

AIDS, Security and Democracy: Expert Seminar and Policy Conference,  
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## **Issue Paper 1: HIV/AIDS and the Military**

### **Overview**

This Issue Paper addresses a range of questions related to the impact of the HIV/AIDS epidemic on armed forces, peacekeeping operations and the security of states. It frames these issues within a traditional or realist conception of security, rather than human security. In addition, it deals with the nexus of conflict and HIV, and questions pertaining to militaries, conflict, gender relations and HIV. In this area the approach is principally empirical.

There is a considerable literature on these issues, and this Paper does not attempt to be a thorough literature review. Rather, it attempts to survey the state of existing knowledge, the main questions that have been addressed or which remain to be addressed, and some of the implications for policy. The main conclusion is that the accepted wisdom, that HIV levels are invariably higher in the military, that HIV jeopardises the functioning of militaries, that conflict increases HIV and that HIV contributes to conflict, need close scrutiny. The generalizations that have been accepted in this field must be replaced by a much more fine-tuned, empirically-informed and context-specific analysis of these issues. There is reason to be concerned, but the problems, although very serious, can be contained or solved with the correct policies and programmes.

The main findings that arise from this analysis include the following:

- The current received wisdom about extremely high levels of HIV in the armed forces of many countries needs closer scrutiny.
- Existing 'best practices' for AIDS in the uniformed services may need to be fine-tuned to accommodate the variety of circumstances facing different armed forces.
- A series of ethical and policy dilemmas on military-civilian relationships in the context of HIV need to be handled, including the status of individuals discharged from the military who are living with HIV, the status of military orphans, the financing of military AIDS policies, and drug policies in the military.
- Existing policies for HIV among peacekeeping forces and regional stand-by forces appear to be appropriate, and need to be sustained.
- HIV/AIDS does not appear to directly contribute to conflict. But AIDS makes conflict more damaging: the concurrence of conflict, complex humanitarian emergency or a collapsed state and an AIDS epidemic demands special humanitarian instruments and methodologies.

- Gender-based violence during conflict is an important issue which needs continuing attention, specifically targeted to conflicts in which it is a particularly salient issue.
- Conflicts vary hugely in their risk of contributing to HIV transmission. The greatest risk may occur in a post-conflict phase, demanding special attention to minimizing HIV risks during post-conflict rehabilitation, including refugee return and DDR.

## **Human Security**

This Issue Paper is deliberately structured around classic or realist security concerns rather than the broader framework of human security. The human security perspective is equally important, however. All aspects of human security: life expectancy, integrity of the person, health, freedom from hunger, employment, sustenance of the social fabric, physical security and fulfilment of individual potential are affected by HIV/AIDS. In a globalizing world in which democracy is the aspiration and increasingly the norm, state security cannot be secured without the achievement of human security for citizens. This provides an underlying theme for Issue Paper 2, concerned with democratic governance. Human security provides a multi-dimensional framework for understanding the impact of AIDS on all aspects of human existence, keeping the individual at the centre of analysis.

Moreover, the wider impact of the AIDS epidemic has the grim potential to affect all of these dimensions of human security simultaneously, thereby pushing countries into a spiral of decline. Thus far, despite the immense human suffering unleashed by the epidemic, this has not occurred. But countries that are now on the cusp of suffering serious epidemics should not be lulled into a false sense of security: the epidemic's hideous potential for reversing all gains in social and economic development and human security should not be underestimated.

## **HIV/AIDS Levels in the Military**

For about a decade, conventional wisdom among researchers and advocates has been that rates of HIV prevalence are typically two-to-five times greater among soldiers than comparable civilian populations. While HIV levels in military populations remain a controversial and inadequately-evidenced subject, we can say with confidence that this is not the case in sub-Saharan Africa. It may have been true at an early stage of the epidemic in that continent, when general population HIV prevalence was in the order of 2-5% while rates in some militaries were considerably higher. This, for example, was the finding of CMA surveys in the early 1990s. Such claims served a useful purpose in sounding the alarm and making armies take notice of the problem. Current data indicate that these elevated levels are not found in sub-Saharan Africa today. In other parts of the world, where HIV prevalence in the general population is low, relatively higher rates may prevail in militaries. Good data are generally lacking.

