FORCED MIGRATION review

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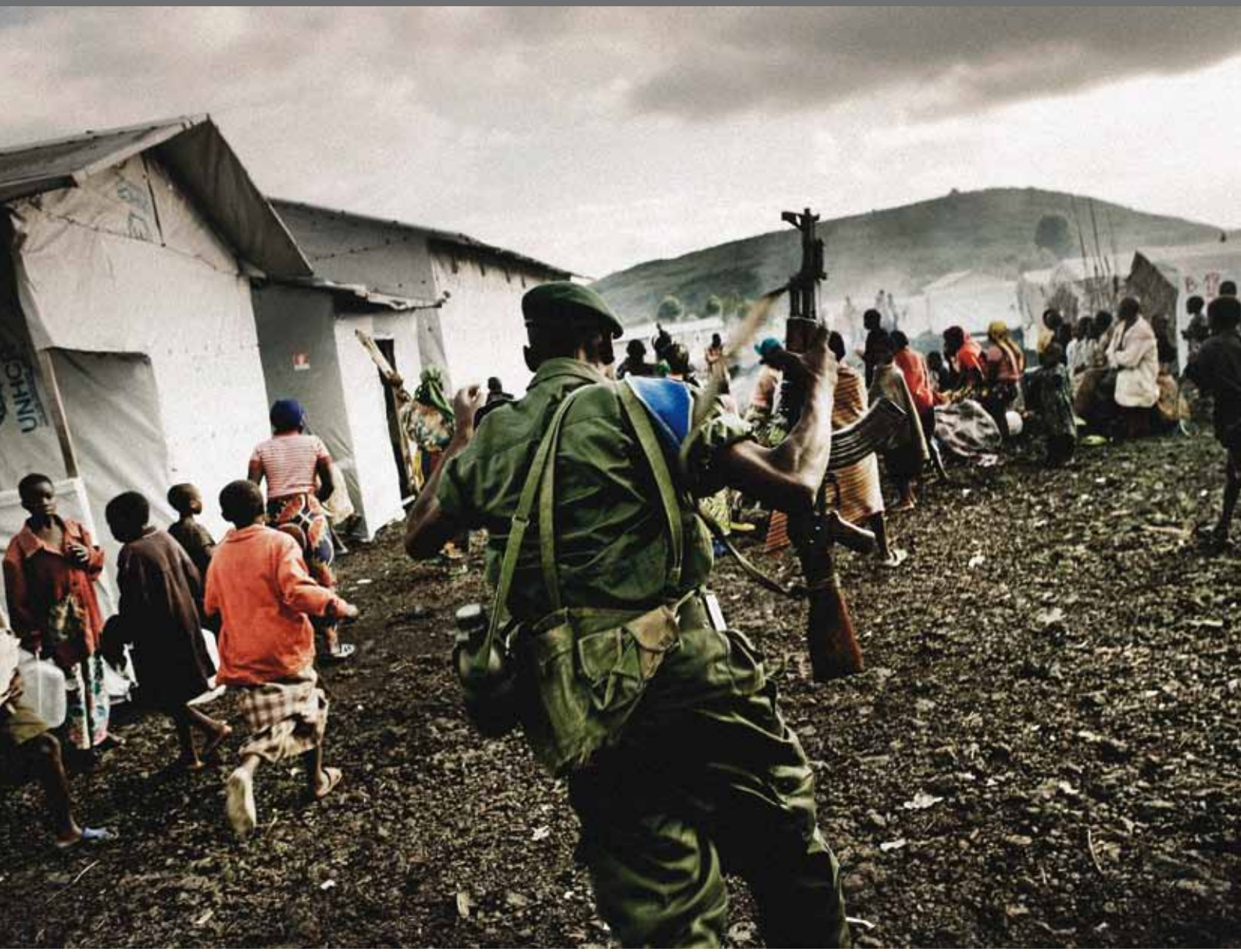
HIV/AIDS, security and conflict: making the connections



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(FMR) provides a forum for the regular exchange of practical experience, information and ideas between researchers, refugees and internally displaced people, and those who work with them. It is published in English, Arabic, Spanish and French by the Refugee Studies Centre of the Oxford Department of International Development, University of Oxford.

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from the editors

The interconnections between conflict and HIV/AIDS are more complex and less obvious than is often thought. HIV/AIDS affects the lives of many: those people caught up in conflict, those who are the protagonists in conflicts, and those whose role it is to provide security during and after conflict.

The AIDS, Security and Conflict Initiative (ASCI) undertook research over a number of years to examine the connections, to gather evidence and to advance analysis. This special supplement of FMR presents a selection of the ASCI case-studies alongside a number of other articles on the subject which were submitted in response to an FMR call for articles. All 27 ASCI studies are listed on the back cover.

We would like to thank our Guest Editors, Pam Delargy of UNFPA and Jennifer Klot and Dana Huber of SSRC, for all their work and assistance in the preparation and production of this special supplement of FMR. We are grateful to both SSRC and UNAIDS for their financial support for this supplement.

The English edition is online at http://www.fmreview.org/AIDS/ It is also being published in French (which will be available online at http://www.migrationforcee.org/SIDA/).

Best wishes

Marion Couldrey and Maurice Herson
Editors, Forced Migration Review

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Kibati camp for displaced people, DRC.
Christian Als www.christianals.com

People displaced in conflict (and on return home) often find themselves in contact with people carrying weapons in various guises. Equally, people carrying weapons are themselves generally mobile, whatever their relation to a conflict or its aftermath. In particular, members of security forces in situations of forced displacement can be agents of positive change in relation to HIV and AIDS – or part of the problem.

Vulnerable mobile populations overlooked

Leo Kenny, Manuel Carballo and Thobias Bergmann

Many countries have been seemingly overwhelmed by the speed with which the HIV epidemic has spread and its impact on forced migrants and other mobile populations.

Millennium Development Goal 6 (MDG 6)[1] seeks improved access to HIV prevention services and AIDS treatment, care and support, and halting and reversing the spread of the HIV epidemic by 2015. Universal access to HIV/AIDS services can only be achieved if the global effort to scale up HIV prevention, care and treatment includes such highly vulnerable populations as the estimated 200 million people affected annually by humanitarian crises (and, frequently, by the ensuing displacement), the approximately 50 million uniformed services personnel, and regular and irregular migrants. UNAIDS has created a new Outcome Framework[2] to galvanise support for key objectives which include reducing sexual transmission of HIV, improving access to treatment, social protection, empowering young people and combating gender-based violence. UNAIDS is promoting the strong partnerships that can deliver results on the ground.[3]

Meeting MDG 6 will not be easy for a variety of reasons. At the end of 2008, only 42% of people in need of treatment were receiving anti-retroviral therapy. While this represents a significant increase over the previous year's coverage of 33%, reaching all those still in need of antiretrovirals will require a major reallocation of human, financial and logistical resources. Countries will need to take a more comprehensive view of demographic realities in order to ensure inclusion of IDPs, refugees and migrants.

Mobile populations

Among those who have traditionally not been reached by HIV (as well as other health) interventions, mobile populations rank especially high. These vulnerable groups are growing in both number and diversity and comprise a varied mix of people forced to move as a result of war and natural disasters and people who move in search of work and economic opportunities. Differences between refugees and IDPs are not only limited to legal status, but also to living conditions and socio-economic opportunities, depending, for example, on whether people are living in camps or not, which can in turn affect their ability to integrate into the host community.

There are also millions of people who are typically referred to as economic migrants, but who also vary widely in terms of their status, how they move and how they are received. Some move officially, and are known as regular or documented migrants; they have a type and degree of access to health care that unofficial or irregular migrants, who are not documented, and are often smuggled or otherwise travel under difficult conditions, do not benefit from.

In coming years, changing climatic patterns and environmental conditions are expected to displace many more people,[4] and this will add massively to the demographic, social and cultural complexities confronting health planners and those responsible for designing HIV programmes.

What all of these forms of human movement have in common is that the backgrounds people come from, the conditions under which they move, and the ways in which they are received and resettled (even for temporary periods) can influence both their physical health and their psychosocial well-being, and can affect patterns of incidence of HIV, TB and other diseases. If the gap between rich and poor countries, and between rich and poor people, continues to grow and as transportation and information options improve, the speed with which people move will increase – and this in turn will impose on governments an ever greater need for pro-active planning, flexibility in health policy and rapid response capacities.

Due to the circumstances of their movements, forcibly displaced populations, as well as migrants, can be at a higher risk of gender-based violence, including rape, which in turn can increase the risk of HIV infections. Combating sexual violence which is a serious violation of human rights in itself, is therefore also a key priority in order to prevent HIV transmission and to protect the rights of mobile populations, especially – but not only – in conflict settings. It is crucial that uniformed services, such as militaries and peacekeepers, are targeted not only with HIV services (as they are highly mobile groups themselves) but also as agents of change, to combat gender-based violence and the spread of HIV.

The health and human security of migrants and refugees, however, are also a function of the extent to which migrants have access to, and are able to use, health and social services in the countries they pass through and settle in. In some cases this is influenced by legal and administrative requirements, while in others it may be more a function of social, cultural and linguistic factors. In most situations it is a mix of all of these factors and more.

In principle, the right of refugees and asylum seekers to health care and to HIV services is protected by international conventions, and documented migrants are also likely to be assured of access to the same health care as nationals. The extent to which undocumented migrants are able to or feel free to access services, including for HIV, in the countries where they live and work varies considerably. In general, undocumented migrants have come to constitute a particularly marginalised group in most parts of the world, and have far more limited

IRIN/Manoocher Deghati

access to health care services than other types of people on the move.

Many countries have not had the time or the insight to develop the policies and programmes needed to reach newcomers adequately. Others have simply chosen to neglect the question of HIV and mobile populations, in some cases assuming or hoping that people will not stay for long, or that the needs of newcomers will prove to be no different from those of their host populations. As a result, migrants and refugees are being overlooked everywhere, even though they may be made all the more vulnerable to HIV because of the work they do and the type of lives they are forced to live

Today the question of how to achieve greater and better access to prevention, care and treatment for HIV looms large. It is unlikely that MDG 6 will be met without far more outreach to all forms of displaced populations and migrants, regardless of their status, and to the uniformed services that in many cases interact with them. Specially tailored programmes to ensure universal access to vulnerable groups must become an integral part of national HIV policies and strategies, and a key item on the agenda of the international community.

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1. To combat HIV/AIDS, malaria and other diseases. http://tinyurl.com/MDG6-disease

2. Joint action for results: UNAIDS Outcome Framework, 2009-2011, available at: http://tinyurl.com/UNAIDS-OutcomeFramework

3. Partnerships especially with WHO, UNHCR, UNFPA, WFP, UNICEF, UNDP, UNODC, ILO, IOM, and ICMHD.

4. See FMR 31, Climate change and displacement at http://www.fmreview.org/climatechange.htm and in particular 'Health challenges' by Manuel Carballo, Chelsea B Smith and Karen Pettersson at http://www.fmreview.org/FMRpdfs/FMR31/32-33.pdf

Forced migration and HIV/AIDS in Asia: some observations

Nafis Sadik

Although most of Asia has not suffered from a generalised HIV epidemic, there is reason to be concerned about how forced migration and economic crisis-related migration may increase the risks.

A thorough discussion of how and why forced migration can increase risks of HIV transmission in the region would require reviewing a myriad of social, cultural, economic and even physiological dynamics. So I will focus on a few issues of particular relevance – HIV in humanitarian settings, security-related programme developments, and the special needs of the millions of Asians who, out of desperation, find themselves exploited and unprotected as labourers in foreign lands.

In my capacity as Special Envoy, I have advocated for stronger prevention, better care, and destigmatisation of HIV/AIDS throughout the region. I have also worked for the recognition that migration within and outside the region plays an important epidemiological role and that there must be much greater attention paid to the rights, needs and protection of migrants. Over the past decade, there has been significant progress in HIV awareness and adoption of ever more progressive and effective policies and programmes by many governments. A good example of recent change is the lifting of immigration restrictions based on HIV status by China, setting a good example for other countries.

