex. In 2004, Paul Spiegel challenged the mainstream view that conflict-affected refugees and internally displaced persons possessed higher prevalence of HIV than settled populations (Spiegel, 2004). His review of epidemiological data indicated that HIV prevalence in conflict situations was not uniformly high and was determined by many factors, in particular the HIV prevalence among the populations from which refugees came in comparison to their hosts, the degree of interaction between the two, and the level of services provided to the refugee population. This analysis helped lay to rest the fear that refugees could be described as vectors of HIV and stigmatized accordingly. Later, Spiegel and his colleagues took the case beyond refugee populations and argued that armed conflict in general had no epidemiologically measurable impact on the course of the epidemic at a population level (Spiegel et al., 2007). Spiegel et al. also drew the conclusion that there are no data to show that wide-scale rape raised the overall prevalence of infection in the populations of seven countries reviewed. Their research raised considerable debate about the limitations of existing data and methods to associate widely accepted HIV risk factors with actual impacts (El-Bushra, 2008; Jewkes, 2007). Key issues of contention included the absence of baseline data and data among populations at greatest risk (i.e. highly mobile groups), the time frame and aggregation of findings, and the role of intervening variables, such as HIV programmes and higher mortality rates of rape victims before the surveys were conducted (Jewkes, 2007).

Other research confirms these population-level conclusions. A study commissioned by aids2031 into HIV and rapid political and economic transitions (Paxton, 2009) included a statistical analysis of the impact of armed conflict on HIV over the period 1990–2006. Paxton found that rapid economic growth had no significant impact on HIV prevalence and that major political transitions from authoritarianism to democracy were associated with an increase in HIV prevalence of about 0.9%. He determined that interstate war had no statistically significant effect on HIV prevalence but that internal war was associated with a suppression of HIV prevalence by about 1.7%. Paxton interpreted this not to mean that war pushes HIV prevalence down but rather that rates would have been higher were the country not at war. A later study by Zorn & Iqbal (forthcoming) suggests that internal conflict has little or no impact on HIV prevalence and that the AIDS-conflict nexus is changing and may in fact be breaking down over the years. Given the bluntness associated with using large datasets with simple indicators, drawing causal inferences is difficult, but one possible explanation would be that stepped-up international HIV efforts have dampened impacts (cf. McInnes, 2009).

This last point is particularly important because it would be both easy and erroneous to conclude that the lack of association between conflict and population level HIV means that no problem exists and therefore that policy-makers can safely neglect the challenges of HIV among conflict-affected populations. One of the reasons for the negative finding may be precisely because the relationship has changed over time and that this is due to successful HIV and AIDS policies and programmes by, among others, the UN High Commissioner for Refugees and the UN Population Fund (UNFPA).

The central point is that snapshot indicators — whether they are measurements of the “severity” of conflict or of HIV prevalence — fail to capture the dynamic and complex nature of the social and epidemiological changes taking place and evolving over time. In their ASCI-commissioned research, Seckinelgin, Bigirumwami & Morris (2008) make a point, both methodological and analytical, that is worth quoting. Following on a rich description of how the protracted conflict has entailed far-reaching social and economic changes, even during periods in which levels of violence have been relatively low, the authors indicate the importance attached to the categorization of a conflict and the perils of a simplified labelling of a conflict, such as in Burundi. They contest the standard label of “low intensity conflict”, which they say is “misleading” and “does not reflect the experiences of people who have lived through the [conflict] period”:

The focus on the episodic intensity of fighting as a relevant reference point for HIV/AIDS assessment seems to be simplistic. It seems that the relationship between conflict and HIV/AIDS in Burundi is more about: a) the way armed groups mobilized, in particular, as rebel groups that were dispersed across the country; b) displacement experienced by the population; and c) the duration of the displacement and the long-term mobilization of military and rebel groups in the country. We argue that these processes allowed gender disparities ... to be exacerbated. (p. 38)

In summary, analysis and policy response need to be both fine-tuned and holistic. ASCI therefore focused on analyses at both the population and much more local levels.

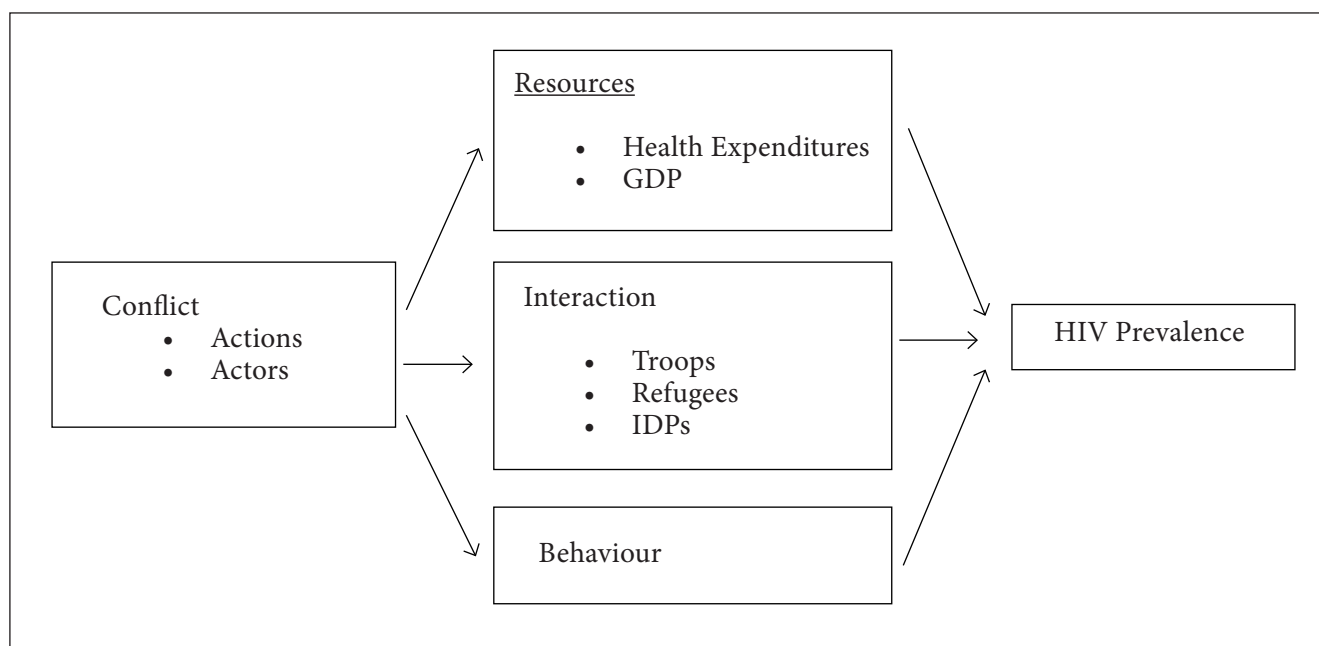
4.1.2 The conflict-HIV nexus

ASCI commissioned Davenport & Loyle (2009) to investigate, empirically and quantitatively, the conflict-HIV nexus to ascertain empirical associations between conflict and prevalence of HIV. The researchers utilized and expanded a model developed by Zorn & Iqbal (forthcoming).

The Davenport & Loyle study had two components: a quantitative analysis across all countries for which data are available ($n = 197$) to assess the relationships (if any) between conflict at a national level and national HIV prevalence, and a subnational analysis of HIV prevalence and conflict in Rwanda, using data for genocidal killings and conflict duration in 1994. The model includes behaviour, resources and interaction (Figure 4.1). The behaviour factor is intended to capture the extent to which conflict changes the individual's personal security and risk calculations. The indicators used — conflict duration, magnitude and geographic scope — serve as proxies for the direct effects of conflict on HIV. Resources include a range of economic factors, including the health expenditure of the country, international trade and gross domestic product. Interaction includes not only refugee movements but also other interactions between populations (with different HIV prevalence), including armies and peacekeepers. Noting that conflicts can involve greater or lesser numbers of soldiers (originating from populations with varying HIV prevalence and playing different roles as combatants, peacekeepers, etc.), the study seeks to capture these factors as well. Davenport & Loyle also examine the prevalence of HIV among populations generating refugees and host populations, hypothesizing that a refugee population travels with its HIV prevalence (but not with its medication, security or shelter).

The study found that the direct effects of conflict, measured in magnitude, duration and geographical scope, had no correlation with national HIV prevalence. This finding was consistent for the global dataset and for sub-Saharan Africa. Davenport & Loyle found an association between overall national resource availability and HIV, indicating that increased resources implied lower HIV and vice versa, along with a positive correlation between armed conflict and the reduction of resources. Refugees from high-prevalence countries tended to increase the prevalence among their hosts, while those from medium- and low-prevalence countries did not have the same effect.

Figure 4.1
Davenport & Loyle HIV and conflict model



Davenport & Loyle (2009, p.14).