In a generalized heterosexual epidemic, such as in southern and eastern Africa, there are several reasons why armies would be expected to have HIV levels comparable to, or even lower than, the general population.

- In armies that rely heavily on national service or conscription, or which are primarily composed of infantry, the majority of soldiers will be young men aged approximately 18-25, mostly from rural backgrounds. HIV rates among this population category are lower than in the general adult population including young women of the same age. Surveillance of conscripts to the Ethiopian army, and testing of those discharged from the army, provides support for this. This demographic factor is the single most important reason that we would expect low HIV prevalence. Among armies that are smaller and rely more on specialised units (including those that specialise in peacekeeping missions), the age structure will be older, making it more likely to have higher HIV prevalence.
- Many military units are poorly paid, immobile and stationed in remote areas for long periods of time. The stereotype of an over-sexed, aggressive, mobile and well-paid soldier is often inaccurate. In addition, there are suggestions—as yet not adequately investigated—that garrisons attract groups of sex workers who cater exclusively to soldiers, and moreover the sex workers themselves follow a hierarchy that matches the ranks of the army, so that the lower ranks mingle with one group while officers prefer another. This would imply a relatively closed sexual network of lower-ranking soldiers (with, we may assume, low prevalence of HIV) and their sex workers. These conditions do not facilitate accelerated spread of HIV. We must, of course, be alert to those situations in which soldiers are indeed a high-risk group, and the stereotype is closer to reality.
- All armies screen recruits and reject those they consider physically unfit. Increasingly, HIV testing is part of medical screening, and HIV positive status is considered reason for rejecting a potential recruit. In a number of armies, HIV testing is also required for renewal of contract, promotion or further training.

New recruits and young soldiers may therefore have a lower level of HIV than their civilian counterparts. In some circumstances it is quite possible that professional soldiers face higher risks of HIV than their civilian peers while they remain in service. Middle-ranking officers fit the demographic and occupational profile of a high-risk group.

In other parts of the world, such as Latin America or south-east Asia, which are not suffering generalized epidemics, soldiers may be a significant vector in a concentrated HIV epidemic, and potentially also a bridge to the general population. Since the peacekeeping operation in Cambodia, where foreign peacekeepers are widely credited with having significantly increased HIV prevalence, this has been a major and warranted concern of international peacekeeping operations, for example in Belize and East Timor. The deployment of peacekeepers to Darfur, Sudan, which is not believed to have a high HIV prevalence, is another case.

More research is needed into these issues. The different structures of armies and differences in the ways they are trained and deployed would be expected to lead to highly different patterns of exposure to HIV. The risks they face also depend very strongly on the nature of the epidemic to which they are exposed. Generalised heterosexual epidemics imply very different patterns of infection to concentrated epidemics, whether they are focused on sex workers, men who have sex with men or injecting drug users.

Two kinds of policy recommendation arise from this sketchy analysis. The first is that it is important to correct the misapprehension, still part of the mainstream literature, that soldiers are especially at risk of HIV simply because of their profession. Any such assertion needs to be highly context-specific. The second is that a single one-size-fits-all 'best practice' may be inappropriate. A more finely-tuned approach to controlling AIDS in the military is called for, as the next step in military AIDS policies.

### **HIV/AIDS as a Threat to the Functioning of Militaries**

There is strong anecdotal evidence that, at the very early stage of the east African epidemic, some militaries were hard-hit by the loss of officers to AIDS. This gave rise to fears that armies would be 'hollowed out' by the disease, leading to lack of combat readiness. Like a snowball, this plausible concept gathered size and pace. Fears of indiscipline and possible national insecurity were added. If one country's army were ravaged by AIDS, it was argued, its neighbour might be tempted to attack. AIDS might be used as a weapon of war.

The snowball gathered pace through argument by historical analogy. Historical examples of armies stopped in their tracks by infectious diseases were cited in support of such scenarios. This sounded the alarm, and armies responded. The comparison is very inexact, however: influenza or malaria can overtake a division or garrison in a matter of weeks, throwing immediate military deployment into chaos. AIDS cannot do this, except in the one-off situation in which an undiagnosed epidemic is suddenly discovered among troops about to be dispatched on mission.