But there remains much room for improvement when it comes to widespread establishment of effective, rights-based policies and programmes for HIV prevention and care. There are particular needs for more attention to those at risk due to being displaced. There are millions of Asians who have left their homes and areas of origin and are living, often without their families or other social support, in new communities. Many are facing circumstances which make them more vulnerable to contracting HIV while at the same time they have lost access to information and means of prevention.

Over the past decade there has been a great deal of conflict-related displacement in the region. Civil war or insurgencies in Afghanistan, Nepal, Myanmar, Sri Lanka, Indonesia, Pakistan, India and the Philippines and across Central Asia have created large numbers of refugees and IDPs who have required humanitarian support. Although HIV prevention, as a part of the minimum package of reproductive health services, was adopted as a critical component of humanitarian response in 1994[1], resource constraints and social and cultural factors have impeded universal access to information and means of prevention among these populations. (It should also be pointed out that for some people the first information they ever received on HIV was from humanitarian agencies.)

Some types of conflict or displacement have brought much more particular risks of HIV infection. For example, long years of refugee

camp life and lack of employment or recreational opportunities have contributed to intravenous drug use in Afghanistan and Pakistan border areas; this is a driving factor in the epidemic in these countries just as it is in Central Asia. The destitution of Burmese refugees in Thailand has led to widespread 'survival sex' which has driven the infection in that sub-region. The sexual violence used as a weapon of war in Timor Leste, Central Asia, Sri Lanka and other conflicts has undoubtedly increased HIV risks. And although it is often not considered an armed political conflict, the horrific levels of social and interpersonal violence in Papua New Guinea are also thought to be important factors in the epidemic there. Throughout the region, there is not only need to ensure that HIV prevention and care services are provided for displaced populations but there is also need for serious analysis of the HIV impact of the conflicts and for the inclusion of the special needs of the displaced in every national AIDs action plan.

The Asian region suffers more natural disasters, especially floods and earthquakes, than any other region in the world. The displacement of millions due to such events is a regular annual occurrence. In many places, such as Pakistan, Indonesia and Sri Lanka, populations have suffered both conflict- and disaster-related devastation. In addition to the trauma of the disaster and the difficulties of living in temporary shelter, the loss of livelihoods and assets accompanying natural disasters can affect families and communities for years, leaving them destitute and vulnerable to sexual exploitation or even trafficking. There is some evidence that domestic violence also increases in post-disaster periods. All of these are risk factors for HIV infection. While provision of HIV education and basic prevention measures, including condom distribution, are part of the minimum standards for humanitarian response[2], full implementation of these standards has not been accomplished due to resource constraints, or stigmatisation, or both.

HIV and the security sector

Many Asian countries have been leaders in the area of HIV and security. Thailand and India were among the first countries to recognise the need to provide comprehensive HIV prevention programmes within the security sector (national militaries, police and other uniformed services) and they have shown the way for many other countries in the world. The Thais, as in so many other aspects of HIV prevention, pioneered peer education and condom distribution programmes for uniformed services. The MAITRI programme in India was one of the first programmes established to support military families and dependents, not just individual members of the military, with comprehensive health and HIV education and counselling as well as other social support.[3]

With the support of UNAIDs, UNFPA and others over recent years, there has been good progress in the region among national uniformed services, groups who are important both because of their risk factors (age, mobility, etc) and because they can serve as role models in their societies. It is particularly important that members of militaries and police in the region have both knowledge of HIV and prevention skills because Asian countries provide a very large proportion of international peacekeeping forces and so are deployed all over the world, including to places with higher HIV prevalence. Pakistan, Bangladesh and India are the largest contributors to UN peacekeeping, sending on average over 10,000 peacekeepers a year; Thailand, Nepal, Australia, New Zealand, China, Indonesia, Fiji, Malaysia, Nepal, Sri Lanka, Mongolia, the Philippines and Korea are also significant contributors. Since the adoption of UN Security Council Resolution 1308 on HIV/AIDS in 2000, the UN has established HIV prevention programmes in all peacekeeping missions. For some troops from countries without national programmes, their first exposure to reliable information is during peacekeeping deployment.

Migration due to economic and social crises

Within migration studies there has long been a hearty debate about the 'push' and 'pull' factors determining individual decisions to migrate and what constitutes forced or voluntary migration. Traditionally, labour migration has not been considered as forced. I would like to challenge that notion in the case of much of the labour migration within and from Asia today. The severity of the economic and social crises in the region has led thousands to leave their families and homes to go to foreign lands and engage in low-wage labour with little protection from exploitation, no legal rights and inadequate access to even basic social services. This must surely be considered not as a lifestyle choice but as something forced on the migrant by circumstance. The conditions of such migrants are such that their risks of harm, including of HIV infection, are multiplied. And yet their resources for protection are sparse. This is an area in which I would like to encourage much more documentation and analysis to inform policy advocacy.

Thousands of Asian women are working as domestic workers or in the service industries, particularly in the Middle East and Europe, and there are daily and sometimes horrific examples of exploitation and sexual abuse, including HIV infection. Yet these workers are without consular oversight or legal protection in the countries where they are working.

To compound the problem, if they do become infected with HIV, they are deported and thus left without a livelihood. This has implications not only for their own health but for their families and communities and countries of origin who must then provide care. In some cases in the past, when the country of origin has protested at such policies, the receiving country has simply responded by suspending or restricting labour migration from that country, which can have enormous negative consequences for others seeking work.

At the same time, many countries in and outside the region require HIV testing for work permits and immigration (and sometimes even for a visit) and reject applicants based on their HIV status. So even if a person is under treatment and healthy, they will not be able to take up a job for which they are qualified. This stigmatisation and the denial of travel and employment rights are issues that have been taken up

by UNAIDs and the International Labour Organization as well as by parliamentarians seeking to change laws in countries such as India and Australia. While these are welcome developments, there remains much to do in the region both to alleviate the conditions leading to such migration and to protect the health and well-being of those who are forced to work abroad.

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1. UNHCR, WHO and UNFPA, *Field Manual on Reproductive Health for Refugees*, 1996. Now revised as *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010. www.unfpa.org/emergencies/manual/

2. Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, 2004. www.sphereproject.org and IASC, *Guidelines for HIV/AIDS Interventions in Emergency Settings*, 2003.

3. http://www.maitri.org.in

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

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

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

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

Summary of findings

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

Key recommendations

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

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

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

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

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

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

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

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

8. ASCI identified the pressing need for HIV/AIDS interventions within the police and other law enforcement institutions. Law enforcement practices, especially in relation to stigmatised and criminalised activities and groups, influence the trajectory of national and regional epidemics. Issues such as harm reduction for injecting drug users, policing sex work and trafficking, and decriminalising homosexuality are all central to this. A global programme of collaborative learning on law enforcement and HIV/AIDS is recommended.

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

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

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

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

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

Conclusion

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

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

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

1. ASCI is a research partnership between the Social Science Research Council (New York) and the Clingendael Institute for International Relations (The Hague).
2. See http://tinyurl.com/ASCIreport4

HIV in emergencies – much achieved, much to do

Paul Spiegel

Entrenched misconceptions about HIV/AIDS in humanitarian emergencies have been refuted but there is still work to do to ensure that HIV is adequately and appropriately addressed.

A decade ago, HIV/AIDS in humanitarian emergencies was not considered a priority in either the HIV or humanitarian worlds but was rather thought of as a development issue. Provision of antiretroviral therapy (ART) for displaced people was thought to be inappropriate, and adequate guidelines for HIV in humanitarian situations did not exist. Furthermore, it was widely believed both that conflict exacerbated HIV transmission and that displaced people brought HIV with them and spread the virus to host communities.

Progress

The HIV and humanitarian worlds have come far in the past decade. In 2002, two large UN agencies – the World Food Programme and UNHCR – became co-sponsors of UNAIDS and started advocating for HIV strategies, policies and interventions to be included in humanitarian emergencies. Around the same time, Médecins Sans Frontières (MSF) began advocating for and providing ART to persons affected by humanitarian emergencies. In 2003, the Inter-Agency Standing Committee (IASC) created a Task Force for HIV in Humanitarian Situations.[1] These efforts, and many others, have helped ensure that HIV is no longer considered solely a development issue but an important matter to be addressed in humanitarian emergencies.

HIV is a complex and 'political' disease that clearly goes beyond the health sector. Human rights and protection interventions are major components of addressing HIV in all populations, especially those affected by conflict. A decade ago, it was commonly believed that HIV transmission would increase in areas affected by conflict. Since refugees and IDPs would be displaced from these same areas, they would have a higher HIV prevalence than surrounding host communities, and consequently be vectors of transmission. Although counter-intuitive, research has shown this generally not to be the case, although it is context specific.[2]

Factors in reducing HIV transmission during conflict compared with what would normally be seen during peacetime include isolated and inaccessible populations and reduced urbanisation as well as reduced migration and transportation due to insecurity and destruction of infrastructure. This knowledge has helped reduce stigma and discrimination towards HIV-affected persons displaced by conflict and has been used to advocate for their inclusion in policies, strategies and funding proposals. It has also highlighted the need for the international community to focus on post-conflict situations.

MSF led the way in advocating for access to ART for all as a basic right. It showed that provision of such essential medications and acceptable levels of compliance were possible in conflict and post-conflict settings. ART policies and guidelines followed. Although not always simple, the continuation of ART in the acute phase of conflict and the need to provide more comprehensive HIV services including ART in protracted and return situations is now considered the norm.

Therapeutic nutritional centre in Cameroon where both local populations and refugees with HIV/AIDS and malnutrition are treated.

Shortcomings

The HIV and humanitarian communities, as well as governments, still have a long way to go to ensure that HIV is adequately and appropriately addressed in humanitarian emergencies and post-conflict settings. In 2001, the UN General Assembly Special Session passed a Declaration of Commitment on HIV/AIDS[3] which aimed by 2003 to "develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection; and where appropriate, factor HIV/AIDS components into international assistance programmes".

Sadly, this commitment has yet to be met. Refugees and IDPs are generally excluded from national HIV strategic plans or proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria. In its 2009 annual list of the top ten ignored humanitarian crises, MSF included inadequate donor support for AIDS treatment.[4] Besides the legal obligations of those governments that have signed the 1951 Refugee Convention, there is a public health imperative to include all groups affected by conflict in HIV national strategic plans and funding proposals as well as to develop contingency plans. It is essential for their inclusion if we are to achieve universal access and other targets set out in Millennium Development Goal 6.[5]

Human rights violations have also not been sufficiently addressed in humanitarian emergencies and there have been few protection interventions. Gender-based violence – and its individual and community effects on the transmission of HIV – is an important issue that still needs much more political commitment and practical field intervention. Mandatory HIV testing for refugees, migrants and other displaced persons is still relatively common in many parts of the world and those found to be positive are routinely forcibly returned (refouled). The recent US decision to stop undertaking mandatory HIV testing for refugees accepted for resettlement is welcome and it is to be hoped that other governments will follow its lead. This measure needs to be augmented by robust public health measures to ensure that on their arrival in the US resettled refugees have the opportunity to choose to be tested and receive ART if indicated.

In 2005, UNAIDS developed the Technical Support Division of Labour[6] in an attempt to simplify HIV support at the country level and provide improved accountability. This development was followed by the humanitarian reform process that aimed to provide increased predictability and accountability to conflict and natural disaster response.[7] Unfortunately, the two processes were not coordinated and there has never been sufficient clarity on HIV response in non-refugee humanitarian situations. Thus, HIV coordination and response in humanitarian emergencies (and natural disasters) remains incoherent and ad hoc. The current revision of the UNAIDS Division of Labour provides an opportunity for clarity in coordination and response of HIV in non-refugee humanitarian emergencies. This needs to be coordinated with the IASC at a senior level to ensure that the humanitarian reform process also addresses this issue in a clear manner that will result in an integrated HIV response within the cluster approach.

Conclusion

Recent research has confirmed the effectiveness of HIV interventions in post-conflict settings. As societies begin to recover from the trauma of conflict, factors that did not exist during conflict – such as the rebuilding of infrastructure, increased urbanisation, wide-scale migration and an improving economy – may provide a fertile environment for the spread of HIV. At this stage, as well as during the 'transition' phase between emergency and post-emergency settings, when a breach in funding mechanisms for HIV interventions may occur, appropriate funding and interventions for HIV in post-conflict settings are neglected priorities.