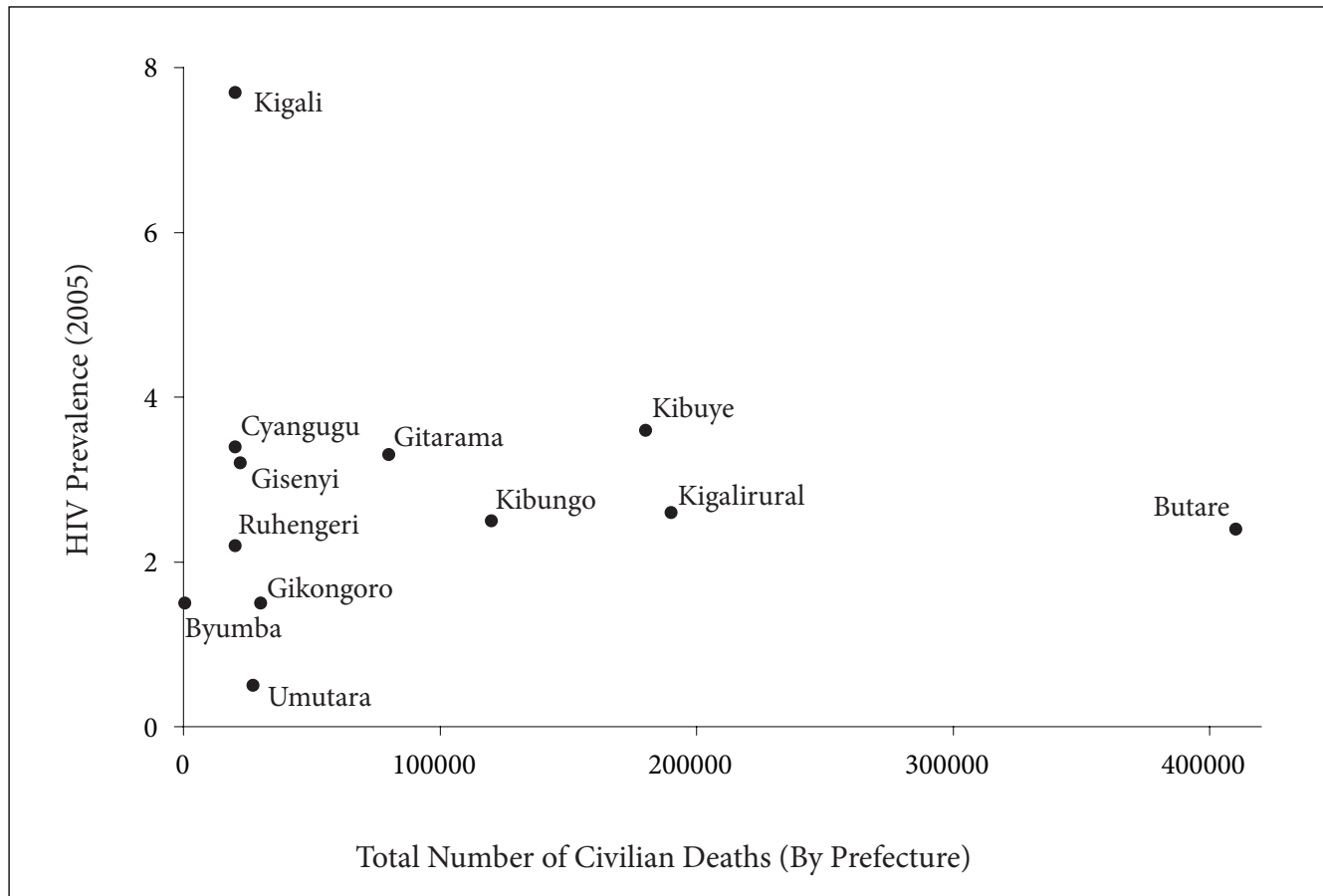
Davenport & Loyle also found that the presence of international peacekeeping troops had a significant negative correlation with HIV prevalence in the country of deployment and speculated that this might be due to the development and humanitarian resources that become available to a country that is hosting a peacekeeping mission. This is consistent with Lowicki-Zucca, Karmin & Dehne (2009), who determined that peacekeepers do not introduce HIV epidemics into host populations with previously low HIV rates.

The Rwanda case-study explored the links between HIV and conflict at a subnational level, thereby allowing greater attention to the specific vectors by which the infection is spread. Rwanda data allowed the different components of the framework to be tested at a more local level. Davenport & Loyle used data for violence perpetrated during the 1994 genocide and civil war (magnitude and duration, both of which varied significantly among prefectures) and data for HIV prevalence in 2005. Large numbers of Rwandans were displaced or became refugees during and after the genocide, and in addition to the belligerent armed forces inside the country, there were peacekeeping missions present. While reliable data for sexual violence during the genocide are not available, investigations indicate an exceptionally high number of rape survivors among the genocide survivors and very high levels of HIV among those rape survivors. Subsequently, HIV prevalence data indicate a decline in both urban and rural infection levels. Meanwhile, post-genocide Rwanda has established a highly regarded health system, including an HIV and AIDS programme. However, the resource factor was not included in the study because it was not possible to disaggregate it by prefecture.

Davenport & Loyle determined that the duration of the genocide and civil war in 1994 was a significant predictor of HIV prevalence 11 years later, but there was no effect of the magnitude of the violence (numbers killed) on HIV prevalence (Figure 4.2). They found (contrary to their wider conclusion on this issue and illustrating the importance of taking local contexts into account) a positive relationship between the presence of UN peacekeeping troops and HIV prevalence, but this might have been skewed by the urban bias of the peacekeeping presence. There was no impact on HIV of the French Operation Turquoise. The location and movement of refugees was associated with higher HIV prevalence.

Taken together, the two components of the Davenport & Loyle study confirm that the important effects of conflict on HIV are indirect and variable. The particular associations of concern are the impacts of political violence on resource availability within the country and on the increased interaction between high prevalence and high-risk (but lower prevalence) populations. The study therefore pointed towards the need for greater focus on specific populations and specific circumstances.

Figure 4.2
HIV and conflict magnitude: Testing the conflict hypothesis in Rwanda



Davenport & Loyle (2009, p. 38).

4.1.3 HIV and food emergencies

Another controversy has been related to food insecurity and the question of whether HIV contributes to the risk of “new variant famine” (NVF). First published by de Waal & Whiteside (2003), the NVF hypothesis argues that HIV undermines the resilience of individuals and households under stress, creating new patterns of hunger and food insecurity. The relevance of this hypothesis to ASCI is that such crises may (a) affect state or community viability over the long term, thereby contributing to security crises; (b) overlap with or intersect with conflict or insecurity; and/or (c) impact individual or household survival strategies, contributing to higher risks of HIV transmission as affected individuals, particularly girls and women, follow strategies that increase their vulnerability.

The NVF hypothesis has been investigated in various forms by research programmes into the impacts of HIV on agrarian livelihoods, food security and nutrition. The consensus view, backed by data, is that the effects of HIV are real but relatively small in comparison to the impacts of climatic fluctuations and economic factors (de Waal, 2006b; Gillespie & Kadiyala, 2005). There is evidence for a vicious interaction between HIV and extreme food insecurity as extremely poor and vulnerable individuals resort to activities that expose them to elevated risks of HIV (Weiser et al., 2007; Vogel, 2007; Gillespie, 2008). Prominent among this evidence are accounts of young women turning to sex work, transactional sex and “survival sex” out of extreme economic hardship. It was in the wake of the 2002–2003 emergency in southern Africa that the then-UN Secretary-General announced an initiative into what he termed the “triple threat” of HIV, food insecurity and lack of state capacity (Annan, 2003). This initiative remains relevant.

4.2 Sexual Violence and HIV Transmission Risk

Although many scholars, practitioners and policy-makers have long assumed or argued that sexual violence — particularly in conflict situations — is associated with heightened HIV risk, it has yet to be identified as a specific factor in either epidemiological models of risk transmission or as an entry point for HIV prevention and response. The dissonance between widely accepted “grey literature” documenting these links and the biomedical and epidemiological “science” of HIV measurement is fuelling a growing debate within humanitarian, security and public health arenas. The course of this debate, and its conclusions, will have significant implications for the global HIV response, security sector reforms and humanitarian action.

Numerous reviews of the literature associating sexual and gender-based violence with HIV risk have been carried out (Andersson, Cockcroft & Shea, 2008; Barahona-Strittmatter & Luciano, 2008; Dunkle et al., 2006; Silverman et al., 2008). Andersson, Cockcroft & Shea summarize the types of evidence used to establish the link between sexual and gender-based violence and HIV infection: (1) follow-up studies showing increased risk of HIV among previously HIV-negative rape survivors; (2) cohort studies in Africa of HIV-discordant partners showing an increased risk of infection among partners who report violence; (3) studies associating childhood sexual abuse with HIV risk later in life; (4) studies of the indirect consequences for HIV risk of coerced first intercourse at any age; and (5) increased HIV risk associated with intimate partner violence. A sixth form of evidence is surveys documenting the practice of “transactional sex” as the mechanism placing women at increased risk (Poulin, 2007).