Fears that militaries would collapse on account of HIV/AIDS have not materialized. But serious causes for concern remain. Prominent among these is the issue of combat readiness. A soldier who is HIV positive is not desirable as a member of a combat unit for several reasons. He may be unable to receive all the necessary injections and medication for deployment. He may have difficulties sticking to a treatment regimen under operational conditions. If he is wounded, his colleagues may have difficulties in treating his wounds without being exposed to infected blood. Even the suspicion that he may be a liability to the unit may undermine unit cohesion. For these reasons, all armies prefer to screen out HIV positive soldiers for operational duties, including peacekeeping missions.

Several considerations indicate that armies are well-able to cope with the institutional threats posed by HIV/AIDS and the human resource losses it entails. But this coping comes at a price.

- Many armies have a flattened age-rank pyramid. That is, for every individual who wins promotion, there may be three or four candidates, with the unsuccessful often choosing honourable discharge or early retirement. This is especially the case for national service-based armies. There is built-in redundancy. This is unsurprising: an army that is engaged in combat should expect to take casualties and still remain functional.
- A well-functioning army is highly disciplined, so that command and control are retained even amid high levels of death and incapacitation. The hypothetical scenario of organized dissent in the ranks because of untreated HIV/AIDS is not only improbable, but if it should occur, should be containable by normal measures for the suppression of insubordination and mutiny.
- By deploying the measures of mandatory testing and provision of health care, armies have been able to minimize the impact of HIV/AIDS on their officer corps and specialised units. In these parts of the armed forces, priority programmes can be applied. The problems arising from rationing treatment can be overcome by the military practices of secrecy and command authority over life and death.

There are a number of serious issues that arise from the HIV/AIDS epidemic that pose challenges for army commands. These include:

- The budgetary strain of providing ART to soldiers, amplified by the question of whether treatment should be extended to partners and children. Defence budgets are under pressure, and the question of what counts as a military expenditure becomes more significant as military health spending rises. A related question is whether military health departments should have access to international AIDS funding.
- The question of care for military orphans. Many armies are total institutions, which provide housing and schooling for the families of soldiers. The status of orphaned children, when their numbers are higher than expected and their mothers may have died as well, is causing problems for some armies.
- The question of mandatory testing and the responsibilities of the army to those who test positive and are rejected or discharged. In most developing countries, armies have better quality health care than the civilian sector, and the discharge of HIV positive individuals, often without having informed them of their status, amounts to burden-shifting and poses important ethical and public policy issues.
- Management of drug use and whether to promote harm reduction policies such as needle exchange. This is a particularly important issue in the former Soviet Union and could be so in some south-east Asian countries.

- The existence of a sufficiently large pool of healthy young men from which to recruit. In countries where demographic, health and socio-economic factors are already putting pressure on the pool of recruits, the existence of an HIV/AIDS epidemic may worsen that situation. This may be the case in some countries of the former Soviet Union, on account of several decades of declining birth rates and concurrent health crises. In African and central/south Asian countries with a ‘youth bulge’, even if they suffer much higher rates of HIV, the pool of healthy recruits is unlikely to be depleted significantly.

All of these issues have implications for civil-military relations, the position of the armed forces within the government and its AIDS policies, and the setting of national security policies. All require policy attention. Countries are at very different stages in acknowledging and responding to these problems.

Issues surrounding HIV transmission and the status of soldiers’ sexual partners obtain heightened salience in the context of peacekeeping operations, when soldiers are better paid, by definition mobile and away from their home community, and are serving under the auspices of the UN or a regional organization with a special responsibility for upholding the highest standards of ethical behaviour. The initiatives taken by UNAIDS OSHR, UN DPKO and various regional organizations to require best practices for AIDS policies and programmes, and the highest level of ethical behaviour for peacekeepers, have undoubtedly heightened awareness of these issues and enabled considerable strides in addressing the problem. Although there is much remaining to be done, this specific area has received the attention that it warrants and remarkable progress has been made. For these reasons, it will not be discussed further in this paper.