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1. http://www.aidsandemergencies.org/cms/

2. Spiegel P B et al. 'Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan African countries: a systematic review', *Lancet* 2007;369 (9580); Plewes K et al. 'Low seroprevalence of HIV and syphilis in pregnant women in refugee camps on the Thai-Burma border'. *International Journal of STD & AIDS* 2008;19 (12); Strand RT et al: 'Unexpected low prevalence of HIV among fertile women in Luanda, Angola. Does war prevent the spread of HIV?' *International Journal of STD & AIDS* 2007;18 (7).

3. http://tinyurl.com/UNGA-Commitment

4. http://tinyurl.com/MSF-TopTen-2009

5. http://www.un.org/millenniumgoals/aids.shtml. See also article pp3-4.

6. http://www.unaids.org/en/Cosponsors/DivisionOfLabour/default.asp

7. See FMR 29 Humanitarian reform: fulfilling its promise? http://www.fmreview.org/humanitarianreform.htm

HIV, refugees and conflict-affected populations in Asia

Ann Burton

Evidence-based experience, good assessment and a readiness to adapt programmes to local realities have been key to tackling HIV in Asia.

UNHCR's HIV activities in Asia – which began in earnest in 2005 – were based on approaches outlined in its 2005-2007 and 2008-2012 Strategic Plans but adapted to accommodate factors specific to the Asia region. These included the low-level and concentrated nature of epidemics in most countries (with HIV infection concentrated around unprotected paid sex, the sharing of contaminated injecting equipment and unprotected sex between men); the fact that most Asian countries are not signatories to the 1951 Refugee Convention or its 1967 protocol[1]; and the significant population movements within the region (both conflict and non-conflict related).

Achievements over the last five years include:

- expanded access to prevention services[2] for most-at-risk populations with 55% of sites in 2009 addressing at least one key population – an increase from no sites in 2005
- increased access to key HIV services for refugee populations in 66% of sites
- considerable progress in the availability of antiretroviral treatment (ART): of those countries hosting more than 10,000 refugees in the region, 100% of them offer refugee populations access to ART where it exists for local populations
- increased availability of HIV-related information with 66% of refugee sites at the end of 2009 having standard HIV information systems in place
- expanded evidence base on HIV vulnerability and risk amongst conflict-generated internally displaced persons (IDPs).

While progress has been made, experience in the region has highlighted a number of challenges at different stages.

Emergency phase

It is now widely recognised that for HIV to be adequately addressed in humanitarian settings interventions need to begin early on in the response and expand as the situation stabilises. However, there is inadequate attention given to the need to prioritise interventions based on what is feasible and what will have the most impact in the early phase – given competing priorities. Furthermore, there is still inadequate understanding of the multisectoral response to HIV in the region and the role that key sectors such as shelter, protection, water and sanitation have in reducing HIV vulnerability and risk.

In addition, existing national HIV programmes in countries affected by conflict and displacement are often slow to adapt to the changes associated with displacement and the need for prioritisation. This is compounded by the fact that those UN agencies with a development focus are often unwilling to adapt their long-term strategies to meet the more immediate and rapidly evolving needs. Finally, but crucially, in conflict situations insecurity invariably hampers response. In 2008 in Sri Lanka the national HIV quality assurance scheme for HIV testing had still not extended to the conflict-affected North-East although all other regions of the country were included.

Post-emergency phase

In the post-emergency phase there are other challenges. Refugees and IDPs are often not included in National HIV Strategic Plans (NSPs). In relevant countries in Asia in 2006 45% of NSPs mentioned refugees but only 18% mentioned activities for refugees; and only two of the nine countries with more than 10,000 IDPs acknowledged them in their plans – and none had activities directed towards IDPs. Displaced populations, especially refugees, often lack advocates during strategic plan development processes and development of other national HIV initiatives, such as Global Fund Proposals, as they are viewed as politically sensitive. However, some progress is being made, with both Sri Lanka and Thailand acknowledging displaced people in their more recent NSPs.

Considerable experience has been accrued globally and in the region on addressing HIV in camp-based refugee settings. In Asia there are large numbers of refugees who are living in non-camp settings including in urban areas – such as in Iran and Malaysia. Refugees in such settings present many challenges in the delivery of services, including HIV services. They are often scattered geographically, have minimal contact with UNHCR or its partners, and receive health and HIV-related services from a number of providers, including private providers. Information about the services they access and their specific HIV and health-related needs is often scarce. As a result a variety of interventions is needed to reach non-camp, including urban, refugees.

Improving access to sexual violence services has been challenging. Access to specialised centres may be limited for refugees and other forced migrants and where national laws oblige health providers to report survivors of sexual violence to the police, health providers are unable to offer confidential services. Furthermore, national gender-based violence programmes are often very poorly developed. Post-exposure prophylaxis for HIV is not part of many countries' responses to sexual violence.

While significant progress has been made in programming this has not been matched by progress in behavioural or biological surveillance in those most-at-risk amongst conflict-affected populations in the region. In refugee and related settings it has been difficult starting HIV interventions for most-at-risk groups because of factors such as the closed nature of many settings and the considerable stigma and discrimination these populations face over and above their displacement status. Other challenges include small sample sizes and ethical considerations. Furthermore, there is a dearth of both biological and behavioural data amongst urban refugees. Progress has been made, however, in qualitative approaches such as participatory learning and action which has been used to identify risks and vulnerabilities associated with sex work amongst urban refugees in Delhi. Rapid assessments have been done in relation to substance use in Thailand and Pakistan, resulting in improved programming.

A refugee visits community health worker Zafor Ullah (right) in his home for a fresh supply of condoms, Nayapara camp for Rohingya refugees, Bangladesh.

Lessons

Inclusion of refugees and displaced populations in national HIV initiatives is a necessary first step but as an isolated measure will not guarantee access to services. Advocacy for the inclusion of refugees and related populations in national HIV initiatives is a key component of UNHCR's HIV programming at country level. However, while a national policy may be supportive of refugee access, refugees often have special needs which may hinder uptake of services. These include different language and cultural backgrounds from those of the host community, lower literacy levels than the host community, fear of harassment and arrest, and uncertainty about their rights. All of these need to be taken into consideration.

HIV prevention activities amongst refugees and other persons of concern in the region must target those most at risk of infection. Refugees and IDPs are often seen as homogeneous populations whereas, like all populations, they contain persons with varying degrees of risk. In keeping with regional guidance on addressing HIV in low prevalence/ concentrated epidemic settings, HIV interventions for persons of concern in Asia need to target those most at risk of infection, such as sex workers and their clients, men who have sex with men and injecting drug users. General population interventions such as mass awareness activities, though appearing to reach more people, will have less impact.

It is possible to reach marginalised and highly stigmatised populations with HIV-related services in a closed setting, even in the presence of strong socio-cultural constraints. Building trust with the concerned community may take time but is necessary to facilitate uptake of services - and it is essential that this trust be maintained. Working with peers and trusted community gatekeepers will assist in reaching most-at-risk persons.

Proper assessment of HIV risk and vulnerabilities and the operating environment in each population of concern is necessary to design appropriate interventions. Each context is different and a 'one size fits all' approach is not appropriate. Local assessment is needed to determine which interventions are most appropriate and why, and to identify possible barriers to planned activities and potential solutions.

Innovative approaches in Malaysia

Malaysia hosts over 70,000 refugees, mostly from Myanmar/Burma, who are mainly scattered throughout the Klang Valley area (incorporating Kuala Lumpur). At the end of 2009, there were 124 refugees receiving ART supported by the Ministry of Health and UNHCR. Following expressions of concern regarding adherence to ART amongst refugees, a number of measures to support refugees on ART and to facilitate their adherence to treatment programmes were introduced, with considerable success.

A multi-level approach at home, community and facility level was adopted. Home interventions included dosage boxes, mobile phone alarms and support for adequate nutritional intake. Community activities included assigning people living with HIV to a community counsellor, mobile phone 'hotlines' and treatment support groups. All refugees access services at one hospital, Sungoh Bulai, in Kuala Lumpur, which has structured its services to meet the needs of refugees. All new and follow-up appointments for refugees, for example, are scheduled on the same day of the week to facilitate access to interpreters in appropriate languages and trained counsellors.

Following these interventions, medical providers reported that average viral load suppression in refugees had improved significantly and was comparable to nationals. Refugee satisfaction with the support received was high.

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1. Signatories to the 1951 Refugee Convention in Asia include Cambodia, China, the Philippines and Iran.

2. Including STI management, male and female condom provision, clean needles and syringes, peer outreach, peer support groups and behaviour change communication.

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

Priya Marwah, Pamela DeLargy and Lara Tabac

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

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

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

Yet there are also unique opportunities in post-conflict environments to mitigate such an epidemic. Ex-combatants (either in formal militaries or non-state armed groups) and women and children associated with armed groups are considered especially at-risk groups for HIV due to their age range, their mobility patterns and their conflict experiences. The risk-taking attitudes of members of armed forces and groups are also known to increase their probability of exposure. If sexual violence or other forms of sexual exploitation have been factors in the conflict, then female ex-combatants, women associated with armed forces and groups, dependants and abductees are also frequently at high risk of HIV and other sexually transmitted infections (STIs). Disarmament, demobilisation and reintegration (DDR) processes, which help reintegrate ex-combatants to civilian life, can be designed such that they both help identify and diminish HIV risks and also reinforce national and local prevention and care programmes.

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

HIV awareness in DDR programmes

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

By 2000, when the Security Council passed Resolution 1308 on HIV and Security[2], it was widely recognised that post-conflict periods were critical points for HIV interventions. The Resolution emphasised the importance of HIV awareness and prevention within both peacekeeping and demobilisation processes. In the same year, Security Council Resolution 1325 on Women, Peace and Security[3] emphasised the specific HIV risks faced by women and girls in conflict situations and brought attention to the previous neglect of women, girls and children in

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

Integrated DDR Standards

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

Since the adoption of the standards, the Gender, HIV and DDR Sub-Working Group[5] has been working with a number of UN missions to address gender and HIV within DDR processes. Funding was secured from UNAIDS, the British and Irish governments and the European Commission to implement HIV-DDR programmes in several countries, including Sudan, Côte d'Ivoire, Nepal, Colombia, Liberia, Sierra Leone and DRC. While political and operational factors heavily determine the progress of DDR overall and impede its smooth progress, there has been significant progress in use of the guidelines and in 'mainstreaming' HIV considerations into many DDR processes.

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

Lessons, achievements and challenges

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

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

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

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

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

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1. http://tinyurl.com/UN-LiberiaDDR
2. http://tinyurl.com/SCR1308
3. http://tinyurl.com/SCR1325
4. http://www.unddr.org
5. chaired by UNDP and UNFPA and including DPKO, UNIFEM, UNICEF, UNAIDS, WHO and ILO

Ex-combatants as entry points for HIV education in southern Sudan

Anyieth M D'Awol

Disarmament, demobilisation and reintegration (DDR) interventions provide potential avenues to help reach those who are most vulnerable to HIV transmission.

Southern Sudan has been affected by conflict since the 1950s. The Comprehensive Peace Agreement (CPA), signed on 1 January 2005, brought an end to the second civil war, and the process of development and recovery is underway. Efforts to develop coherent HIV policies, however, are in their infancy. In a vast area devoid of almost all infrastructure, the challenges are enormous. The limited data available reveal that HIV is prevalent across southern Sudan, but the exact extent is unknown.

Returning Sudanese refugees receive information on HIV/AIDS and landmines at UNHCR's way-station on the Sudanese border.

This article presents the findings of research focusing on the Sudan People's Liberation Army (SPLA) as a high-risk group which, with its close community links, is a potentially effective entry point for responsive HIV policy development during the disarmament, demobilisation and reintegration (DDR) process.