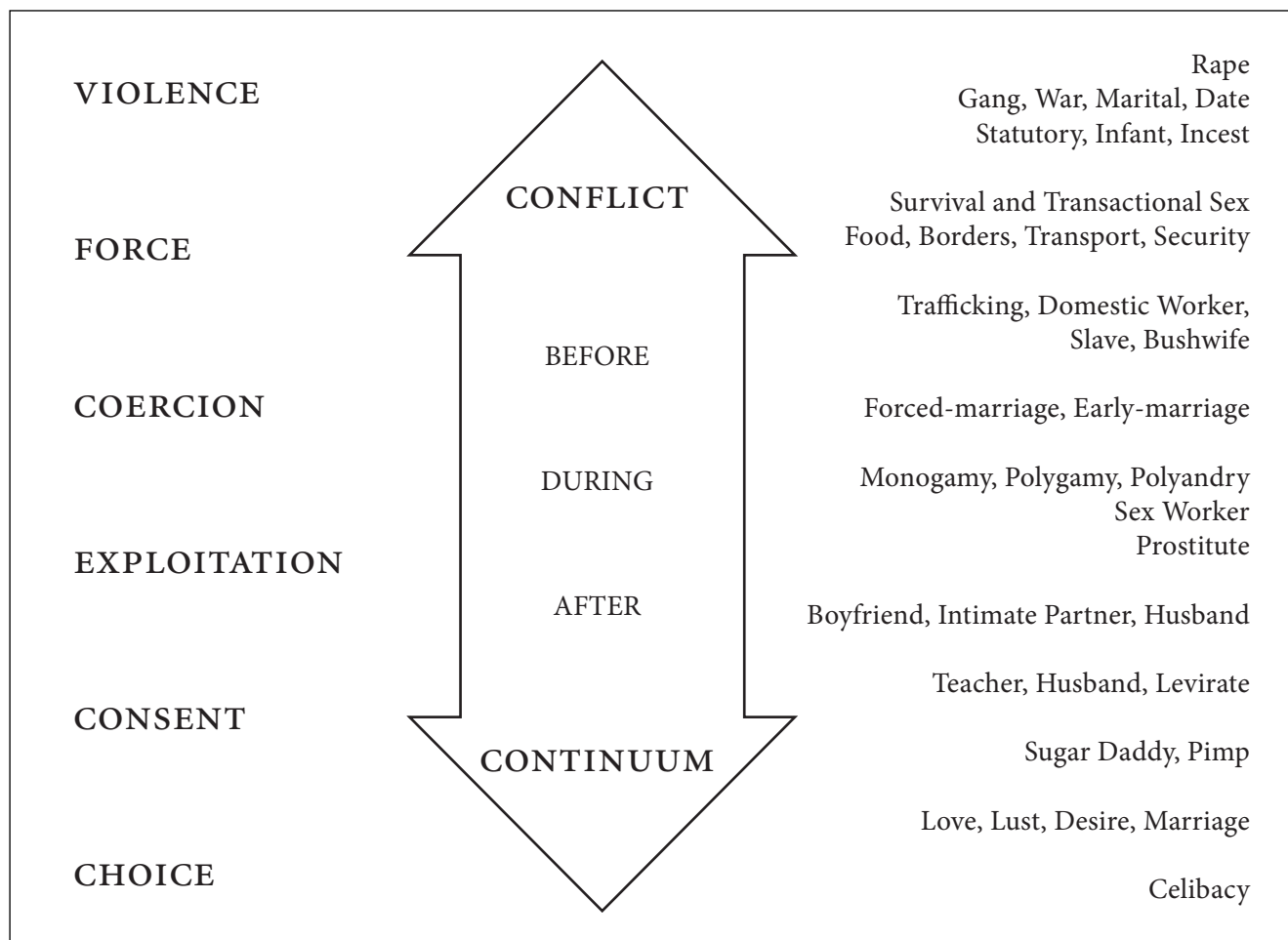
While many of these studies come from Africa, only some address situations of conflict. As indicated by Seckinelgin, Bigirumwami & Morris (2008), the gendered impacts of conflict are particularly difficult to capture in general population data. Data limitations have been well established, both with regard to HIV prevalence before, during and after conflicts take place and for nationally representative data regarding sexual violence within and outside the family. Even the physiology of sexual violence has yet to be considered within biomedical assessments of HIV transmission risk. Gaps are even more pervasive on the incidence of infant rape and other forms of incest and sexual violence committed against men and boys. These challenges are compounded by the absence of an agreed-upon definition of sexual and gender-based violence across the public health, humanitarian and human rights communities and the frequent coexistence of different forms of violence and exploitation. Underreporting of sexual violence and the challenge of identifying levels of coercion and force within sexual interactions (and indicators for measuring them) render analyses of association much more complex. In conflict settings, these factors are crucially important to follow over the medium and longer term (Figure 4.3). This will be the only way of understanding the complex and cumulative impacts of physical, sexual and emotional violence that create environments of vulnerability to HIV.

Given these challenges, it is not surprising that Spiegel and colleagues argue that “there are no data to show that wide-scale rape raised the overall prevalence of infection” (Spiegel et al., 2007, p. 2193) or that widespread rape only raises the overall level of HIV prevalence in a country by 0.023% (Anema et al., 2008). There are many reasons why increased levels of HIV transmission associated with the act of rape or the subsequent increased vulnerabilities of the rape survivor may not be reflected in either population-level statistics or the available datasets. Some of these factors are mentioned by Spiegel et al. and Anema et al. Others are not.

For example, in the case of Rwanda, HIV rates as high as 70% were reported among rape survivors after the genocide (Mujawayo & Blewitt, 1999; Elbe, 2002). Many of these survivors also suffered serious injuries, illnesses and psychological trauma. But it was not until 10 years later that special efforts were made to provide antiretroviral treatment (ART) to these women (African Rights, 2004). A very high mortality rate among rape survivors living with HIV and AIDS is a logical inference from these facts. Also, given that the female survivors were almost all widows and remained single, they had very low fertility levels and would not have been picked up by surveillance based in antenatal clinics. Genocide and rape survivors were a very small percentage of the overall population, comprising an almost insignificant proportion of those included in a population-based seroprevalence survey in 1997 (National AIDS Control Programme, 1998). By the time a demographic and health survey of the general population was undertaken in 2005, the numbers of rape and genocide survivors were further depleted by mortality and would have made a still-smaller impact on HIV patterns in the general Rwandan population.

Another contributory explanation for Anema et al.’s finding might be that it overlooks the significance of rape and sexual exploitation in HIV transmission in non-conflict societies. It is a commonplace that sexual crime is

Figure 4.3
Sexual violence conflict continuum



Source: J. Klot

hugely underreported. It is possible that levels of peacetime sexual and gender-based violence in countries like Rwanda were so high that wartime made little difference to the overall prevalence of the crime, but just changed its pattern.

The perils of arriving at over-hasty conclusions from general population data are well illustrated by these studies and call for much greater nuance and better tools with which to understand the dynamics of sexual consent and violence in situations of conflict and displacement. ASCI research points to three central explanations for the dissonance of findings about the reciprocal links between sexual violence and HIV: (1) the underestimation of physiological susceptibility and social risk factors in epidemiological and behavioural models of transmission risk; (2) the absence of reliable baseline and comparative data for both HIV and sexual violence incidence and prevalence before, during and after conflicts take place; and (3) the lack of agreement on definitions of sexual violence as measurement indicators. The following pages assess the physiological and social factors linking sexual violence with HIV transmission risk and present new arguments establishing causation.

4.2.1 The physiology of sexual violence

Despite the emphasis in HIV and AIDS research on biomedical and social factors associated with transmission risk, existing epidemiological models of risk have yet to reflect the physiology of sexual violence as a risk factor. Biological transference of the virus is rendered more likely when sex is accompanied by violence, and sexual relations characterized by violence are statistically more likely to lead to infection (WHO & Global Coalition

on Women and AIDS, 2004; SVRI, 2007). In non-conflict settings, sexually transmitted infections are among the most common medical problems following sexual assault (Adlington & Burnett, 2004). Factors that may increase HIV transmission during forced sex include the higher likelihood of genital injury and trauma and the higher prevalence of HIV and STIs observed among perpetrators. Genital injury influences the risk of HIV acquisition by disrupting the multilayered stratified epithelium that lines a woman's reproductive tract and acts as a natural barrier to infection. Protective vaginal secretions that are normally present in uncoerced sex are absent in cases of rape (Adlington & Burnett, 2004). There is also evidence that children and older women are more susceptible to genital injury following rape due to size and mucosal characteristics that are specific to the less-developed reproductive tracts in younger girls and women and the more fragile reproductive tract lining in older women (Sommers et al., 2006; WHO & Global Coalition on Women and AIDS, 2004). Age-discrepant relationships and the inability of women to negotiate condom use (or obtain condoms) also contribute to the significant HIV disparities between men and women (Gregson et al., 2002).

The literature also distinguishes between assaults with single and multiple sites of trauma. Studies in trauma centres have recorded the proportion of women suffering genital injuries as ranging from 36% to 53%. This is partly why risks are likely to increase if there are multiple perpetrators. Assaulted women sustain tears that breach the skin/mucus membrane and cause genital bleeding, potentially facilitating the entry of the HIV virus. Women who are raped are more likely than consenting women to suffer from multiple-site trauma. UNFPA has reported that thousands of women in the eastern Democratic Republic of the Congo presented themselves for treatment of traumatic fistula caused by systematic, violent gang rape that took place over five years of war. So many cases have been reported that the destruction of the vagina is now considered a war injury and is recorded by doctors as a crime of combat (Reproductive Health Matters, 2004). However, despite this evidence of increased injury, there are no estimates of how this may affect the "per-sex-act" probability of HIV transmission. Heightened risk may also be associated with the likelihood of anal penetration, which has a higher risk of transmission than vaginal penetration and a decreased probability of condom use.

A number of sources also suggest that purposeful HIV infection was used as a weapon of war during the genocide in Rwanda and its aftermath (Mills & Nachega, 2006; Donovan, 2002; Cohen, d'Adesky & Anastos, 2005; African Rights, 2004). Donovan reports eyewitness accounts of marauders who carried the virus describing their intentions to rape and infect women as an ultimate punishment that would guarantee long suffering and tormented deaths. According to Mills & Nachega, in 2006, the transitional government of the Democratic Republic of the Congo made submissions to the African Commission on Human and Peoples' Rights alleging the purposeful transmission of STIs, including HIV, through rape. They claimed that as many as 2 000 HIV-infected foreign soldiers from Rwanda and Uganda committed sexual violence to propagate HIV in the eastern provinces. The responding states did not refute the allegations, and the Commission ruled that they had violated the first Protocol Additional to the Geneva Conventions of 1949 as well as the African Charter on Human and Peoples' Rights and called for reparations (Mills & Nachega, 2006). Though the foreign ministries of Uganda and Rwanda have denied these allegations, they have not addressed the Commission's findings directly.

4.2.2 The social science of sexual violence

There is a growing body of public health and social science research in non-conflict settings that identifies various social factors as determinants of HIV risk in the context of sexual relationships or transactions. Watts et al. (2009) summarize this literature: In South Africa, women with violent partners are more than 50% more likely to be HIV infected than other women. In Tanzania, the odds of reporting violence are 10 times higher for young, HIV-positive women compared to young, HIV-negative women. Among married women with violent partners in Goa, India, the risk of STIs is three times higher than among married women without violent partners. And in Rakai, Uganda, girls who report forced or coerced sex have higher risk of HIV infection. In these cases, it is plausible that the increased risk of HIV transmission is not only attributable to the use of force but also to the likelihood that men who are violent may also have multiple sexual partners, for an increased risk of STIs and HIV. Westerhaus et al. (2007) relate HIV risk to physical and structural violence in northern Uganda, including political repression, economic inequalities and gender-based discrimination.

Sexual violence and coercion are used in conflict and post-conflict situations for a wide range of reasons — as a deliberate strategy of war, to degrade communities or to extort, punish or torture. El-Bushra (2008) urges attention to the many dimensions of "sexual violence" and their associated risks in conflict situations. "We cannot,"

she writes, “assume one-off, opportunistic rape to be the only, or even the main, variety of sexual violence in the contexts under discussion. Indeed, sexual violence in war contexts often takes the form of violently enforced long-term sexual relationships, which may range from the “sexual slavery” into which abducted girls may be taken as “wives”, to strategic and deliberate attempts at the destruction of the person by multiple attackers over periods of weeks or months” (p. 2). It can also be short term with frequent partner change, increasing STI and HIV transmission risk.