A different set of issues arises for an army that is already dysfunctional and ill-disciplined. Some such armies are already threats to the national security of their countries. In other cases, countries have learned to contain that threat. In some extreme instances, governments have deliberately undermined or incapacitated armies. The analysis of the nature and level of ‘threat’ posed by AIDS to such a force needs to be analysed on a case-by-case basis. It is reasonable to suppose that in some cases, high levels of HIV will impede security sector reform, while in others, attrition due to AIDS may in fact make that reform easier. The handling of security sector reform in the context of AIDS is an important policy issue.

### **AIDS and Irregular Forces**

There are anecdotes that suggest that HIV prevalence is high among irregular forces. For obvious reasons this is remarkably difficult to prove empirically. The assumptions behind this are plausible but as yet unsubstantiated. They include the supposition that irregular forces are either self-recruited from disenfranchised young men, or their commanders recruit indiscriminately from such groups, and that these young men are more likely to be HIV positive. A second supposition is that irregulars are ill-disciplined and likely to be sexually active with multiple partners including inflicting rape.

There are horror stories from several conflicts in central and west Africa that appear to support these hypotheses. However, as analysed in the following section, the best proxy indicator—HIV prevalence in the general conflict-affected population—does not lend support to this. To be precise: if guerrillas in these conflicts do indeed suffer higher HIV prevalence, this has not proved epidemiologically significant for the wider population. But we must enter a major caveat here: data are signally lacking for the most important of these conflicts, namely the Democratic Republic of Congo.

There are reasons for caution with regard to the ‘HIV is higher among guerrillas’ hypothesis. First, some guerrilla forces are relatively well-disciplined and, insofar as they are drawn from the host population, under social pressure to behave well. Historical exemplars are the Eritrean and Tigrayan liberation fronts which, in the 1970s and ‘80s, enforced a complete ban on sexual activities by their members. Second, most guerrilla forces are small, because of the risks and hardships their members endure and the difficulties of sustaining them in the field. A small proportion of any aggrieved or conflict-affected population joins a guerrilla army. The motivations of recruits vary enormously, from the noble to the criminal. Irregulars are usually unpaid and posted in remote rural areas, often for very long periods without rotation. Urban postings are rare and bases are in difficult-to-reach locations or in refugee camps. Third, many guerrillas are young men and boys from rural areas, a group that has low HIV prevalence. Their officers’ profile may be different, as with regular armies. A few guerrilla units undoubtedly fit the stereotype of an urban gang, criminalised, drug-taking and sexually aggressive. This is a picturesque exception to the tedium and hardship of the great majority of guerrilla war. The significance of this group for the epidemiology of HIV is unknown. Evidently, there is an important research agenda here.

Most political and institutional contacts between guerrilla armies and the international community occur during humanitarian operations, peace negotiations and in the post-conflict phase of rehabilitation and DDR. There is room for improvement in handling AIDS policies and programmes in all of these contexts. One recommendation is to use former guerrillas as a peer group to assist current guerrilla forces in adopting best practices. The politics of dealing with irregular groups will always be a sensitive political issue, but the added aspect of the health and humanitarian concerns resultant on the HIV/AIDS epidemic means that new norms for dealing with such groups may be necessary. Specifically, there is good reason for governments to tolerate international organizations doing business with their adversaries on issues of HIV/AIDS.

### **Conflict and HIV Transmission**

There is an advocacy consensus that the ideal conditions for rapid spread of HIV include poverty, dislocation, gender inequity and sexual violence, the breakdown of health and education provision and the disruption of normal, stable life. If this is correct, then conflict should provide the ideal conditions for accelerated spread of HIV. The fact that Africa’s first national epidemic occurred in Uganda, coincident with foreign invasion followed by an unusually horrible civil war, lent credence to this view. It is arguable that the Ugandan and Tanzanian militaries provided a ‘bridge population’ whereby a

concentrated heterosexual epidemic, was spread to the general population. Further fuel was added by the fact that the two groups known to have the highest HIV prevalence in Thailand were soldiers and sex workers, and by the widely-held supposition that foreign peacekeepers were responsible for increasing rates of HIV in Cambodia. This consensus that conflict facilitates HIV transmission is based on few pieces of hard data but is very powerfully reflected in agency literature. It is so powerful that some researchers who have found low HIV rates among conflict-affected populations, have concluded that because of the shortcomings of study methodologies they failed to find what was indubitably there.