The post-conflict context

The post-conflict environment in southern Sudan is unstable and constantly changing. People are returning to the region after decades of forced displacement both internally and across borders, and many of them come from urban areas or displacement camps with better service provision. Widespread gender-based violence in both rural and urban areas has both been the cause of increased HIV infection and has posed challenges for HIV interventions. Severe gender inequalities exist, and concurrent sexual relationships exist as a result of transactional sex, inheritance of multiple wives and the encouragement of early marriage and polygamy. Scarification with non-sterile tools and the view of circumcision as taboo also increase HIV risk. Most people lack access to basic services, and infrastructure for managing HIV policies is largely absent. Interventions for HIV prevention need to be innovative and applicable without reliance on basic health services. Many southern Sudanese have never heard of HIV, or do not know how it is transmitted or prevented. Additionally, protection through behaviour change is a choice many do not have.

Accurate data on HIV/AIDS prevalence in southern Sudan is almost non-existent, though a few studies have been conducted to try to determine the extent of the epidemic in the region. One study showed that HIV prevalence is between 2 and 4% of the population, while a 1996 study at antenatal clinics suggested HIV prevalence was 5%. Amongst different tribes various names are given to HIV/AIDS, making data collection more difficult. Despite the lack of precise data, the high-risk post-conflict environment, combined with the lack of infrastructure, has presented both the necessity to establish and implement HIV prevention and mitigation policies – and the difficulties in doing so.

The SPLA – the army of the Government of South Sudan (GoSS), previously the armed wing of the main southern Sudanese rebel movement (the SPLM) – is in the process of transforming from a guerrilla army to a professional military force. Challenges during the transition include ambiguity surrounding command structures, and increased cultural variation among soldiers (as all other armed groups, based on mainly tribal identity, had to be absorbed into the SPLA). The SPLA plans to downsize through the DDR process, which presents an opportunity for HIV interventions as soldiers make the transition to civilians.

During the years of conflict, SPLA soldiers were constantly told they were the instruments for repopulating southern Sudan. Unsurprisingly, therefore, soldiers forgo protection with commercial sex workers. For their part, vulnerable and lacking a normal community life, women seek refuge with soldiers, and often engage in transactional survival sex. HIV interventions must address these realities if communities are to be able to move away from environments where HIV can thrive.

The DDR process provides a valuable opportunity to screen a high-risk group while still in DDR sites, creating a unique entry point where people who will soon be part of a civilian community can be addressed. DDR provides an opportunity for

those who are dependent on the army to receive clear, targeted and relevant reintegration opportunities and HIV interventions to encourage self-sufficiency and reduce vulnerability for themselves and others. Additional populations such as child soldiers and women associated with armed forces and groups should also benefit.

However, progress towards demobilisation of SPLA personnel has been slower than anticipated, with problems relating to staffing and technical assistance. While the CPA envisaged that DDR support would be given for 180,000 southern and northern combatants, it was reported by the UN in July 2010 that only 23,700 have completed DDR programmes[1] – and of these only 6,000 have been demobilised in southern Sudan.

The final milestone of the CPA is the forthcoming referendum scheduled for January 2011 which will determine whether Sudan is to remain one country or be split into north and south Sudan. This has become the overarching priority for all government institutions and donor communities since uncertainties regarding security and indeed risk of renewed war following the results (for unity or secession) could mean that current efforts in DDR may be undone.

> "...I don't want protection. All these years we have been suffering, we have not produced and some of our children even got lost. We need to produce children... and if we were to die, we would have died in the bush. AIDS doesn't kill..." SPLA soldier, April 2008

HIV policy development

The SPLA has made HIV prevention a priority but it is unclear if these messages have been absorbed throughout the ranks. It has a voluntary testing and counselling policy, and an HIV/AIDS Secretariat, established in 2006, which is responsible for the oversight and implementation of an army-wide HIV response. The lack of sufficient command, however, remains a challenge for the SPLA's war against HIV.

Additional attempts to create HIV policy have been met with varied success. The New Sudan National AIDS Council (NSNAC), formed to coordinate HIV policy efforts, was developed in 2001 but was unsustainable due to insufficient funding and institutional support. As a result, scattered HIV policies were generally put in place by independent NGOs, which were both short-term in focus and limited in scope. In June 2006, the Southern Sudan AIDS Commission (SSAC) was established in partnership with the GoSS at state and county levels. Both the SSAC and the SPLA have created long-term plans intended to implement HIV/AIDS prevention policies. Specifically, the SSAC has partnered with key stakeholders to develop the Southern Sudan HIV/AIDS Strategic Framework (SSHASF) for 2008-2012.

Both the SPLA and the SSHASF agree on key policy areas:

- creating an enabling environment for a sustained financial, legal and institutional framework for HIV interventions
- emphasis on prevention to reduce new infections
- care, treatment and impact mitigation to improve the quality of life for people living with HIV
- mitigating exposure to and impact of HIV among emergency-affected populations during the post-conflict and reconstruction phase
- capacity building to strengthen, decentralise and sustain a national HIV response
- monitoring and evaluation to strengthen evidence-based management of national multi-sectoral HIV response at all levels.

This response appears to be comprehensive but many challenges still exist in creating relevant frameworks and fine-tuning policies across each of these thematic areas. These difficulties include policy coordination between the SPLA and SSHASF and maintaining consistent budget allocations for the management of HIV response. In addition, it needs to be better understood that the determinants that place people at risk of HIV relate more to the socio-economic and cultural factors in people's lives than to the desire of individuals to be promiscuous or engage in concurrent relationships. For policies to be effective, the SPLA and SSAC should identify all groups that need access to HIV prevention materials, including often overlooked groups such as widows. Policies must also address the instability of the post-conflict region, with special consideration for formerly displaced people returning to the region.

Recommendations and next steps

Despite the volatile environment, there are many opportunities for HIV interventions, particularly within the SPLA, which must match their rhetoric with action. Military leadership must be at the forefront of efforts to tackle the epidemic within the institution, implementing and enforcing a code of conduct – and also protecting others associated with barracks. Funding should be consistent to implement programmes, and mandatory testing – accompanied by confidential counselling and treatment – should be encouraged for the SPLA to understand the scale of the epidemic within its forces. The SPLA can use its command structure to reach a very high-risk group, encouraging responsible behaviour and reducing new infections through discipline and a holistic approach. DDR is also an opportunity to teach new skills –in agriculture, for example – for future self-sufficiency. Only known family members should be allowed near military barracks, in order to eliminate dependency and survival sex.

Post-conflict conditions pose a real challenge and threaten to compromise progress made to date. Interventions must reach the majority and must affect behaviour amongst people with little or no access to resources. That said, the simple 'ABC' approach – Abstain, Be faithful, Condomise – will not work in the region, and HIV policies must take into account cultural practices.

The SSAC should take the lead in maintaining a political commitment to improve conditions for HIV interventions, and lobby for line ministries that affect the socio-economic drivers of the epidemic. The SSAC should identify areas where traditional behaviours are high risk, and should target groups such as

midwives, healers and chiefs as entry points to discuss unhealthy practices.

Although post-conflict analysis offered in the fuller study is non-exhaustive, it reveals a range of challenges that can weaken intended HIV policy direction if it is not evidence-driven, practical and realistic. Vulnerability to HIV/AIDS in the region is high, and many typical prevention strategies involving education, sensitisation and advocacy will have limited impacts because of gender inequalities, absence of rule of law and weak governance structures. The potential for effective HIV intervention is high; there is a large and captive audience within DDR programmes, and these individuals present important entry points for reaching many at the individual level.

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1. http://tinyurl.com/UN-ddr-southsudan

Challenges for antiretroviral provision in northern Uganda

Matthew Wilhelm-Solomon

Uganda faces major challenges to ensure the continuity and sustainability of treatment programmes for IDPs returning home.

Northern Uganda is in a phase of momentous transition. The end of hostilities between the Lord's Resistance Army and the Ugandan government in 2006 paved the way for the return of hundreds of thousands of IDPs. The challenges of treating HIV in the post-conflict phase are almost as formidable as during the conflict itself.

A 2004-05 study by Ugandan Ministry of Health suggested in 2006 that northern Uganda had an HIV sero-prevalence rate of 8.2%. There are indications based on this sample that northern Uganda has the highest rates of recent HIV incidence in the country[1], though reliable data from rural areas and camps is scarce, and the validity of the evidence disputed. In 2007, St Mary's Hospital Lacor, a surveillance site, recorded an antenatal sero-prevalence figure of 9%. Recent data from other health facilities suggests that prevalence has been increasing over the last three years.

Antiretroviral therapy (ART) to conflict-affected communities is now being promoted and viewed as feasible by governmental and non-governmental institutions in northern Uganda and internationally, including Médecins Sans Frontières (MSF) and UNHCR. However, it is important to prepare for the post-conflict transition and the return of the displaced in order to ensure continuity and sustainability of treatment programmes.

Research in northern Uganda between 2006 and 2009 into ART programmes implemented by the AIDS Support Organisation (TASO)[2], St Mary's Hospital Lacor[3] and the Ugandan Ministry of Health indicates that, for those who have been able to access it, ART is helping transform HIV infection from a terminal to a chronic illness. Antiretrovirals, and associated treatments for opportunistic infections, have brought about substantial improvements in the health of those with HIV. In addition, the frequency and intensity of stigmatisation, especially linked to fears of transmission, have declined. ART has saved thousands of lives and created new possibilities for friendship, family and productivity.

Provision of ART was started in 2002 in Gulu, the region's main urban centre, and from 2004 was extended to other towns, and from 2005, to some rural areas and IDP camps. By March 2010, there were over 22,000 HIV-positive people on ART – mostly free or at low cost – in previously conflict-affected districts.[4] High adherence rates to treatment have been shown for the TASO and St Mary's Lacor programmes, using community-based strategies.

Over the period of return, data does not show a significant impact on treatment adherence for TASO and St Mary's, though field workers claim that food scarcity may be affecting the adherence of some patients. However, there has been a definite impact on patient retention and missed appointments, which has strained resources. Adherence and patient retention data is mostly lacking for state health services in northern Uganda, though interviews suggest similar problems.

Uncertainties for patients and providers

Many of those living with HIV faced significant anxiety around the return period, often choosing to remain in camps or towns as long as possible. The burdens of return may be severe and include reconstructing homesteads, restarting agriculture, moving to areas where service provision is weak, and the withdrawal of food assistance. As Nighty Acheng, an HIV-positive woman in Pabo camp, explained in 2008, "when we go back to the village you don't have the strength to dig anymore. And there are cases where some of us have been neglected by our families."

ART requires rigorous life-long adherence. Unmanaged interruptions to treatment can lead to treatment failure, as well as the emergence of drug-resistant viral strains. Monitoring adherence was relatively simple in displacement camps. Many people could be reached easily and even during the conflict provision was rarely interrupted. Support groups were also created in the camp environment, providing networks of care.

Return movements, and the opening of trade routes, have made continuity

of treatment much more complicated. The scattering of the population and increased distances between patients and their nearest health centre have created difficulties for patients and providers. Some are so sick they cannot come to collect their medication and those who have lost all their relatives have nobody to collect their medication for them. All programmes have had to contend with patients who miss appointments or who give up attending.

The potential challenges of the return period for HIV treatment were generally under-estimated during the conflict. For instance, Ministry of Health ART was expanded to some rural health centres in 2005 with no contingency plan for return and often little capacity for treatment monitoring. Coordination between programmes and sharing of experience were also problematic. The Health, Nutrition and HIV/AIDS cluster meetings chaired by the World Health Organisation focused on the more immediate challenges of transition, such as the hepatitis E and malaria outbreaks, and were not appropriate forums to develop longer-term approaches or monitoring capacity for patient retention in HIV as well as TB programmes. State health services have suffered from severe shortages of staff and drugs as returns have placed more strain on services.[5]

Selected rural health centres with ART provision were supported by different branches of MSF, which included community support, although these faced staff and supply-line challenges once MSF withdrew. In late 2006, the five-year Northern Uganda Malaria AIDS/HIV and Tuberculosis Program (NUMAT) was established to assist state health services with supply lines, community support and the decentralisation of treatment. This was a welcome development though in places community support started after the return movements. Treatment is still unavailable in a number of rural health centres, though coverage has improved significantly since the cessation of hostilities.

Even relatively well-resourced NGOs have come under severe strain. TASO's strategy of home-based provision and monitoring using motor cycles was very effective when populations were static – but came under strain when patients moved further away. In the first two quarters of 2008, over 10% of patients were lost in each quarter. However, a strategic shift to using community members to monitor and track patients, as well as decentralised treatment distribution points in rural areas, allowed TASO to radically reduce lost patients to under 1% in the second half of 2008.