An additional dimension to this, discussed in Elbe (2002), is the threat or fear of acquiring HIV during a rape, which means that many women have to worry whether they have acquired HIV as a result of rape or, if they became pregnant as a result of rape, whether their unborn child will be HIV-positive. So there is also an important psychological dimension that is independent of the fact of whether transmission did actually occur. If women do not have access to testing, they cannot rule out the possibility that they might have been infected.

During conflict and upheaval, the protective social factors relating to mores around premarital sex are often eroded. In situations of desperation, the use of sex as a survival strategy — by women and girls (and to a lesser extent, men and boys) — finds expression in various forms of violence and coercion in the context of schools, crossing borders and early marriage. A social gender assessment in Uganda camp settings found that women in households with insufficient resources to feed, clothe and shelter the family may engage in transactional sex with men, including members of the host community, better-off refugees or internally displaced persons (IDPs), or soldiers, traders or camp workers, who can provide them with food or money or meet their other basic needs. Many women in IDP and refugee situations resort to commercial sex or bartering sex. Asylum-seeking women are often required to perform sexual favours for host farmers in return for work and food and may take semi-permanent partners in the host community who will provide them with food.

A WHO study in eastern and central Sudan (WHO & Global Coalition on Women and AIDS, 2004) stated that 27% of single mothers had become sex workers to earn a living. Women had to engage in survival sex or trade sexual favours in exchange for basic necessities. Low levels of education and awareness also increased their HIV vulnerability, while denial and stigma were widespread, including the conviction that HIV does not exist and is a foreign invention.

Hankins et al. (2002) claim that because of the potential for income and the associated protection, what soldiers call “rest and recreation” (R&R) areas appear near military bases. Due to boredom or frustration, soldiers frequent these R&R areas, where widespread prostitution occurs, creating groups that are at high risk of acquiring HIV.

In El Salvador, the increase in HIV infections among soldiers was attributed to high levels of sexual risk behaviour associated with a 12-year civil war and numerous sex work centres surrounding military posts (Wollants et al., 1995; quoted in Hankins et al., 2002). In Uganda, the early geographical patterns of HIV were correlated closely with ethnic patterns of recruitment into Uganda’s National Liberation Army after the overthrow of Idi Amin in 1979 (Smallman-Raynor & Cliff, 1991; quoted in Hankins et al., 2002). Widespread prostitution and sexual exploitation, including concubinage, near military bases and R&R areas in surrounding countries is also likely (Hankins et al., 2002, p. 2246).

In conflict-affected communities in northern Uganda, sex work is mostly practiced by unmarried, widowed or separated women in the camps and in the host community who have few other opportunities to earn money to meet their basic needs. Fees charged range from U Sh 200 to U Sh 2 000 (US\$ 0.12 to US\$ 1.20). It is further reported by some men in the host communities that, due to their personal financial circumstances, refugee sex workers are “cheaper” compared to Ugandan female sex workers (World Bank, 2005, p. 87). In the refugee camps, some women reported that incest was on the increase. Drunken male relatives were said to be the main perpetrators. Most respondents blamed the increase in incest and defilement on the demise of the traditional culture of the predominant Acholi ethnic group in the camps and the absence of strong cultural institutions. Wife-beating was also reported by camp leaders and married women to be on the increase. This was partly attributed to the psychological tensions that most people were under in the camps, often associated with alcohol consumption (World Bank, 2005, p. 114).

In the same World Bank study, researchers in the Democratic Republic of the Congo found that men may tacitly permit or even encourage their wives, daughters or other female family members to engage in transactional sex with men in the host community (World Bank, 2005, pp. 49-50). This is primarily due to the unavailability of alternative sources of livelihood, particularly for men. In such situations, household survival depends on the

food, money or other resources obtained through sexual transactions. In the few cases reported in which men have used sex for food or other gain from women in the host community, these additional resources have tended to not be shared with the family.

Sexual violence within militaries is prevalent but highly underreported, among both men and women. Chapter 3 explains how “soldiers-as-vectors” arguments may be less applicable to contemporary conflicts, where prevalence among militaries appears, in many cases, to resemble that of civilian populations. Although few data are available, HIV risk is also associated with increased sex between men in situations where partner choice is limited to same-sex partners, as is the situation in prisons or war camps (Hankins et al., 2002). These close environments provide opportunity for acts of sexual violence, such as male-male rape. Greater understanding is needed about male perpetrators and victims of sexual violence, with a view to understanding relations dynamics and possibilities for intervention (Andersson, Cockcroft & Shea, 2008, p. 81).

4.2.3 Sexual violence and HIV risk in the aftermath of conflict

A growing number of studies show that sexual violence in war does not disappear when conflicts officially end, that is, when peace agreements are signed (Meintjes, Turshen & Pillay, 2002; Mock et al., 2004; Jewkes, 2007). In a number of post-conflict settings, such as in Liberia, levels of sexual violence remain high, and in some countries, violence against women may actually increase in the aftermath of a conflict, though dynamics may change (Rehn & Sirleaf, 2002).

D’Awol (2008) demonstrates how the post-conflict context in south Sudan encompasses many adverse factors that contribute to risk of a generalized epidemic. Many of these are the consequence of war, prevailing sexual and gender-based violence, customs and cultural barriers, and the troublesome environment subsequent to the signing of the country’s Comprehensive Peace Agreement. D’Awol points to the unfavourable conditions under which HIV interventions must take place: lack of basic services, physical infrastructure and human resources; low literacy rates; and ongoing violence and tensions as a consequence of dowry-motivated cattle rustling and associated abductions and sexual violence against women and children. A high female ratio of up to 65% of the population in some locations has led to early marriages, “wife inheritance”, transactional sex and polygamy, as well as high divorce rates. This is further compounded by the high influx of sex workers from neighbouring countries. All these dynamics and practices are creating conditions for an accelerated HIV epidemic. At the same time, south Sudan is devoid of a meaningful health infrastructure, while a sizeable number of south Sudanese have never heard about HIV, how it is transmitted and how to prevent its transmission (D’Awol, 2008, pp. 7–8).

In a study done for ASCI on sexual violence and exploitation (SVE) in the post-conflict transition in Sierra Leone, John-Langba (2008) similarly finds that poverty, insecurity and weak social support networks are likely to increase women’s vulnerability to SVE, while there is limited access to sexual and reproductive health services or other support services. During the conflict, an estimated 33% of all women and girls were subjected to sexual violence, including abductions, sexual slavery and forced marriages. Sexual violence was perpetrated by all parties to the conflict, including the Economic Community of West African States Monitoring Group peacekeepers, and had serious health, mental and social implications. Rejection by families of the victims coupled to impunity extended to the perpetrators led to a double victimization of the survivors of violence (John-Langba, 2008, pp. 12–15).

Despite all those factors, HIV has received little attention in Sierra Leone until recently (Denov, 2006). During the last few years the government has, however, shown the political will to engage in efforts to deal with HIV, while international funding has secured the functioning of a number of intervention programmes. Both Denov and John-Langba conclude that the patriarchal nature of the society and subordinate status of women, forced marriages and genital mutilation, cultural beliefs and practices, low educational attainment among girls, and violent manifestation of masculinities all pose challenges in the efforts to prevent the spread of HIV. In current post-conflict transitions these issues remain as pervasive as they were during conflict, though the violence may become more prominent at the domestic level. Understanding how these patterns change over time is essential for effective HIV prevention and response.

4.2.4 Modelling sexual violence as a risk factor of HIV

Building upon Spiegel et al. (2007), Anema et al. (2008) show that national-level HIV prevalence estimates may not provide a sensitive enough measure to capture the complex and opposing effects of conflict on HIV transmission. They use modelling to conclude that rape contributes only a small percentage to HIV prevalence. Using the same mathematical model, Supervie, Halima & Blower (2009) were not able to replicate those findings and reached the opposite conclusion: that mass rape in conflict-affected countries in sub-Saharan Africa may be significantly associated with increasing HIV incidence. Their results show that a median of 8% (IQR 3–17) of the annual incidence in the seven conflict-affected countries in sub-Saharan Africa could be attributed to mass rape. The annual number of new HIV infections in women due to rape varied substantially among countries, from a median of 70% (IQR 32–139) for Somalia to a median of 1581% (IQR 727–3157) for the Democratic Republic of the Congo.

ASCI-commissioned research (Foss et al., 2009) used mathematical modelling to estimate the extent to which different situations of violence, coercion or population movement may increase an individual's risk of HIV acquisition. Foss et al.'s findings suggest that for a range of plausible conflict scenarios an individual's risk of HIV may be increased substantially. Their analytical equation and model describe the relative probability of acquiring HIV infection in conflict scenarios versus comparable non-conflict scenarios and also estimate potentially significant impacts of rape on population HIV incidence (Table 4.1). Four key determinants of individual HIV risk as a result of rape and sexual violence in conflict settings relative to non-conflict settings can be inferred: (1) HIV and STI prevalence; (2) the extent of coercion and genital trauma and the degree to which this facilitates HIV transmission; (3) the number of male partners/assailants and the number of sex acts; and (4) access to services, including for HIV, STIs and PEP. HIV and STI prevalence is twice as high among higher risk/violent males compared to other males.

For anal sex the transmission probability per sex act is assumed to be 10 times more than for vaginal gang rape as it assumes a trauma cofactor of 6, to account for increased physical trauma, rather than 3. Conservative assumptions were used regarding the probability of male-to-female infection per vaginal sex act (0.002) and the probability of male-to-female infection per anal sex act (0.01). The model assumes genital trauma increases per-sex-act risk by a multiplicative factor of 1.5 for single sites of trauma, 3 for multiple sites of trauma (e.g. gang rape, penetration with objects), and 6 for anal rape (probability without trauma = 0.02). There is a three-fold probability increase of HIV associated with STIs.