Low measured levels of HIV in Angola and Mozambique in the 1990s obliged scholars to qualify this view. It was argued that in these rather special circumstances—when the outbreak of war pre-dated the emergence of an HIV epidemic, and the war kept the national population isolated from its neighbours—war would not have the effect of driving up HIV rates. More recent evidence from Sierra Leone, Sudan, Somalia, Uganda, northern Ethiopia and even the Democratic Republic of Congo seems to suggest that this exceptional case is in fact the norm. HIV rates appear consistently lower in these conflict-ridden countries and do not appear to be rising. Similarly, a review of HIV rates in refugee camps suggests they are not higher than in regular civilian populations.

Generalization is perilous because of the uniqueness of each case and the paucity of detailed epidemiology including the study of disease patterns in their social context (including sexual networks). However, the pattern is sufficiently consistent that ‘conflict protects against HIV’ may shortly become the scholarly consensus. What is the reason for conflict being protective of HIV in so many cases? The ‘isolation’ argument may be appropriate to southern Sudan, but does not work for others. In the IDP camps and dormitory settlements on the edge of northern Ugandan towns, the fact that the camps are heavily policed and allow little privacy may mean that there is a reduction in sexual activity. In northern Ethiopia, the fact that HIV rates did not measurably increase while the army was deployed may be related to the exclusive sexual networks of the soldiers, who, as rural conscripts mostly screened for HIV, were deployed with low HIV rates. In that case, the army had an unusually good HIV programme also.

Evidence points to a general tendency for refugee camps to have lower HIV incidence than normal communities. Peter Spiegel has argued persuasively for this. Remarkably, this is the case in the refugee camps of north-east Kenya, where there was an extraordinarily high incidence of rape in the early 1990s, with a mixture of Somali militiamen, bandits and local police and security forces responsible. Health workers noticed an increase in HIV diagnoses among camp women at the time. More recent HIV surveillance data seem to indicate this did not lead to a very high prevalence. Whether this was due to low HIV among the rapists, low HIV transmission during the rapes, or effective measures by UNHCR and camp authorities to extend protection to women, thereby reducing the incidence of rape, is unclear.

Among survivors of the genocide in Rwanda, almost all of whom are female and the majority of whom were raped, often multiple times in extremely violent ways, the rate of

HIV is many times higher than in the general population. This is powerful evidence for rape during genocide being the cause of infection. It appears that at least some of the rapists knew they were HIV positive and aimed to transmit the virus. This is a uniquely appalling case, made worse by the neglect of these women in post-genocide treatment and care programmes. Fortunately, to date, it is the only proven one of its kind.

If it turns out to be correct that, as a general rule, conflict lessens the societal vulnerability to HIV, the finding needs to be interpreted with extreme caution. It is not difficult to envision circumstances in which the opposite is true. For example, if conflict in a relatively high-prevalence country leads to a flow of refugees to its lower-prevalence neighbours, we would expect HIV rates to rise in those neighbours. The conflict in Cote d'Ivoire may be having this effect. Similarly, the presence of troops from Uganda, Rwanda and Zimbabwe in DRC may have led to pockets of high prevalence. Also, in cases of extreme and systematic rape, such as during the 1994 genocide in Rwanda, we would expect a sharp increase in HIV incidence. There is strong anecdotal evidence that this indeed occurred in Rwanda. If a country that is already suffering a high prevalence of HIV is consumed by conflict, the deterioration in health services and disruption to the population may exacerbate that epidemic.

The concurrence of a humanitarian emergency and an epidemic of HIV/AIDS poses major programmatic challenges for relief organizations. How are AIDS programmes including both prevention and treatment to be sustained during emergency conditions? Humanitarian programmes typically involve hard choices of prioritization and rationing, with most attention being given to traditionally vulnerable groups such as young children. Are these priorities to be sustained during a crisis? These are tough questions needing close study.