St Mary's Hospital Lacor shifted to a community-based monitoring strategy from the outset of their programme, with the help of the community organisation Comboni Samaritan – a strategy which has proven very effective in ensuring continuity of treatment. Extensive networks of community-based treatment monitors were chosen from different geographic areas and few patients were lost during the return period, never exceeding 2% in a quarter. The success of St Mary's shows that extensive community networks can be as effective as decentralising treatment provision in ensuring ART continuity.

Community-based adherence monitors employed by most HIV programmes are themselves mostly HIV-positive and are also battling with the difficulties of transition. The small stipends provided are often inadequate to cover even their time, and community monitors across programmes said they were unable to follow patients as rigorously as in the camps. One of them, Simon Omara of Comboni Samaritan, reported, "the major difficulties I face are that the distances are far, most people take their medication at eight o'clock when it is already dark, and you may find it has started to rain. You may encounter drunkards on the way who disturb you, and another problem is if you have to cover a long distance that makes you weak."


Matthew Wilhelm-Solomon

A newly formed HIV support group in a return area of Oyam district, Uganda.

While some organisations like TASO are shifting to livelihoods programmes, there were few programmes supporting those with HIV in the transition from displacement to return. All the programmes also have HIV prevention components to them, although the St Mary's programme do not provide condoms, thereby limiting patients' reproductive health options particularly in rural areas where other services were not easily available.

Recommendations

Experience in northern Uganda is of relevance to other situations in which large numbers of people have been displaced for long periods. Among the lessons to be learned is the importance of working with national health ministries and NGOs to:

- acknowledge that post-conflict return processes can pose significant challenges to HIV treatment programmes as a result of increased distances between

service providers and often mobile HIV-positive populations

- acknowledge the reality that state-provided ART programmes are under-resourced
- decentralise treatment and fund community-based support to help ensure continuity of treatment
- recognise the burdens placed on community-based ART adherence monitors, especially those who are themselves HIV-positive
- target support to HIV-positive patients so that while they are struggling with transition they are also helped with treatment adherence
- use community workers to help patients overcome anxiety over the return period through providing information about treatment options
- ensure that data collection in post-conflict situations focuses not just on adherence but also on patient attrition.

In addition, data from well-resourced non-governmental programmes cannot be viewed as representative of all programmes; there is a need in northern Uganda, and elsewhere, for an assessment of more poorly resourced state antiretroviral programmes. While treatment provision can be successful to conflict-affected communities, the transitional phase poses a new set of challenges which have affected patients and may have increased the chances of drug resistance developing.

Those living with HIV in northern Uganda – as in other post-conflict contexts – show a remarkable capacity to adapt to the difficulties of return by forming new support groups. However, they remain vulnerable and live in fragile circumstances. The long-term sustainability of ART relies on the fostering of strong communication and support between donors, civil society, national health authorities, patients and local providers.

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Gendered violence and HIV in Burundi

Hakan Seckinelgin, Joseph Bigirumwami and Jill Morris

Pre-existing gender relations changed for the worse during the conflict and interventions to promote disarmament, demobilisation and reintegration (DDR) failed to address the dynamics which shape the spread of HIV.

Conflict has scarred Burundian society since independence in 1962, although in recent years a still fragile peace has emerged from a series of ceasefire agreements signed by armed groups.

A series of interviews with men, women, youth, ex-combatants, IDPs and sex workers highlighted the extent of conflict-related changes in Burundian society and how HIV prevention efforts must take these changes into account. Each interview aimed to elicit a narrative of experiences before, during and after the conflict in order to understand gender relations and perceptions of HIV/AIDS. They explored the traditional role of women as household care-givers and agricultural producers; the gendered hierarchy of decision-making which disempowers women; and legal restrictions on women's ownership of land. These structural gender norms and vulnerabilities, remaining as constraints on women's role in society, have facilitated the spread of HIV/AIDS.

In the literature on HIV/AIDS and conflict, it is often stated that conflict increases the likelihood of spreading HIV. However, the possible links between conflict and HIV/AIDS are complex. The literature largely focuses on the military, often simplistically relying on a single causal link between men and women. 'Military' implies a male gender position while the use of 'general population' suggests a female gender position. This is a limited way of thinking about gender and conflict. Groups in conflict are linked in many other ways and these linkages do not necessarily allow a sharp distinction between protagonists in a protracted conflict as in Burundi.

Rather than attempting to prove or disprove the existence of a clear link between conflict and the spread of HIV/AIDS, it is more productive to think about how both processes create gendered vulnerabilities.

Gender context

The interviews produced evidence to suggest that while it is possible to argue that the conflict intensified and worsened gender disparities by exposing women to more violence, the particular forms of violence and deprivation during the conflict were shaped by pre-existing gender disparities. One of the things that has changed as a result of conflict is people's sexual behaviour; for

example, extra-marital relations were formerly regarded as shameful and an acute embarrassment to the family if publicly known but have now become commonplace.

HIV has further exacerbated the vulnerability of women. Even when women are responsive to HIV/AIDS training and prevention messages, their capacity to deal with them in their everyday lives at present seems to be constrained. Many interviewees stated that men always blame women for their HIV status. Although most women stated that they were sexually active only with their husbands, men generally terminate relationships on learning of their positive status. This leaves women without husbands and unable to access land and other resources.

Gender and conflict

After 1993, conflict occurred between the government and multiple armed groups. As the conflict became prolonged, women became increasingly impoverished and exposed, left to defend themselves and to look after their families. The interviews indicated that when women joined armed groups to increase their chances for survival they were ill-treated. Those who went into IDP camps were also exposed to violence. General militarisation meant that many households lost adult males, while the situation for those women who did not have a formal marriage was particularly precarious. The relationship between wives who had been left behind and their in-laws and male relatives changed as the conflict continued. Often male in-laws sought to get rid of sisters-in-law in order to absorb property back into the family.

As women came to be regarded as dispensable many had no option but to engage in transactional sex. Their vulnerability is very much related to the collapse of well-negotiated family relations and this search for security. Poverty, powerlessness and male expectations of female meekness made it hard for women to resist advances by armed combatants. Traditionally, once women are approached even casually to talk, it becomes difficult for them to refuse the advances of a powerful man. In the case of the conflict this mechanism was much more pronounced as a way of obtaining sexual favours.

Most of the ex-combatant informants reported hearing nothing about HIV/AIDS during the conflict. The fact that a large and powerful group remained unsensitised added to the vulnerability of women over whom they exercised sexual control.

Conflict created an environment within which existing gender vulnerabilities were exacerbated, pathways to transmission were opened and the scope for talking about HIV or mass sensitisation was reduced. Burundi was not able to participate in early regional efforts to contain the epidemic and the increase in risky male sexual behaviour during the conflict has made it additionally harder for Burundi to catch up. Post-conflict interventions have been implemented with limited capacity and insufficient resources. There has been a tension between raising awareness and providing treatment.

DDR insensitive to gender vulnerabilities

Demobilisation camps are integral to DDR, the first point at which ex-combatants have an opportunity to receive information on HIV/AIDS. Informants stated that while sensitisation and testing were important there was insufficient time for many ex-combatants to digest information and reflect on the personal implications for their behaviour as they prepared to return to communities from which many had been absent for many years. HIV programmes did not reach either the few women in demobilisation camps or the greater number of female ex-combatants who reportedly demobilised themselves. During DDR, female combatants were tested, but testing in general took place in environments that did not cater for their particular needs as women and as female combatants. If found to be positive they were generally condemned by men upon their return, and forced to fend for themselves while men were taken care of by families and relatives.

In Burundi, the DDR process was located within traditional gender structures that made women vulnerable during the conflict. Women coming out of the bush, or who were pushed out of their communities, were not integrated in a way that allowed them to become functioning members of society and they remain vulnerable to sexual violence.

Conclusions

In Burundi and elsewhere, the relationship between conflict and HIV/AIDS is complex and mediated by gender norms and values that pre-date the conflict. Prolonged conflict, displacement and restrictions on movement damaged social relations and traditional livelihood options, creating increased vulnerability to HIV. In this prolonged conflict, both within the household and outside, women were the most vulnerable, while pre-conflict gender relations had also created expectations among females from early childhood that they should be voiceless and submissive.

All interventions dealing with the spread HIV/AIDS, before and after conflict, need to take account of the sociological context of a particular conflict as well as structural gender characteristics – and must acknowledge how the various actors are interlinked.

DDR processes should not focus solely on military and armed groups. Given the nature of the conflict and the extent of violence experienced by so many people, DDR initiatives must address the underlying causes of violence, especially gendered violence. If they do not, they can become part of the HIV/AIDS problem, rather than assist the response.

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Post-conflict transition and HIV

Manuel Carballo, Calixte Clérisme, Benjamin Harris, Patrick Kayembe, Fadila Serdarevic and Alexandra Small

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


IRIN/Neil Thomas

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

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

Post-conflict donor neglect

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

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

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

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

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

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

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

DDR interventions of limited benefit

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

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

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

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

Conclusion

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

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

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

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

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

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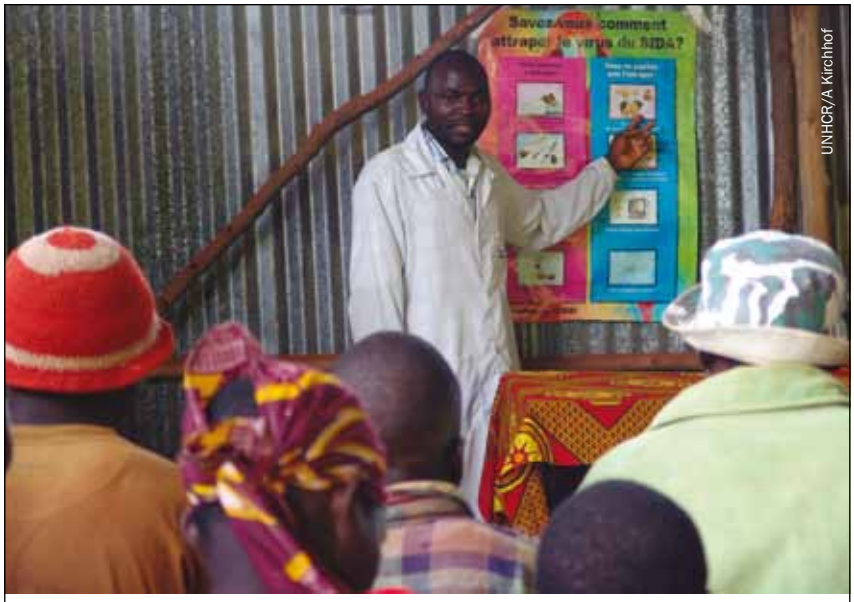
1. http://www.icmh.ch/

Understanding sexual violence, HIV/AIDS and conflict

Judy El-Bushra

A broad gender approach is needed to understand the social context of HIV transmission within conflict environments.

Rates of HIV transmission are often presumed to increase in situations of violent conflict, due to high levels of sexual violence, poverty and displacement which create a high risk environment for the spread of HIV. Claims of a link between sexual violence and HIV infection have been supported by prevalence data amongst specific groups who suffered a high incidence of violence during war time. A study in Rwanda found that seropositivity[1] was 60-80% among women who had been raped during the 1994 genocide, compared to 13.5% of the general population.[2]



Information session on HIV/AIDS for returnees from Tanzania, Mugano transit centre, Burundi.

However, other studies have challenged this claim, pointing out that conditions of violent conflict can both raise and lower transmission rates and emphasising that high prevalence rates for specific at-risk groups should not be extrapolated to the entire population.

These varying viewpoints reflect assumptions about types of behaviours and their impact on transmission. It is often assumed that one-off, opportunistic rape is the only form of sexual violence in conflict contexts. However, it also includes other forms such as sexual slavery and other strategic and deliberate attacks over time. There is evidence that both long-term exposure to the virus and violent sexual activity are associated with increased risk of transmission.

Clearly, rigorous analysis of available data is important in understanding sexual violence and HIV transmission within conflict environments. However, we also need a 'gender approach', exploring the social and cultural dimensions of sexual relationships within conflict settings to help the design of measures for effective prevention.