Table 4.1
Model scenarios: Violence and coercion against adult women

Conflict Scenario	Comparison	Risk Ratio
Adult female, forced to have sex by unknown combat assailants	Same number of consensual acts with 1 partner from community	4.3
Adult female raped by 3 men—with low risk male partner w/ whom she has 3 consensual acts	3 consensual sex acts with low risk male partner	5.3
Adult female trades sex with several male members of uniformed forces (trauma once in every 8 acts)	Same number of consensual acts with one man from own community	1.5
Adult woman, 1/4 of sex acts are forced by her highly exposed male partner (single site trauma)	Same number of consensual acts with male partner who has not been to high risk situation	1.6
Anal rape of adult male or female by 3 men; low risk partner of opposite sex with whom s/he has 3 consensual penile-vaginal acts	3 consensual penile-vaginal sex acts with low risk partner	86

Foss et al. (2009).

Foss et al. also modelled a scenario of the potential effect of population movements that may arise in conflict and post-conflict settings. Not surprisingly, the influx of a population that had a higher exposure to HIV into a less-exposed population resulted in a higher risk than if no population movement had occurred, while the influx of a lower-exposed population into an area of higher exposure was associated with reduced risk.

4.2.5 Implications for policies and programmes

The debate around sexual violence and its role in HIV transmission raises crucially important questions about the explanatory power and utility of biomedical indicators — and particularly national prevalence data — for assessing individual risk, understanding HIV impacts and drivers, and targeting interventions. ASCI findings highlight both the challenges of collecting epidemiological data and their relevance in the absence of reliable baseline and comparative data for either HIV or sexual violence incidence and prevalence (particularly over comparable time periods, study groups and age groups, and among men/boys). They also point to significant flaws in epidemiological models that have yet to consider the virological implications of sexual violence for transmission risk.

Andersson, Cockcroft & Shea (2008) pose the pivotal question at the centre of this debate: will reducing sexual and gender-based violence in HIV-hyperendemic countries also reduce HIV risk, particularly of young women and girls? Although HIV prevention is likely to be a first-line response to sexual violence (through STI treatment, provision of PEP, etc.), it is far less likely that sexual violence prevention is utilized as an entry point for HIV prevention in the context of disarmament, demobilization and reintegration programmes; information and education campaigns; and reconstruction and early recovery programmes. For the most part, addressing sexual violence is considered (and therefore resourced and programmed) as a part of human rights advocacy or as a reproductive health or gender issue.

Since most research on sexual and gender-based violence (SGBV) and HIV is from North America, Andersson, Cockcroft & Shea point to the need for more research and capacity strengthening for SGBV and HIV planning. ASCI concludes that urgent action is needed to ensure that the phenomenon of sexual violence and exploitation obtains a central position as an organizing frame for the global response to HIV and AIDS, as well as within biomedical, public health and social science research. SGBV must also be considered as a factor in epidemiological models of transmission. Until the role of force or coercion is made explicit in the data linking HIV with factors such as sexual debut, levels of sexual experience, age difference between partners, age of marriage and even condom usage, any potentially decisive impact on transmission risk will remain hidden. Theoretical, legal and policy agreement are needed on what constitutes sexual violence and force across different sociocultural settings, and more research is called for to explain the patterns, scale and scope of sexual violence over time.

4.3 HIV Risk in Post-Conflict Transitions

A major finding of ASCI's research has been the neglected importance of post-conflict transitions as occasions in which HIV risk may increase and simultaneously as neglected opportunities for policy and programmatic engagement. Heightened vulnerability associated with post-conflict transition can be seen in both the changing environment that follows the end of a conflict and the disruptions in institutional support for health services and humanitarian assistance that may accompany a shift from emergency to development assistance frameworks. (In other instances the factors may operate differently.) Gender relations are central to the constitution of social identity in a post-conflict situation and — like elsewhere — are based on pre-conflict patriarchies and patterns of exclusion (Seckinelgin, Bigirumwami & Morris, 2008). Meanwhile, many of the particular vulnerabilities that developed during the conflict may persist into the immediate post-conflict period.

These findings should be interpreted in the light of other related research. An example is the importance of multiple intersecting sources of stress, including HIV, in contributing to social crisis in affected communities (de Waal et al., 2004). The resilience of an affected community is closely associated with both the number and the nature of shocks and also with the extent of community support networks. The cumulative impacts of protracted conflict can lead to diverse outcomes. In some circumstances, the destruction of safety nets and community support mechanisms is likely to contribute to greatly increased vulnerability, both to HIV and to its impacts. In others, conflict creates new and stronger social networks that can mitigate these impacts.

A second important point in assessing HIV risk factors in the aftermath of conflict is the accumulation of experiences within the context of changing social and family structures and what appear to be growing rates of sexual and gender-based violence. In turn, the continuity of and access to services and treatment in camp settings and post-conflict contexts is an important and underexplored challenge.

4.3.1 Provisioning gaps in health services

One of the key issues that emerge from ASCI research across all themes is the importance of continuity of health service provision during crisis and transition and consistency of health access among different groups. Health care provision to refugee and displaced populations is rarely adequate, but in the poorest countries it may be better than the population has received beforehand and — more important — may not be sustained into the post-conflict period. As part of the ASCI research programme, the International Centre for Migration, Health and Development (ICMHD) conducted focus group discussions in four post-conflict situations (Carballo, 2009). These discussions highlighted the ways in which post-conflict transitions are opportunities for improved engagement on issues of health, including HIV and AIDS — but emphasized that these opportunities are commonly missed on account of failures of donor and government policy and the poor use of resources. The absence of appropriate information may also inhibit uptake of services even when they are available. In one case in Uganda, some men strongly believed that the main mode of HIV transmission was through blood transfusion at the health centre. For such men, avoidance of the health centre “at all costs” was considered enough to stem the spread of HIV (World Bank, 2005, p. 87). As Samuels, Harvey & Bergmann (2008) stress, much has been learned about how health services can be sustained with minimal interruption throughout emergencies. Even though more resources may have been spent on relief operations, reproductive health and HIV activities in reconstruction settings have not grown commensurately. These are important programming and policy opportunities.

The neglect of and lack of access to health resources described by the focus groups reflects a general lack of services in poor, fragile conflict and post-conflict countries. Already underfinanced and under-resourced, the health care systems of these countries have seen their patient load increase at a time when their capacity to respond has diminished. In some settings a combination of fear of HIV, high mortality among health staff, and excessive, underpaid work has meant early burnout of remaining personnel. The outmigration of health workers can have a devastating impact on overall health indicators, including HIV and AIDS. These losses can be severe: before civil war broke out in 1989, Liberia had 250 qualified licensed doctors, but now just 50 doctors serve 3.5 million people. According to government statistics, many have gone overseas to work.

The collapse of the health system in some conflict-affected countries has meant that structures that might otherwise have been capable of delivering HIV prevention, treatment and care services simply have been unable to even maintain basic services, such as condom distribution, and have certainly been unable to mount serious ART and outreach services (Carballo, 2009). In Liberia, access to services and HIV prevention was better in camps than in locations of return, such as villages.

Moreover, the loss of highly trained and experienced people in government can have far-reaching implications for the maintenance of complex institutions and can influence how the public sees government institutions and those who staff them. Høg's (2008) study of Mozambique offers an interesting example of how public health service provision can be an intrinsic part of the legitimizing framework for a state, with the implication that failures to provide essential health care, including AIDS treatment, can have negative repercussions for citizens' confidence in the state.

A different perspective on the importance of consistency in provision of health care and the dangers associated with governance disruption is provided by Smith's (2008) research in the Papua region of Indonesia. This study deals with the development of local governance from the Dutch colonial period through the New Order era and up to the present. Smith notes that fundamental inequalities, among regions and between indigenous groups and immigrants, and patterns of exclusion and extreme poverty as a consequence of biased government spending persist until today. These patterns tend to correspond with variations in HIV prevalence and suggest that high-risk environments have been created where prevalence is rising or above average. Recent local government and electoral reforms may well have exacerbated problems of public service delivery, in part through devolving responsibility for HIV programming to local government, where there are many competing spending priorities. Despite higher funding channelled from the central level, local HIV expenditures may decline. This study shows

how the form of local government and especially reforms to the local government system may shape the trajectory of the epidemic in that province.

4.3.2 Psychosocial consequences: Gendered patterns of difference

In 1999, Paul Richards made known a command given by young Sierra Leonean fighters attacking and looting a medical clinic: “Hurry, we are all dying of AIDS” (Richards, 1999). This was widely taken to mean that HIV was helping to drive antisocial behaviour and foreshortened perspectives on the future. However, HIV prevalence in Sierra Leone at the time was about 2%, which would not have translated into a demographic crisis. A closer reading of Richards’ account shows that the fighters’ destructive behaviour was driven by other social and political realities but justified on the grounds that “we’re all going to die of AIDS anyway”. This anecdote reveals how the representation of HIV and AIDS as an unparalleled disaster has fed into the social imaginations of young people attuned to global realities by the media and how their statements need to be carefully interpreted in context.

Similar clusters of constrained life chances and desperate beliefs continue to exist in west Africa today. Former Liberian combatants, in focus group discussions with ICMHD, shared an almost universal sense of fatalism about HIV. One expression they commonly used was “a bullet or AIDS”, implying that if they didn’t die from one, it would surely be the other. All ex-combatants stated that they had not received any counselling or formal HIV information at all (Carballo, 2009). The focus group found a high level of resignation to poor economic opportunities and expressions of willingness to engage in violence again if the situation does not improve. There were also indications of high levels of post-traumatic stress disorder (PTSD) and high levels of expressed need for psychological help.

In Bosnia and Herzegovina, former combatants in the ICMHD focus groups were not well informed about HIV and AIDS. They expressed a great deal of misunderstanding about how HIV is transmitted and as a result had unfounded fears about the dangers of infection from people living with HIV (Carballo, 2009). The risks of HIV transmission among the general population in Bosnia and Herzegovina are very low, but many demobilized soldiers had inflated fears. Former soldiers were struck by the fact that refugees returning from western Europe knew far more about HIV than they did. An abiding problem for the former combatants was fatalism — about HIV, about the chances of surviving during war and about future prospects after war.

Much less is known about the psychosocial consequences of war for women and children associated with armed forces and groups. If attention is given at all, it is usually in the context of support programmes for survivors of sexual and gender-based violence. But rape and sexual violence are not an exclusively female issue. While far less is spoken or known about the problem, rape of men is not uncommon and in times of war and post-conflict transition is often an even more emphatic way of eroding local culture and social structure. It can take many forms; rape with penetration, forced sterilization, forced public nudity, forced public or private masturbation, and physical damage to genitalia are some of them. To what extent sexual violence against men in conflicts has been associated with HIV is not clear.