Sexual violence in the Great Lakes

During the wars which have been fought in the African Great Lakes region for the past 20 years various patterns of sexual violence have been identified. In Rwanda, much of the reported sexual violence has been associated with the genocide, although domestic violence has emerged as a concern more recently. During the LRA war in Uganda, army personnel allegedly perpetrated widespread rape of men and women, while rebel militias were accused of abducting male and female children, with girls forced to serve as 'wives' of commanders. Similarly, rape by military personnel (both from the national army and from local militias) has been widespread in the Democratic Republic of the Congo (DRC) and Burundi, and there have also been reports of coercion ranging from abduction to violent force to economic enticement.

Common features found across the region include the sheer number of rapes, the extreme brutality of sexual encounters, the continuation of sexual violence after the war has ended, including 'civilian rape' and the 'double violation' whereby victims encounter stigma and are disowned by their families and communities after suffering sexual violence. Sexual violence in the region has attracted media attention, contributing to the emergence of well-funded international interventions. Although many individual projects have been effective, the overall impact has been limited. This has been partly because of assumptions about who the victims and perpetrators are. There has been a narrow range of types of support offered to victims, poor coordination between agencies, and greater focus on medical and psychosocial recovery with less attention to legal and economic support. Target beneficiaries have primarily been adult women, frequently ignoring the broader range of victims including young women and girls, as well as men and boys.

Most damagingly, inroads have not been made into the phenomenon itself, which in many parts of the region (notably DRC) continues at similar levels to the past. Long-term solutions for preventing sexual violence have not been identified,

as the focus has been on response rather than prevention. Efforts at prevention, where they exist at all, have been focused on containment (through legal reform, for example) rather than on understanding the factors that have contributed to the outbreak of sexual violence. A possible explanation for this neglect is that the discourse around sexual violence in the Great Lakes has been dominated by the notion of sexual violence as a 'weapon of war'. As long as we assume sexual violence to be perpetrated by marauding men of arms, we feel impotent to challenge or eradicate it.

It is beginning to become clear, however, that the 'weapon of war' explanation is insufficient to explain either the extent or the form of the phenomenon, and that much sexual violence in such settings is carried out not by armies or militias but by non-military civilians. This raises the question of who the perpetrators are, and what creates the conditions in which they carry out these crimes.

The archetypal aggressive male

The one-dimensional model of the aggressive male fails to provide an explanation of the root causes of sexual violence during and after conflict. It does not account for the social rejection suffered by raped women nor does it explain the continuation of violence after fighting has ended. The suggestion that 'civilian' men committing rape are demobilised soldiers having difficulty adjusting to civilian life is highly speculative. This model assumes that sexual violence of this intensity was unknown before the war, although there is virtually no firm evidence on which to make a comparison. It is possible that the dominance of this model in the international response contributes to the failure to bring sexual violence under control.

The gender literature is divided in its interpretation of sexual violence in war. One view holds that war is by definition 'war on women', and that rape in war functions as part of a 'scorched earth' approach, causing terror and destabilising the social fabric and identity of a community by forcing its women into extreme vulnerability. Other researchers describe a more complex reality, in which both men and women can be seen both as victims and as perpetrators. Literature on post-conflict changes in gender relations suggests that where women make gains during wartime a backlash often follows, implying that the underlying values that deny women a role in decision-making have deep roots.

Individuals can be shaped by their context and their experiences, and war can have the effect of narrowing the range of options through which the values that are critical to a person's sense of identity and self-esteem can be lived. If this is the case, then does a conflict environment enhance violent sexual behaviour? There is a suggestion that in northern Uganda the deprivations of war have prevented men from attaining their ideals of manhood, leading to violent behaviour towards others as well as various forms of self-harm.[3] Interviews with Congolese rank-and-file soldiers suggest that, for them, the military establishment provides a backdrop of suffering and frustration against which violence appears comprehensible.[4] These findings suggest the possibility that perpetrators can be seen as being in some way victims of their situations. This would mean that strategies to alter these contextual factors may help to change behaviour.

Understanding the context in which perpetrators grow up and are socialised, the problems they face and how they conceptualise them, the sorts of rewards and sanctions they receive from those around them and how these are reinforced by international actors would enable identification of strategies that cut to the root of the problem rather than just reacting to its consequences.

The image of the powerful man and his vulnerable woman victim raises the question as to whether brutal and violent rape is really a separate phenomenon. Should we rather see it as one end of a continuum linking it with other forms of coercive sex, as well as with a range of other oppressive relationships? And is it really an issue of man versus woman, or are both victims in different ways of the same patriarchal power dynamics? Does the one-dimensional depiction of 'woman as victim' help to perpetuate the very power imbalances it seeks to undermine?

A 'gender approach' to sexual violence in conflict

A gender lens can contribute powerfully to strategies for addressing HIV/AIDS, sexual violence and violent conflict. Considering gender within a socio-psychological framework is more powerful than the current archetypal model. We need to address not just the everyday behaviour of men and women but also the structures within which power relations operate, as well as their ideological underpinnings. Such an approach might lead to more holistic policies and strategies, with a broader range of interventions, better coordination and synergy between them, and a stronger emphasis on mechanisms that involve agencies and local communities acting together in a shared search for solutions.

HIV transmission is driven by relationships whose intimate nature brings to the fore people's deepest feelings about their identity and values. Effective HIV prevention programmes have emphasised the importance of building relationships based on mutual respect. During conflict, when moral underpinnings are compromised, these foundations are essential for the prevention of both sexual violence and HIV transmission. Understanding the social and cultural context describing these relationships is a step towards effective prevention, both of the HIV virus itself and of sexual violence.

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Mobility and power in HIV transmission

Cathy Zimmerman, Charlotte Watts, Anna Foss and Mazeda Hossain

Social scientists are working with epidemiologists to produce evidence that questions traditional epidemiological HIV 'core group' models.

Epidemiological analysis and mathematical modelling have demonstrated the significance of commercial sex and high-risk behaviours as factors in the widespread transmission of HIV. This has frequently singled out commercial sex-workers as a focal point of the spread of the epidemic. Research in the social sciences has spotlighted the multifaceted complexities of participants in sex work settings, describing their mobility, particular vulnerabilities and heterogeneities. This variation includes the diversity of the sex industry in high- and low-conflict and post-conflict settings where, for example, women may move to locations where military troops are based to sell sex, or where women in refugee settings may sell or trade sex to survive.

Classic 'core group theory' proposes that core groups (those who, when infected, are most likely to spread HIV multiple times) spread infection among a wider 'bridge' population of male clients who may in turn pass the virus to their partners. The identified core group is generally the primary population targeted for HIV prevention and, as such, most likely to be stigmatised. Results from our modelling exercise on HIV core groups suggest the potential significance of police and other men in positions of power for HIV transmission and question the long-held assumption that sex workers form a core group of HIV transmitters.

Shortcomings of classic core group theory

When considering HIV prevention, epidemiological theories can help identify priorities within HIV responses. Core group theory has offered considerable guidance in priority-setting, but, in its simplicity, it may miss important elements.

Within classic core group theory, there is an assumption that sex workers are a homogeneous group with equal potential to transmit infection. However, social science research, in particular, highlights the many variables indicating the heterogeneity of this group, including sex worker mobility, age, stage of progression of the disease, access to services and protection, experiences of violence and work environment (e.g. those in regulated brothels compared to individuals in informal settings or transactional and survival sex).

Traditional core group theories predict that the total number of people that an HIV-positive person will infect in a susceptible population is determined, in part, by the rate of partner change. However, there is limited attention given to men who are often central to sex work settings, including non-commercial or non-paying users and those who control or profit from the local sex industry. These are frequently men in positions of power, including pimps, police or soldiers. Importantly, current theories also fail to consider how mobility – the movement of groups in and out of a setting and the length of time in different locations—might influence the risk of transmission and transmission patterns.

We have introduced 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.

In particular, conflict-related sex trafficking may increase the mobility of sex workers while decreasing their ability to control the circumstances of sex. Large and profitable networks of arms, drug and sex traffickers make it possible to traffic women very quickly to avoid detection. Under these circumstances, sex workers are less likely to form a stable reservoir of the virus. Rather, this 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 group that often includes police) – in transmitting the virus to newly recruited sex workers. We identify scenarios in which this group may constitute a 'sustaining population', because they provide a potentially more stable, long-term reservoir for the virus than do the more transient sex workers whom they infect.

Although there is little quantitative data on key characteristics of sex workers and those who control them to construct verifiable epidemiological models, this theoretical model offers thought-provoking considerations from which to revise current assumptions about the core group. This revised perspective suggests the potentially important, if not central, contribution of the controlling group of men in sustaining HIV transmission in certain settings where there is high sex worker mobility. Indeed, this group's longer duration in a setting may make their influence more significant than that of sex workers, versus in settings where the sex worker population is more stable and the classic theory may be more robust. This suggests that HIV prevention policies and programmes should aim to reach those who control the sex trade by addressing, for example, their risk-taking behaviours and their economic and coercive power over women and girls.

More broadly, there is still limited debate about the underlying power structures and power differentials behind sex work. Current prevention efforts frequently avoid questioning the status quo and the power

that men may have by virtue of their employment, social or economic status, physical power or ruthlessness. In situations of low- or high-level conflict, international resources may inadvertently even place men in these powerful situations and humanitarian agencies and donors may look the other way when this power is used to the detriment of women. If those men empowered by virtue of their position – such as peacekeepers, camp staff, border control officials and soldiers – are not sufficiently professional, they may create and maintain situations of vulnerability and exploitation and help sustain HIV infection.

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Addressing HIV and sex work

Ann Burton, Jennifer Butler, Priya Marwah, Cecile Mazzacurati, Marian Schilperoord and Richard Steen

Sex work is an indisputable reality in humanitarian settings. UNHCR and UNFPA have demonstrated the importance of multisectoral interventions to address HIV in sex work.

There is emerging evidence of how conflicts and disasters may lead to sex being sold or exchanged for accommodation, protection, food, gifts and other items or services. This can be attributed to many factors, including high levels of poverty, lack of livelihood opportunities, separation of families, breakdown in community support mechanisms and an increase in gender-based violence (GBV). Yet programmes addressing HIV and sex work in humanitarian settings are often poorly developed. HIV programmes typically follow generalised approaches, with insufficient attention being paid to those individuals and groups who are most vulnerable and at highest risk of acquiring and transmitting HIV and other sexually-transmitted infections (STIs).

Initial steps have been taken to address HIV and sex work in some refugee programmes in the East and Horn of Africa, Latin America and parts of Asia. Based on these experiences, and under the overall framework of the UNAIDS Guidance Note on HIV and Sex Work[1], UNHCR and UNFPA have developed a Technical Note as guidance for field staff and programme managers on addressing HIV and sex work in humanitarian situations. The primary objective is to inform humanitarian actors of steps that can be taken to reduce risk and vulnerability related to sex work.[2]

Sex work is an important driver of HIV transmission. Unprotected sex between clients and sex workers and between clients and their intimate partners contributes to increased risk of HIV transmission. Thus, sex workers and their clients are critical to an effective HIV response. Frequently, though, sex workers are marginalised and face widespread discrimination, reducing their participation in HIV prevention and their ability to access health, legal and social services. There is evidence that if sex workers are involved in the provision of services, both uptake and access usually improve. A growing number of countries that have scaled up interventions with sex workers have reported stabilisation, and even reversal, of their HIV epidemics.

Recognising these opportunities and challenges, UNAIDS promotes a human rights-based, evidenced-informed approach to HIV and sex work based on three 'pillars' which have been adapted to meet needs in humanitarian settings:

Pillar 1: assuring universal access to comprehensive HIV prevention, treatment, care and support through planning and preparing to maintain services, implementing basic services in the emergency phase and building more comprehensive services as conditions stabilise.

Pillar 2: strengthening partnerships and expanding choices through working with sex workers to ensure supportive environments in which all sex workers can access the services they need.

Pillar 3: reducing vulnerability and addressing structural issues by ensuring protection, access to food, shelter and other basic needs together with related measures to prevent GBV and minimise pressure to enter sex work.

These pillars form the foundation for a comprehensive response to HIV and sex work and inform the recommendations presented in the *Technical Note on HIV and Sex Work in Humanitarian Settings.*

Sex work in humanitarian settings

The characteristics that define humanitarian emergencies, including conflict, social instability, poverty and powerlessness, can also facilitate the transmission of HIV. Power imbalances that make girls and women disproportionately vulnerable to HIV infection become even more pronounced during conflict and displacement. There may be increased pressure to engage in sex work. HIV risk for sex workers and clients may be increased due to lower condom use and increased violence.

The vulnerability of children to sexual exploitation and abuse is also heightened during humanitarian crises. While conditions, contributing factors and programmatic responses may overlap with those for adults, there are fundamental and important

differences. The UNAIDS Guidance Note "affirms that all forms of involvement of children (defined as people under the age of 18) in sex work and other forms of sexual exploitation or abuse contravene United Nations conventions and international human rights law". While improving conditions related to sex work is part of the response for adults, the programmatic response to sexual exploitation is protection and removal of the child from the conditions of exploitation.

Humanitarian settings present important opportunities for preventing HIV transmission. Forced displacement and humanitarian crises – whether associated with conflicts or natural disasters – usually involve armed groups, uniformed services and other men from within or outside the community whose presence often leads to an increase in sex work. In these settings, some sex workers openly sell sex whereas other sex workers prefer not to identify themselves as such, often working on a more part-time basis. As in non-humanitarian contexts, some sex workers will choose to continue in sex work while others would prefer economic empowerment opportunities to reduce their reliance on sex work. An important area of intervention is to educate law enforcement officials such as police personnel to be agents of change within their own communities, to respect the rights of sex workers and sensitise their peers on HIV prevention.

Key strategies for response

It is important to work on multiple levels and across sectors to reduce risk and vulnerability related to HIV while protecting the safety and human rights of affected populations. By being aware of conditions that heighten vulnerability and risk, humanitarian actors can take steps to ensure services and support are in place to protect the human rights of sex workers and their clients, minimise risks of HIV transmission and meet the broader health and social needs of sex workers. The Technical Note outlines steps to protect populations and prevent unwanted entry into sex work. Its recommendations reflect experience from many different settings and are adaptable to local conditions and cultural contexts. The starting point for all these interventions is engagement with sex workers and communities.

The steps set out in the box below illustrate how sex work can be addressed in humanitarian settings. Most activities are extensions of health or protection services that should be implemented as part of the humanitarian response. Additional attention to sex work may involve very little extra effort but can yield important results in terms of protecting the rights of the population and averting HIV morbidity and mortality.

In Kenya and Uganda, UNHCR and implementing partners have worked closely on developing programmes with sex workers, based on sustainable and improved comprehensive services including HIV and reproductive health, community social services and livelihood interventions. In both cases there is evidence that much can be achieved within a six-month period: sex worker-led organisations and peer groups were established, confidential and respectful health-care services were provided and protection systems strengthened. These examples illustrate how the active engagement and involvement of sex workers is not only possible but also leads to improved quality of HIV prevention measures.

Key activities per phase

Preparedness

1. Integrate HIV and sex work into contingency planning
   - Identify existing sex worker networks and programmes
   - Map services and develop contingency plans for rapid restoration if disrupted

Emergency phase

2. Expedite registration, risk identification and protection
   - Identify those most at risk: single-parent, female-headed and child-headed households, unaccompanied minors
   - Ensure protection and establish GBV services
   - Promote codes of conduct
3. Ensure safe shelter and access to food and basic necessities
4. Provide basic SRH (sexual and reproductive health) and HIV services
   - Implement MISP (Minimal Initial Service Package)[3]
   - Establish basic STI services within SRH and outpatient clinics
   - Implement basic HIV services
5. Start outreach
   - Use contacts to begin mapping and engagement with sex workers
   - Identify sex-work venues, distribute condoms and information

Stabilised phase

6. Build supportive environments and partnerships
   - Establish peer groups and support sex worker-led approaches
   - Strengthen existing women's groups to reach non self-identified sex workers
   - Conduct rapid assessments and plan interventions
7. Reinforce protection
   - Strengthen prevention of GBV and sexual exploitation
   - Find ways to involve men
8. Expand to comprehensive HIV and SRH services including STI services
9. Expand targeted services
   - Support transition of peer activities to broader community mobilisation
   - Strengthen venue-based and special clinics for identified sex workers
   - Work with clients to reduce demand for unprotected paid sex
10. Provide social/economic/legal services
    - Strengthen legal protection
    - Establish self-regulatory boards
    - Increase livelihood and educational opportunities for the most vulnerable
    - Prepare for appropriate durable solutions, especially for most vulnerable

In Sierra Leone, the Women in Crisis Movement (WICM), an NGO supported by UNFPA, is devoted to empowering war-affected adolescents and young girls through a combination of vocational training and creation of cooperative employment. WICM has developed a two-year vocational training programme helping girls and young women at two sites who actively chose to leave sex work. Combining vocational training with income-generating activities and the inclusion of sexual and reproductive health as an integrated component in the training programmes allowed them to have access to education, acquire skills and to increase their economic independence.

Conclusion

Interventions to respond to HIV and sex work in humanitarian settings are both necessary and feasible, even during an emergency. In situations where comprehensive HIV programmes have already been established but where sex workers have not yet been reached, a basic set of sustainable multisectoral activities can be established within six months. The integration of HIV into the humanitarian clusters remains a major challenge. Although HIV is recognised as a cross-cutting issue, it is, unfortunately, all too often seen as the domain of the health sector only.

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1. http://tinyurl.com/UNAIDS-HIV-sexwork
2. This guidance is being field tested and will be available for distribution by the end of 2010 on the websites of UNHCR and UNFPA.
3. http://misp.rhrc.org/

The price of liberation: migration and HIV/AIDS in China

Shao Jing

Sale of blood became an attractive alternative to the rural-urban migration induced by economic and social hardships but has been the cause of an HIV/AIDS epidemic in China.

Early in the 1990s, large numbers of commercial blood donors in rural central China, most notably in Henan Province, were infected with HIV. According to conservative estimates released by the provincial government, more than 30,000 people in this province alone were infected. This 'separate epidemic', as it is often referred to in the HIV epidemiological reports in China, defied the well-recognised patterns of progression in this epidemic, particularly in terms of the male-to-female ratio of the infected; from the start, it claimed both men and women as victims in equal numbers but by a transmission route that was far more efficient than sex. Infection occurred when contaminated blood cells were returned to the donor after the harvesting of plasma from their blood, allowing the epidemic rapidly to establish itself over several central provinces.

Labour, blood and HIV/AIDS

The term 'rural resident' is a bureaucratic category that ensures that rural migrants who provide a vast source of cheap labour are excluded from basic social services in urban areas. In the context of economic liberalisation, technological developments have only facilitated the transformation of traditional labour-intensive agricultural systems into capital-intensive enterprises. The value of agricultural labour had thus become increasingly insecure, a surplus with no profit. Under these conditions, 'rural residents' in China's agricultural heartland were compelled to convert their labour surplus into cash by migrating to urban and coastal industrial centres to look for work.

When blood plasma collection began, it was perceived as an attractive alternative way of generating revenue without migration, as it seemed to only take the insubstantial part of their blood, the part not essential to their vitality, physical strength and force.

Many HIV-infected women had returned from working in manufacturing in the cities where they had worked for several years to build dowries. They returned, got married and raised their children in their home villages. Selling plasma gave them an opportunity to continue supporting their families by bringing in cash that could no longer be obtained through out-migration. Plasma in a cash-starved agricultural economy becomes cash by virtue of the demand for the albumin it renders up to a health industry hungry for expansion.

The market for blood products, principally albumin, was created by economic reform in China's health sector. Public hospitals and other health-care facilities, which previously had been supported by state subsidies, now had to compete in the market and generate revenue through the services they provided and the drugs they sold. This arrangement encouraged serious conflicts of interest in health care. More expensive treatments were promoted to patients, and the prices of the drugs became a bogus proxy for their efficacy. In this context, albumin quickly became a favourite drug at hospitals, prescribed often in the absence of any specific indications to patients who were convinced of its restorative efficacy and could afford to pay for this luxury.

The fledgling plasma fractionation industry in China was boosted by a ban in 1985 on all imported blood products which was aimed at keeping HIV and AIDS outside China's borders. The industry grew quickly in the following decade as did the demand for source plasma (i.e. plasma for further manufacturing).


Shao Jing

A former commercial blood donor in rural Henan, China, with her medications for HIV infection and a persistent co-infection of tuberculosis.

In addition to exporting labour to the coastal and urban industrial centres, the central provinces could benefit more directly by supplying them with source plasma.

Pathways of pathology

None of these historical processes – economic reform in the agricultural sector, the economic reform of health care, and the emergence of a plasma fractionation industry – created the necessary conditions for the outbreak of the HIV epidemic. But the pathological confluence of these historical processes determined the geography and demography of the HIV epidemic among plasma donors in rural central China.

In the current atmosphere of overwhelming attention to curbing the spread of HIV in the general population, it is easy to forget that the same social and political conditions and cultural logic that have led to the epidemic in central China continue to shape the experience of the disease of those already infected. Among the earliest symptoms of the progression of HIV disease, and the one most keenly felt by these hardworking villagers, is fatigue. The irreversible loss of their labour power due to HIV infection was a shocking price to pay for money they had made selling plasma years before.

In the midst of intensifying media attention on the AIDS-related deaths in a few villages in Henan, the government hastily rolled out a free antiretroviral (ARV) treatment early in 2003. This limited programme distributed ARV drugs but without adequate medical services to deal with side effects and ensure adherence. Nausea and vomiting were among the most common side-effects of the ARV regime in the free government treatment programme, resulting in loss of appetite or inability to keep anything down, as well as dizziness and sore muscles, which further weakened them. These common side-effects were experienced as life threatening by these agricultural producers, exactly because they seemed to assault the most essential dimensions of their lives: food and labour.

The lack of comprehensive treatment delivery is only part of the reason for the failure of the programme. The villages that saw the greatest decline in participation and adherence were all well-known 'AIDS villages', favoured by pharmaceutical manufacturers and traditional medicine practitioners chasing lucrative dreams of finding a cure for 'the plague of the millennium'. Major research hospitals recruited clinical trial subjects from these villages for pharmaceutical developers. In these villages, government-supplied ARV drugs, which promised only the suppression but not the eradication of the disease, competed poorly with the plethora of free samples of hope represented by remedies of uncertain efficacy but without the pain of the feared side-effects. This epidemiological pattern makes a mockery of the compassion and hope that highly active antiretroviral therapy (HAART) is meant to inspire.

The parallels to be drawn between the out-migration of rural labour, source plasma collection and clinical trials are stunning. Construction companies relied on 'labour contractors' from the villages for their supply of workers; plasma collection centres used 'scouts' to recruit and transport donors; and infectious disease hospitals supplied clinical trial data on drugs under development with the assistance of the same cast of intermediaries living among HIV-positive villagers.

This HIV outbreak and its aftermath highlight the price that China's 'rural residents' have had to pay for their multiple experiences of 'liberation'. A price has also been paid by women, particularly among rural communities, for their even more dubious liberation. The majority of the epidemiological subpopulation categorised as 'commercial sex workers' are also rural to urban migrants. Their entry into China's booming sex industry is aided by that industry's ubiquity and its many disguises. The high turnover of those who work in this industry and their extreme mobility are both significant. Freed to sell sex, for a period of time, with anonymity and perhaps impunity, away from the social world to which they hope to return very much as they would after working in factories, the population of 'commercial sex workers' is difficult to identify and track. Risk taking, often despite knowledge, motivation and skills, is then not simply a behaviour but integral to the temporary nature of the work itself.

How do we, then, effectively block the pathways of pathology? The answer can come from quite unexpected quarters. In 2006, the Chinese government abolished all agricultural taxes, which for decades had been an indispensable source of revenue. A little more than a year later, many hospitals were suffering shortages of albumin. This time, the shortfall was directly caused by the modest amount of money the government now gives to rural residents, which has made selling plasma less attractive and less necessary. An unintended but happy outcome of this shift in economic policy is the reduction of the risk of HIV infection among plasma donors and blood product users.