The focus group studies conducted by ICMHD with displaced women survivors of rape found different reactions in the countries examined (Carballo, 2009). In Liberia, rape was seen as an act of war over which women had limited control. There was little if any reference to PTSD conditions among survivors, but women said they had great trouble entering into new relationships. In Bosnia and Herzegovina, there was considerable reference to PTSD and continued shame by the survivors, supported by medical data. Similar to survivors in Liberia, they reported problems entering into new relationships and a feeling that they had been neglected by the international community, as well as a feeling that they had been locally neglected once the war was over. In the Democratic Republic of the Congo, women reported high levels of chronic fear and believed that the problem of sexual violence was not over. They recognized the danger of HIV infection related to rape and frequently referred to the end of economically viable livelihoods subsequent to rape.

Consultations with displaced women in Haiti found a unanimous feeling of total life disruption and a common experience of many ongoing confrontations with soldiers and local bandits. There were frequent references to gang rape of women of all ages, to living under the threat of death and sexual aggression, to kidnapping of women, to the shame of rape, and to health concerns related to displacement, stress and rape, including hypertension, respiratory problems, psychological problems, amnesia and forced pregnancy. Most of the women were

unwilling to return to their communities, in large part because of fear of rape or memories of rape and the fact that husbands have abandoned them because of rape. The women felt neglected, deprived of security and protection, and without access to HIV prevention, education, care and work support programmes.

Two general findings are important. First, the psychosocial consequences of conflict for men, women and children are enormous and likely to take different forms. Most post-conflict environments lack adequate infrastructure to meet physical reintegration challenges, which range from amputations to traumatic fistula. These needs are not only medical but also for specialized housing, transportation, income generation and social protection. Regenerating a sense of hope among these people, who have so many reasons to despair of their future, is equally important. Second, in different configurations, sexual and gender-based violence affects a range of factors that are, in some circumstances, associated with greater HIV risk.

4.3.3 HIV and disarmament, demobilization and reintegration

Militaries and other security services are the focus of efforts at reform in many countries, especially those in post-conflict transitions. The UN has developed comprehensive guidance for disarmament, demobilization and reintegration (DDR) programmes, which are defined as initiatives that “aim to deal with the security problem that arises when combatants are left without livelihoods and support network during the vital period stretching from conflict to peace, recovery and development” (UN, 2009). This guidance includes HIV policies. In addition, the Multi-Country Demobilization and Reintegration Program has developed guidelines for incorporating HIV and AIDS programming into DDR programmes (MDRP, 2009).

Country DDR initiatives are in place or being piloted in Sudan, Côte D’Ivoire, Sierra Leone, Liberia and Colombia, with the support of UN agencies, including UNFPA, UNAIDS, the UN Development Programme, the UN Children’s Fund, and the Department of Peacekeeping Operations. These initiatives provide voluntary HIV counselling and testing (VCT), reproductive health services, adult literacy and occupational activities and a range of other services. A relatively recent development, many of the DDR programmes are stymied by a lack of dedicated technical staff and financial resources and by limited integration with national health, HIV and SGBV initiatives. These programmes are also hampered by the reality that they are often designed on tight budgets with rapid timelines, under the assumption that it is the task of other rehabilitation and development programmes to take responsibility for HIV and AIDS.

Tailoring HIV interventions to different circumstances and different members of armed forces and groups is a challenge. Although in principle DDR programmes recognize the particular and varied risks facing different subgroups, the capacity for mounting targeted programmes is rarely present. Children associated with armed forces and groups are often sexually active at a much earlier age and face increased risks of exposure to sexual violence and HIV. Female combatants, abductees and dependants are also high risk given widespread sexual violence and abuse.

Whereas DDR and security sector reform (SSR) programmes could serve as ideal entry points for addressing HIV and AIDS concerns, there are many shortcomings in terms of institutional policy, the set-up of programmes, resources, focused approaches for special needs groups and fully gendered approaches (D’Awol, 2008). Several pieces of research commissioned by ASCI indicate that HIV concerns are neglected in SSR and DDR programmes more widely. These processes of reform are often formulaic and rushed, without clear objectives other than meeting somewhat arbitrary targets. There are rarely sufficient time or resources to devote to HIV education, VCT and other related activities. The consequence is that demobilized men and women are not given the basic tools for HIV prevention, much less used as peer educators or messengers for HIV policies and programmes. Similarly, the restructuring of security services proceeds without attention to the multiple personal, institutional and social requirements of handling HIV and AIDS that have been noted in this chapter. This is an obvious missed opportunity.

Not only is the neglect of HIV interventions a missed opportunity, but it is symptomatic of an approach to SSR and DDR that focuses on immediate security symptoms of HIV rather than grappling with the issues of social exclusion, livelihood vulnerability and gender relations that underpin the drivers of the epidemic. The study by Seckinelgin, Bigirumwami & Morris (2008) of post-conflict Burundi argues that the DDR process is not addressing the structural vulnerabilities and dehumanization of women coming out of the bush. If DDR processes

fail to address the underlying causes of violence and especially sexual and gender-based violence, DDR itself may well become a potential source of sexual and gender-based violence, according to these authors (p. 66). The policy response must go well beyond increasing resources and time allocated to HIV interventions. Rather, SSR and DDR programmes need far greater clarity on their strategic goals, and these goals and the mechanisms used to attain them need to be designed with attention to HIV and AIDS.

In principle DDR programmes, especially cantonment of ex-combatants during periods of varying length, present a unique opportunity for educating ex-combatants on HIV and its prevention. However, studies in Liberia, Bosnia and Herzegovina, and the Democratic Republic of the Congo suggest that DDR initiatives have been a lost opportunity for addressing HIV, and many ex-combatants have returned to civilian life with little if any new information on or motivation for HIV prevention (Carballo, 2009). Post-conflict DDR policies are designed as ambitious and generously funded exercises to allow former combatants to be retrained and reintegrated into civilian life with a sense of self-worth, but they often end up as hasty and under-resourced exercises in meeting quotas. This is compounded by extremely limited employment alternatives, insufficient funding for survivors of conflict, and the often conflictual relationships across these groups, including returnees.

4.4 Conflict, Crisis and Post-Conflict Transition Conclusions

An important ASCI finding is that HIV risks may be exacerbated during transition from crisis or conflict to post-conflict situations and also that this is an area neglected by policy and programmatic interventions. Often the challenges associated with these transitions are insufficiently recognized by international policy-makers and donors, whose models are frequently derived from contexts within well-functioning states. In practice, there is often a hiatus of external funding at these critical moments in the peace process. Although the need to address HIV as part of post-conflict initiatives has in principle been recognized and HIV is on the agenda of most organizations (Bensmann, 2003), the steps taken by those organizations have been few and often remain ill defined. International policy frameworks and practices delimit HIV-related assistance to post-conflict countries as they often fail to meet the funding criteria or conditions of stable governance that donor frameworks presuppose.

Another policy bias is the policy and programmatic focus on risk groups rather than risk environments. ASCI research findings point to the importance of the multiple and varied specific environments in which groups find themselves and in particular to the rapidly changing nature of those environments as conflicts unfold or come to an end. The same category of persons (e.g. refugees, single young women or combatants) can have very different risk profiles as these conditions change. This in turn demands a focus upon the specific factors that, during transitions, can shape different HIV risks, either to increase or decrease them. These factors are diverse and include peacekeeping operations, DDR programmes, refugee return and reintegration, urbanization, commercial and infrastructural investment (and sex industries that spring up around them), housing shortages, corruption, dysfunctional cold-chain distribution systems, and primary and reproductive health facilities that are suddenly in the wrong place.

Unless the period that characterizes the end of conflicts and the movement to a development type of condition is given more attention by policy-makers and health planners, it is unlikely that prevention, diagnosis and treatment of HIV (or indeed of any communicable disease) will be given the types of interventions it needs (Chandran et al., 2008). High on the list of priorities must be a better understanding of what happens to groups, such as displaced women and ex-combatants, for whom the end of conflict offers either hope or new social challenges that cannot be taken up without external help.

A final issue is the role of government and external (especially UN) agencies. The role of national and local governments is usually eroded through war to such a degree that they are unable to cope with the demand placed on them. In addition, HIV has rarely been integral to internationally designed projects that have been planned and implemented as part of post-conflict reconstruction efforts. This is not to say that UN agencies and non-governmental organizations have not been aware of the need for action, but rather that they have not recognized the special challenge of HIV prevention, diagnosis and treatment in the special context of post-conflict transition, a context that imposes new and complex demands and risks on people and environments, making them more vulnerable to diseases, such as HIV.

5. CONCLUSION

The combination of conflict and HIV and AIDS is a challenge to academics, policy-makers and practitioners alike. Campbell (2008) has demonstrated that the issue of HIV and security is largely invisible, in both security and HIV discourse. ASCI was set up precisely to remedy this neglect.

Studies commissioned by ASCI are able to point to evidence-based answers to many issues that had been under debate. ASCI research shows that the problem of HIV and AIDS, conflict and security should not be analyzed as a single overwhelming threat. Rather it should be understood as a composite of specific policy challenges, with effective responses within reach. ASCI findings show that a number of earlier, more alarmist relationships that were assumed to exist between national-level state security and HIV and AIDS are not borne out by the evidence. ASCI proposes a new agenda for action that focuses on an intermediary level between national macro-level assumptions and micro-level behavioural and biomedical approaches. ASCI situates HIV risk within the context of sociostructural factors that shape individual behaviour and put some people at greater risk while protecting others. ASCI focuses specifically on how HIV risk is shaped by the dynamics of sexual violence, exploitation and transactional sex; by the role of institutions, particularly in the governance and security sectors; and by gender relations within the broader context of household and community interactions.

5.1 Overview

Gender equality must become part of our DNA — at the core of all of our actions. Together with governments and civil society, we must energize the global response to AIDS, while vigorously advancing gender equality. These causes are undeniably linked.