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Education: critical to HIV prevention and mitigation

Marian Hodgkin and Marian Schilperoord

Good-quality protective formal and non-formal education can provide the knowledge and skills for the prevention of HIV and protection from the impact of AIDS.

Information about HIV prevention and mitigation must be integrated into education responses to emergencies to help ensure that learners and their teachers remain supported and safe. Education can offer one of the points of entry for health, protection and other sectors working on HIV prevention and response and facilitating referral to essential services for those affected by HIV. It is also a fundamental right enshrined in the UN Convention on the Rights of the Child and an accompanying General Comment which emphasises governments' obligations to ensure that children "have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality".[1]

Unfortunately, access to information and services related to HIV and sexual and reproductive health as part of education during emergency interventions is generally haphazard – mostly through non-formal youth programmes or as part of work done with young people in community centres. Inclusion in formal education curricula is less common. Often key messages are not consistently accurate, and teaching methods are usually lecture-based or involve a brief visit from a health centre nurse. There is generally no active engagement with students, development of critical life skills or discussion and active learning.

The Inter-Agency Network for Education in Emergencies (INEE) has recently updated its *Minimum Standards for Education: Preparedness, Response, Recovery*[2] to help practitioners and policymakers consider how every aspect of an education response is not only affected by HIV but also provides an opportunity to prevent new infections and mitigate the impact of HIV.

HIV education is an imperative life-saving intervention but education practitioners should not rush into programming without keeping in mind the context-specific dimensions of an emergency response. Working with communities, teachers, school councils, parent-teacher associations and learners themselves to assess, plan, implement, monitor and evaluate education interventions will help improve programme quality and ensure cultural sensitivity.

Analysis of the context and coordination within the education sector and with other humanitarian response actors in health, protection and nutrition are critical. Education actors will not necessarily have the capacity to undertake a full analysis of the nature and type of HIV epidemic in a particular context but can work with others to determine the level of HIV prevalence and gather information about the most vulnerable and at-risk populations. This will help education practitioners plan relevant educational content and begin to map possible referral mechanisms.

It is critically important – when considering how to enhance HIV prevention and mitigation during crises – to heed the principles of participation, analysis and coordination and to recognise that good-quality education can reduce the vulnerability of learners to HIV and AIDS. Education programming must mainstream HIV issues and consider targeted responses such as the following:

Access to protection and provision of services through education: During emergencies, children and young people are often at greater risk of HIV infection or of being affected by HIV. Education can provide support as well as routines and structures that reduce risky behaviour and enhance protection. Education practitioners should also work with health and protection colleagues to establish referral systems for learners affected by HIV who require health, social or psychosocial services.

Teaching and learning for prevention and mitigation: While HIV and sexual and repro-ductive health education might not be included in formal curricula in normal circumstances, a crisis can provide the opportunity to address these issues in schools and kick-start curriculum reform. International actors should work with communities and national education authorities to define age-appropriate and gender-sensitive content. Curricula should address context-specific knowledge, attitudes, behaviours and practices with scientifically accurate information. Participatory learning processes such as brainstorming, small-group work, role play, debates or storytelling are particularly important for developing life-skills. Trained teachers using carefully developed curricula can also help learners develop understanding and tolerance, thereby contributing to reducing stigma and discrimination against those living with HIV.

Working with education personnel: Teachers and other educators should be supported by institutions and communities so that they can address HIV and AIDS in their own lives and in the lives of those they teach. In some emergencies the teaching force itself may be severely affected by HIV and it will be necessary to recruit replacement teachers, support staff or volunteers. It should also be recognised that education is not necessarily protective. Working with teachers, learners and communities to develop a code of conduct can help to ensure that sexual exploitation and abuse and other forms of gender-based violence are not tolerated and that, where necessary, disciplinary action is taken.

The role of policy development in ensuring that the education sector is prepared and committed to addressing HIV must be appreciated. The inclusion of education for crisis-affected populations in national HIV/AIDS strategies and education sector plans and emergency preparedness plans creates synergies between education and HIV actors. More needs to be done, however, to ensure that responses to emergencies fully address opportunities for positive change:

- It is critical to analyse pre-crisis HIV data and information collected by other sectors and, where appropriate, to include HIV-related questions as part of participatory education needs assessments and evaluations. Sex- and age-disaggregated data and analysis are vital.
- Donor practices and emergency funding mechanisms should require systematic action to address HIV in emergencies, in the same way that gender awareness and mainstreaming are now expected by humanitarian funders.
- Better coordination is needed between national and international HIV actors and those within the education sector so that ad hoc and small-scale HIV education interventions can be scaled up.

Practitioners can draw on the INEE *Minimum Standards*, the Inter-Agency Standing Committee's *Guidelines for Addressing HIV in Humanitarian Settings*[3] and complementary guidance developed by the INEE HIV/AIDS Task Team to strengthen educationalists' response to HIV. A holistic sector-wide approach must address primary, secondary and tertiary education and formal, non-formal and informal programmes in emergency preparedness, response and recovery.

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1. http://tinyurl.com/HIV-and-rights-of-child
2. http://www.ineesite.org/standards
3. http://www.aidsandemergencies.org

HIV/AIDS, security and conflict: What do we know? Where do we go from here?

Pamela DeLargy and Jennifer F Klot

In the ten years since the Security Council's first resolution on HIV/AIDS, much has been learned about the dynamics linking HIV and AIDS, conflict and insecurity. Assessing progress made over the past decade in responding to these dynamics enables us to identify new opportunities for prevention and response.

The articles in this collection together with the findings from the AIDS, Security and Conflict Initiative (ASCI) consolidate a growing body of social science, public health, policy and operational research that challenges earlier assumptions about the interactive effects of HIV/AIDS and insecurity. Contributing authors draw attention to the social factors associated with forced displacement and migration and their central role in shaping HIV exposure risks. Collectively, they reflect an important shift in emphasis from behaviourial analyses of HIV transmission risks to a focus on the structural factors that shape individual behaviour. As demonstrated throughout this collection, risks vary across peacekeeping environments, camp settings, border areas and in regions with higher and lower HIV prevalence.

Important new pathways for HIV prevention and response are identified in the context of humanitarian and recovery initiatives relating to disarmament, demobilisation and reintegration, with respect to uniformed services, and sexual violence prevention and response. New challenges have also been identified. Despite dramatically increased access to HIV prevention, care and treatment, particularly in refugee camps, demand continues to outpace access and availability among those displaced by conflict as well as in resettlement and return areas.

The gendered nature of conflict-related poverty exacerbates risks for women who head households, for women who serve in or are associated with armed forces and groups and, notably, among women without any means of support or legal claims to marital property and assets. With little in the way of alternative livelihoods, many women and girls are forced into high-risk survival and transactional sex and early marriage. Others fall prey to illicit trafficking and sexual slavery. Responding to the range of social and physiological risk factors associated with sexual violence and exploitation in crises and fragile states will require far greater investment in emergency reproductive health care and STI prevention. It will also require gender-sensitive security risk assessments and response among displaced communities, along borders and in return areas and peacekeeping environments.

Some of the greatest gaps in conflict-related HIV prevention and care relate to the uniformed services including the police, military,

navy and the correctional system. Significant advances have been made in pre- and post-deployment prevention, counselling, testing, care and treatment for military personnel, their families and other dependents. But similar investments have yet to be made among police, a group at far greater risk of transmission and with far greater potential to serve as agents of change within the communities they serve.

It is a bitter irony that the countries with the highest HIV prevalence in sub-Saharan Africa are not among those considered the most 'fragile' by current indices of good governance and economic development. This has obscured the urgency of need and related resource gaps, especially at local levels of governance. Even where well thought out, evidence-based programmes have been developed by governments, humanitarian or development agencies, far too many donors simply do not understand the need for comprehensive HIV programming in humanitarian and recovery settings or are under the false impression that it just cannot be done. The evidence does not bear this out. Much greater investment in HIV prevention and response in situations of crisis, displacement and fragility can facilitate recovery and reduce the disproportionate risks faced by women and girls.

Growing recognition of these new challenges and better understanding of the dynamics linking HIV/AIDS, conflict and security suggest a new agenda for action. From our perspective, this agenda calls for a greatly accelerated and more nuanced response that takes into account the following:

- the role of sexual violence and exploitation in HIV transmission, and therefore the need to align HIV and sexual violence prevention policies and programmes
- the way in which gender shapes migration and displacement patterns (forced by conflict or climate change or economic crisis), individual risk acquisition, care burdens and access to prevention, care and treatment
- the mismatch between resources, availability and access to HIV prevention, treatment and care in regions most affected by conflict and HIV, particularly in sub-Saharan Africa
- whether and how the gap between humanitarian funding and recovery mechanisms has resulted in discontinuities in prevention and care for affected populations
- the dynamics of health system recovery in post-conflict reconstruction and the degree to which this shapes the impact of displacement on HIV risk transmission and on access to prevention and care
- the need for renewed attention to the care burdens disproportionately assumed by women and girls, especially in situations with limited access to treatment and weak health care infrastructure
- the real and potential role of uniformed services – and particularly the police – as agents of change and, in some cases, as a 'core group' of HIV transmission
- the dynamics of risk among non-state armed forces, including militias, rebel groups and those associated with them, both during conflicts and afterwards in demobilisation processes.


UNFPA/Pam Delargy

Condom distribution in the Ethiopian military.

When the Security Council turns its attention to HIV/AIDS in 2011, it is our hope that serious consideration will be given to the fivefold challenges of:

- aligning sexual violence prevention and response and HIV prevention and response
- post-deployment HIV prevention, treatment and care for uniformed services personnel and their families and dependents
- ensuring continuity of access to HIV prevention, care and treatment during recovery and post-conflict transitions
- strengthening regional approaches to HIV prevention and aligning policies across countries contributing troops for peace keeping
- the role of uniformed services – and especially police – in HIV prevention and response.

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AIDS, Security and Conflict Initiative (ASCI) resources

ASCI Research Hub
http://asci.researchhub.ssrc.org/rdb/asci-hub

ASCI Full Report
http://tinyurl.com/ASCI-full-report

ASCI Executive Summary
http://tinyurl.com/ASCI-Summary

The ASCI Research Reports listed below can be found at: http://asci.researchhub.ssrc.org/working-papers/

1. **The Police and HIV/AIDS: A Literature Review**
   Hilary Pearce
2. **Current Trends and Issues in Research on HIV/AIDS and Police Forces in Africa**
   Alastair Roderick
3. **HIV/AIDS and the Central American Uniformed Services**
   Dirk Kruijt & Julio Balconi
4. **The Impact of HIV/AIDS on the Operational Effectiveness of Military Forces**
   Robert Kershaw
5. **The Political Dimensions of Responses to HIV/AIDS in Southeast Asia**
   Dennis Altman
6. **Impact of HIV/AIDS on Governance in Manipur and Nagaland**
   Happymon Jacob
7. **HIV and State Failure: Is HIV a Security Risk?**
   Tony Barnett & Indranil Dutta
8. **Russian Demography, Health and the Military: Current and Future Issues**
   Murray Feschbach
9. **State Fragility and AIDS in the South Pacific**
   Michael O'Keefe
10. **Is HIV/AIDS a Threat to Security in Fragile States?**
    Azusa Sato
11. **States of HIV Fragility: Capacity, Vulnerabilities, and Epidemic Evolution in Mozambique**
    Erling Høg
12. **Indigenous Welfare and HIV/AIDS Risks: The Impacts of Government Reform in the Papua Region, Indonesia**
    Claire Smith
13. **HIV/AIDS, Conflict and the Gendered Implications of Transition in Burundi**
    Hakan Seckinelgin, Joseph Bigirumwami & Jill Morris
14. **"First, What is Harm?" The Political Dilemmas of Humanitarian Aid to Burma (Myanmar)**
    Ohnmar Khin
15. **Neither Will nor Capacity: A Review of the Challenges of Responding to AIDS in Fragile States**
    Jon Weigel
16. **HIV/AIDS Policies and Programming in DDR and SSR Activities in Southern Sudan: A Post-Conflict Analysis**
    Anyieth D'Awol
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26. **Revisiting New Variant Famine: The Case of Swaziland**
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Sources for further reading on HIV/AIDS, security and conflict

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