*Michel Sidibé, executive director of the
Joint United Nations Programme on HIV/AIDS (UNAIDS),
at the opening of the Commission on the Status of Women,
United Nations Headquarters, New York, 2 March 2009*

ASCI findings provide new insights about the reciprocal impacts of HIV and AIDS and state vulnerability. They challenge many of the assumptions that underpin the prevailing frameworks of HIV/AIDS analysis and policy design, as well as the indicators used to measure impacts. By redefining the contours and fault lines of what has hitherto been a largely political debate influenced by speculation and foreign policy concerns as much as by evidence, ASCI identifies new opportunities and strategies for HIV/AIDS prevention and response within uniformed services and fragile states and during humanitarian crises and post-conflict transitions.

ASCI questions the efficacy of behavioural approaches that fail to recognize the power dynamics of social and sexual interactions. At the other extreme, ASCI exposes the limitations of analyses that assign direct causation between conflict and state fragility and the acceleration of HIV. In between solely individual responsibility and macro-determinism lies a complex array of factors, constraints and opportunities. ASCI emphasizes these intermediary linkages between macro-level processes and micro-level behavioural and biomedical responses.

In addressing the HIV and security nexus, ASCI advances a “fourth wave” analysis of the pandemic that emphasizes two mutually reinforcing factors of HIV risk: gender and violence (Klot & Nguyen, 2009). The first wave analysis, largely behavioural, drew attention to groups considered to be at high risk of HIV, such as injecting drug users, gay men and sex workers. The second wave emphasized biomedical approaches, including prevention technologies, antiretroviral therapies, microbicides and vaccine development. Subsequent third wave theories about the pandemic’s trajectory began to incorporate a range of social and structural factors, such as poverty, migration and conflict.

ASCI uses gender analysis to identify the power dynamics within social and sexual relationships that influence HIV transmission risk. These dynamics vary across different settings and social contexts — within militaries and refugee camps, across border areas, and even within families and communities. Infant rape, sexual violence within military units, criminal rape and forced, coerced and “survival” sex are only some of the situations in

which victims have little chance of “negotiating” safer sexual practices. Empowerment approaches to HIV prevention directed towards those with the least control over their circumstances miss this fundamental point.

It is precisely those who wield and abuse their power who must change their behaviour and be held to account, whether in families, religious institutions or government or peace operations. For this reason, ASCI research focuses not only on sex workers but also on their pimps, boyfriends, clients and traffickers. It looks at small-unit norms within militaries as well as the role of commanders in establishing principles of conduct and disciplinary procedures. Just as a junior officer’s conduct is more likely to be determined by command leadership than by personal views about gender equality, so too will a rape survivor’s access to care and support be more dependent on family and community acceptance than on a personal sense of individual worth.

Existing epidemiological measures are insufficient to grapple with the intermediate factors and processes that ASCI identifies as most important. Absent an equivalent set of social, political and economic indicators, policy-makers and researchers retrofit their questions and analytical frameworks to be answerable only in biomedical or epidemiological terms. Even though incidence and prevalence reveal little about who is most at risk of HIV and why, social science explanations have yet to acquire the same status as biomedical hypotheses. This is not surprising — but also not helpful. HIV has long been defined as a health issue. But even if a vaccine were created today, the political, economic and social impacts of HIV and AIDS will continue to unfold over generations. The immediate benefits of a vaccine would not be realized without the requisite health care systems, purchasing power and distribution mechanisms, administrative and financial management capacity, human resources, transportation infrastructure, and de-stigmatization of infection. In the absence of a holistic approach, HIVAIDS responses will continue to emphasize individual health status without addressing the related social and political variables.

ASCI charts new ground by proposing alternative ways of conceptualizing and measuring the reciprocal impacts of HIV and AIDS, conflict and fragility. Rather than focusing exclusively on prevalence among the ranks, ASCI suggests a range of methods to assess the impact of HIV on the operational capacity of armies. Instead of focusing on HIV risk as an outcome of the number of sexual partners, ASCI looks at the role of force and coercion between partners, whether they be father and child, humanitarian worker and refugee, or warlord and child soldier.

In sum, ASCI focuses the attention of policy-makers and scholars on an intermediary level, where the problems are significant but tractable and where existing approaches need revision to meet the twin challenges of better HIV prevention, care and treatment in difficult environments and mitigation of the wider impacts of the HIV and AIDS epidemic.

5.2 Policy Recommendations

Drawing from research, analysis and consultations taking place over two years with various constituencies, including the military, police, affected populations, UN peacekeeping personnel, donors and activists, ASCI puts forward 10 policy recommendations. These priorities establish a wide scope for engagement and offer practical and immediate proposals for action.

(1) Align HIV and sexual violence prevention and response.

Urgent recognition must be given to violence, and especially sexual violence, as a physiological and social factor in epidemiological models of risk transmission and in HIV, humanitarian, public health and security policies. There needs to be greater theoretical and policy debate and consensus on what constitutes sexual violence, how to measure and model it, and what its patterns are over time — before, during and after conflicts take place. Until the role of force or coercion is made explicit in the data linking HIV with social and behavioural factors, such as sexual debut, levels of sexual experience, age difference between partners, age of marriage and even condom usage, any potentially decisive impact on transmission risk will continue to be obscured. Finally, sexual violence prevention and HIV prevention must be more closely aligned. Although HIV prevention is a first-line response for survivors of sexual violence, preventing sexual violence has yet to be made central to HIV and AIDS policies and strategies in conflict-affected environments.

(2) Develop command-centred approaches to HIV prevention and AIDS treatment and care in the uniformed services.

A growing number of armies are demonstrating success in responding to HIV and AIDS within their ranks, notably by using integrated and mainstreamed approaches that emphasize military command responsibility for HIV policy development and implementation. ASCI recommends the further elaboration and adoption of command-centred approaches to HIV prevention and AIDS treatment and care within uniformed services and UN peace operations. This type of approach has significant advantages over medical and behavioural strategies. A command-centred approach requires systematic assessments of HIV and AIDS within an institution and the design and adoption of policies that address prevention, care and treatment for uniformed services and their families. An essential element of the command-centred approach is the development of lines of accountability and enforcement mechanisms to prevent sexual violence within military institutions and to ensure remedies for HIV-infected survivors of rape and sexual violence committed by members of national, regional and multinational forces, be they civilian, police or military. The Military Institutional Audit and Force Capabilities Framework assessment, as outlined by Cranfield University for ASCI, are tools that can support this approach.

As the African Union (AU) proceeds with establishing its Common Security and Defence Policy and building up its capabilities for peace support operations, it is called on to adopt the best practices from among African armies, including components of the command-centred approach. It is further recommended that military planners assemble to compare these responses with existing practice and to further develop them into practicable instruments.

ASCI recommends that most aspects of national military HIV and AIDS programmes be harmonized with their civilian counterparts — in pursuit of equitable burden-sharing and common principles across the different sectors — while maintaining their specific relevance and application to the particular requirements of the uniformed services. To this end, technical cooperation and support should be extended for the development of national information-collection systems within uniformed services that can provide more detailed assessments about patterns of HIV incidence and prevalence in relation to geographic region, family status, age, rank and professional function.

(3) Integrating HIV prevention and response into the design and command of peace support operations.

HIV and AIDS policies in international peace support operations, including issues of pre- and post-deployment testing, the inclusion of HIV-positive people in the forces and provision of medical facilities, should be aligned with the operational demands of the mission and the capacities of troop-contributing countries (TCCs). In all situations, testing should be accompanied by counselling and treatment referral. Building upon the operational tools of a command-centred approach to HIV prevention, ASCI proposes the development of a third tool specific to peace support missions: an HIV and AIDS security risk assessment to be carried out as part of the establishment of a peace support mission, performed prior to deployment or upon arrival at the mission area. This would be the responsibility of the UN Department of Peacekeeping Operations (DPKO) but would be coordinated among actual or potential TCCs. This tool would map findings from the Force Capabilities Framework and Military Institutional Audit tools onto the particular operational mandate and locality. The mission would undertake measures to ensure the continuity of HIV and AIDS programmes through troop rotations, for example, making sure that best practices are sustained.

Another recommendation is that the notion of zero tolerance for sexual abuse, both within peace support missions and between peacekeepers and the host population, should be coupled to the agendas of structural prevention and the command-centred approach. Zero tolerance should not be a pretext for a command to halt prevention measures, such as condom distribution, on the basis of a policy of exclusive abstinence.

A third recommendation relates to aligning the practices of national, regional and UN peace support missions. The ultimate goal is a universal standard of HIV prevention, treatment and care across all troop-contributing countries, in line with the global goal of universal access. An interim objective is sufficient alignment of policy and practice to make it possible for there to be a common treatment protocol among the different contingents making up a peace support operation. This requires the involvement of commanders and also touches on the issue of mandatory testing.

Fourth, treatment should be extended to UN peacekeepers as a matter of policy. Having adopted goals of universal access, the UN should aim to extend that access to its own peacekeepers by ensuring that all TCCs adopt best practices for treatment and care.

A fifth recommendation addresses the synergies between peacekeeping and peacebuilding. ASCI recommends increased dialogue among bodies and institutions with complementary mandates in this area, namely, the UN Security Council, the UN Peacebuilding Commission, and the AU Peace and Security Council and other regional mechanisms, to address the heightened risks of HIV and AIDS during post-conflict peacebuilding and to ensure the continuity of HIV prevention during post-conflict transitions, including disarmament, demobilization and reintegration.

The final set of recommendations speaks directly to the centrality of HIV and AIDS to the international peace and security agenda. ASCI recommends that the UN Security Council and the AU Peace and Security Council strengthen their respective responses to HIV and AIDS by (a) calling for the establishment of command-centred approaches to HIV and AIDS; (b) supporting increased regional cooperation and networks in support of HIV prevention and response; (c) aligning HIV and sexual violence prevention efforts; and (d) ensuring that HIV prevention and response efforts extend equally to military, police and civilian peacekeeping personnel.

- (4) Integrate HIV and AIDS prevention and response into disarmament, demobilization and reintegration programmes.

Although disarmament, demobilization and reintegration (DDR) programmes are not always blind to HIV and AIDS, they have made relatively greater progress at the level of policy than where it counts — at the level of programme design and implementation. To be effective, DDR processes must do more than restructure the military and armed groups. They must be conceived of and function as a process of community building.

As only one part of security sector reform (SSR), DDR programmes provide important entry points for HIV prevention, testing, care and treatment but have yet to address several critical challenges. The first is the inherent ethical dilemma embedded in the widespread practice of providing voluntary counselling and testing (VCT) to soldiers and their families without support, care and treatment (CT). ASCI recommends a new approach that incorporates all these elements — VCT-CTP (voluntary counselling and testing–care and treatment plus). Soldiers must be the first among their wives, girlfriends, children and other associated women to declare their status. But without their own access to VCT-CTP, it is highly unlikely that a soldier's family members and associated dependants and partners will do the same without risking stigmatization, blame, ostracism and a reduction in family status and access to resources, including property, inheritance and custody. In addition, ASCI recommends post-deployment VCT-CTP for all uniformed services and peacekeeping personnel. A further recommendation is that HIV and AIDS policies for military and police should be reflected in pension and retirement schemes, funeral and survival benefits, and compassionate leave, disability and medical discharge benefits as well as entitlements for children born out of wedlock and/or from rape. Consistent with UN Security Council Resolutions 1308, 1325 and 1820, the UN, the World Bank and bilateral donors are called on to support national governments in clarifying their policies and implementing more comprehensive VCT-CTP in the context of DDR and SSR.

- (5) Reframe the testing debate.

ASCI recommends a balanced dialogue on mandatory HIV testing and selective deployment of HIV-negative individuals on specified missions. In different forms, mandatory testing is practiced by the majority of armies. The reasons in support of this appear self-evident to military commanders but have been inadequately justified in the context of human rights principles and national HIV and AIDS policies. Principled and practical arguments both for and against mandatory testing and selective deployment should be aired in public.

In favour of testing is the paradigm of international humanitarian law, which is based on recognizing military necessity — that a commander is obliged to use means that will necessarily involve inflicting and risking death and injury to an extent proportional to the military objectives in question. Also in favour is the argument of the right of a state to suspend certain human rights provisions during national security emergencies. Practical and operational arguments are also strong, particularly among severely resource-constrained armed forces.

Objections to testing are framed in terms of universal human rights and the negative repercussions of mandatory testing and exclusion practices, for example, with regard to stigma. Some militaries combine strictly voluntary testing with an insistence on only deploying or promoting individuals who test HIV-negative by requiring a recent seronegative test result as a precondition for being considered for advancement. Others frame their policies in terms of medical fitness in general, leaving scope for discretion on how to utilize soldiers who test HIV-positive. A new debate needs to bring into direct conversation the divergent military and civilian policies for HIV testing. International peacekeeping operations need to participate in this debate.

(6) Integrate HIV prevention and response into policing and law enforcement.

In all aspects, the issues of HIV and AIDS and law enforcement services have been neglected. One dimension of this is the impact of HIV and AIDS on police and other law enforcement institutions, which demands attention. Law enforcement personnel and institutions should be targeted for HIV interventions. A second dimension is the way in which law enforcement practices, especially with regard to stigmatized and criminalized activities and groups, influence the trajectory of national and regional epidemics. Issues such as harm reduction for injecting drug use, the policing of sex work, and the decriminalizing of homosexuality are all central to this. Legal issues, such as family laws regarding age of marriage, inheritance, property rights and citizenship, should also be considered. Developments concerning HIV/AIDS and law enforcement are still at an initial stage, and a global programme of collaborative learning on law enforcement and HIV and AIDS is called for.

(7) Increase focus on HIV and AIDS across borders, and in relation to traffic and trade.

Cross-border issues, including trafficking of women, the drug trade and sexual exploitation and abuse at border crossing points, are all related to risks of HIV transmission. The previously underestimated role of some groups of law enforcement personnel as core group transmitters or maintaining populations warrants further exploration. Although the positive role played by police in regulating condom use in brothels has been documented, its unintended consequences have yet to be assessed. These include creation of informal sex work economies, increased demand for younger women and “virgins” and an increase in premarital sex. Bilateral or multilateral exchange and cooperation is a prerequisite for addressing these questions, and borders should be a special focus for HIV efforts. The nexus between the international trade in illicit drugs, related sex trafficking activities, drug use and the emergence of narco-states in several parts of the world demands particular attention.

(8) Increase continuity of HIV and AIDS responses during post-conflict transitions.

A major policy gap in responding to HIV and AIDS occurs during post-conflict transitions, which can be simultaneously periods of heightened risk for HIV transmission and periods of programmatic weakness because of discontinuities between emergency assistance and reconstruction and development efforts. International policy frameworks and practices restrict HIV/AIDS-related assistance to post-conflict countries as they often fail to meet funding criteria or conditions of stable governance. Policies, if available, also largely focus on risk groups rather than on risk environments. This leads them to ignore the possibility that risk profiles of groups may differ considerably in different contexts.

More refined approaches are recommended, paying attention to a variety of gender-related factors that shape HIV risk during transitions. The linkages between psychosocial recovery and HIV risk are among the most underexplored. The psychosocial effects of war, conflict, displacement, torture and violence have repercussions for interpersonal relations, family and household arrangements, and socialization processes. Both conceptual and applied work are needed to better understand how notions of masculinity and femininity are shaped by conflict and its aftermath so that appropriate interventions can be designed for both men and women, boys and girls that take into account structural vulnerabilities and related HIV risks and consequences. In this context, existing policy successes need to be recognized and sustained, including best practices in responses to populations in refugee and displaced camps and the strengthening of the provision of health services in post-conflict settings.

(9) Address HIV and AIDS in fragile states: strengthen local government, community and family care arrangements.

The relationship between HIV and AIDS and state fragility is highly complex and non-linear. ASCI calls for a reassessment of current national measures of state fragility to take into account the impact of HIV and AIDS on local government, human resources, health sector delivery and community survival. The yet unmeasured toll

that HIV/AIDS takes on family care arrangements must be considered in macroeconomic and sector-specific planning, employment and social protection policies. ASCI research points to the ways in which HIV and AIDS place additional stressors on local government institutions, hindering effective representation and contributing to poor service delivery. In turn, these weaknesses undermine efforts towards achieving the goal of universal access to prevention, care and treatment. ASCI also documents how local government reforms can change social and economic contexts and alter patterns of HIV transmission. While community-based organizations and international partners have played an important role in filling some gaps, it is ultimately national governments that must meet the needs of their citizens and ensure that the decentralization of governance and service delivery is adequately supported.

(10) Rethink the tools of measurement.

Conventional indicators of conflict and HIV/AIDS fail to capture the relevant dimensions of social disruption and related trauma, especially the impacts of protracted conflict, displacement and post-conflict transformation on gender relations, family structures, local government and social services. Consequently, there is a need to develop more finely tuned indicators and approaches that are sensitive to these social and gender dimensions. An important message from ASCI research is the central importance of context to any assessment of risks and responses. New behavioural categories need to be included within models for HIV/AIDS and security to account for local variations in sexuality and violence. Moreover there is a need for studies that are not confined to measuring the impact of the epidemic on highly aggregated national-level indicators but which also focus on individual, community and regional impacts.

5.3 A New Agenda for Action

In reassessing the links between HIV/AIDS and security, ASCI has identified five broadly defined mechanisms for advancing its principal recommendations. ASCI calls on UNAIDS to provide leadership in mobilizing multilateral, bilateral and government support to improve HIV and AIDS responses in situations of conflict and fragility in the 10 areas outlined above. Five mechanisms are identified for channelling resources and technical cooperation.

- (1) National assessments — Provide technical and financial support for national militaries, police, other security sectors and local government authorities to carry out institutional audits and operational assessments of HIV risks in the context of post-conflict transitions.
- (2) Policy development — Provide technical and financial support for policy development on VCT-TCP, command-centred approaches to HIV and AIDS management, conduct and disciplinary policies and enforcement mechanisms, law enforcement practices, HIV and AIDS in post-conflict transitions, and the management of local government under stress due to the epidemic.
- (3) Regional collaboration — Promote collaboration among and within uniformed services to harmonize VCT-TCP policies, facilitate the study of trafficking routes and support HIV-related resource mobilization.
- (4) Information collection and data analysis — Reassess and reformulate standard epidemiological and behavioural models of HIV transmission risk (and related survey instruments) to incorporate factors relating to gender, violence, population movements and access to services; support macroeconomic modelling and health-sector reforms that take into account the costs and consequences of increased care burdens; reassess state fragility indices to reflect the impact of HIV and AIDS on human resources and service delivery; and develop security risk assessment tools for use in mission areas.
- (5) Emerging themes — Support exploratory and new policy research on emerging trends and priorities. Through planning meetings, case-studies, data collection and policy assessments, support is needed to catalyze interdisciplinary and comparative research and policy development in a number of areas: policing, sexual violence, psychosocial factors, masculinities, DDR/SSR, decentralization and trafficking.

UNAIDS and its cosponsors, AIDS ambassadors, and regional organizations, especially the AU, are called on to ensure the deliberation, consideration and implementation of ASCI findings and recommendations in relevant forums. These include multilateral bodies, such as the UN Security Council, the UN Department of Peacekeeping Operations, the UN Peacebuilding Commission, and the World Bank, as well as UN funds and programs, namely, the UN Population Fund, the UN Children's Fund, the UN Development Programme, the UN Development Fund for Women, the UN High Commissioner for Refugees, the UN Office on Drugs and Crime, the World Health Organization and the International Labour Organization. Equally relevant are regional bodies, particularly those involved in peace support operations, including the African Union, the European Union, the Economic Community of West African States, the Intergovernmental Authority on Development, the Organization for Security and Co-operation in Europe and the North Atlantic Treaty Organization. Major donors in conflict and post-conflict countries, as well as those supporting HIV prevention efforts, including UNAIDS, the Global Fund, the World Bank, PEPFAR and the Gates Foundation, should consider the implications of ASCI findings for funding criteria and ensure that existing financial instruments can be leveraged to support HIV/AIDS prevention and response in fragile and conflict-affected states.

ANNEX

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ASCI Commissioned Research Reports

- No. 1 The Police and HIV/AIDS: A Literature Review (Hilary Pearce)
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