The main policy finding arising from this analytical sketch is the need for a more fine-grained epidemiological analysis. Policy recommendations are correspondingly specific and targeted. If there is a particular population sub-group that has high HIV prevalence and is likely to circulate among a wider population on account of war, and thereby spread HIV, that sub-group should be targeted for HIV-related interventions.

### **Post-Conflict Reconstruction, DDR and HIV Transmission**

It has been plausibly argued that the post-conflict period is a time of high societal vulnerability to HIV. The ending of conflict is accompanied by substantial population movements, the opening of roads, the flow of commerce, the deployment of aid workers and civil servants, the reunification of families, and the demobilization of combatants. This level of population mixing, including many components of the national population as well as truck drivers and contractors from neighbouring countries, international aid workers and peacekeepers and others, could potentially be an opportunity for the explosive spread of HIV.

There is credible evidence from South Africa that the early stages of the epidemic, coinciding with the opening of the country's borders and the return of troops who had

been stationed in Namibia, is an example of this. There have been well-argued warnings that the end of conflicts in Angola and southern Sudan may lead to those countries belatedly suffering the epidemics that have already ravaged their neighbours. This is the main lesson from Cambodia also, where the post-conflict phase, including return of refugees, greater mobility and the inflow of foreign relief workers and peacekeepers was associated with a sharp increase in HIV. In post-Taliban Afghanistan, the combination of greater openness, increased population mobility, and an increase in drug production and use, may indicate the conditions for a rapid increase in HIV. These warnings certainly need to be taken seriously and it is better to err on the side of over-response. But, again, detailed and careful epidemiology is needed in order to demonstrate that any specific post-conflict transition is in itself a risk factor for an HIV epidemic, because of the presence and activities of specific subgroups within the population.

Studies of economic development and HIV risk in south-east Asia (Lee-Nah Hsu) indicate that specific economic activities such as road-building are likely to be associated with higher HIV risk, but that appropriate programmatic interventions can reduce this risk. Post-conflict situations can similarly be mapped to identify the highest-risk locations and activities for HIV transmission, with interventions targeted accordingly.

A significant policy recommendation arises from this analysis: post-conflict transitions are likely to be high-risk periods for HIV transmission. At the risk of adding a further programmatic burden on administrative systems already suffering the multiple stresses of transition, HIV/AIDS prevention needs to be prioritised. In line with the main theme of this paper, the challenges of HIV/AIDS in post-conflict transitions are specific to subgroups and particular situations, and are manageable. Policy and programmatic interventions in turn need fine-tuning on the basis of evidence.

### **HIV as a Risk Factor for Conflict**

Writers have proposed that an HIV/AIDS epidemic can increase the risk of conflict in a country. At present there is not a single empirical analysis of this, although it should not be difficult to test using existing multi-country datasets. Rather than empirical investigation we have proposed causal mechanisms, some of which are indirect—and may contain a germ of insight—while others are implausible.

- The ‘security demographic’ argument. The core of this case is that the majority of crime is committed by young males aged 15-25. If a population contains a disproportionate share of this age category, it follows that it is likely to suffer a higher rate of crime. This is a readily demonstrable association, and insofar as a generalised HIV/AIDS epidemic reduces the number of older people, it increases the proportion of youth, and so (other things being equal) increases the overall crime rate and the risks of political unrest. However, we should note that this is a correlation and not a demonstrated causal linkage, and the *ceteris paribus* assumption is pivotal. Also, although robust, the statistical association is small relative to conventional political indicators of conflict risks. By far the most powerful predictor of conflict is ‘war before or war next door’: we can anticipate

conflict because of the unresolved legacy of a previous conflict or the direct spill-over from violence in a neighbouring territory. The verdict on the ‘security demographic’ argument is: interesting and generally valid, but of relatively little use in explaining individual cases and still less use in prediction.

- A stronger version of this argument states that this ‘youth bulge’ will include a disproportionate number of orphans, especially children orphaned by AIDS, who will be poorly socialised, and also unemployed, frustrated and aggrieved, and so more readily available to recruitment to criminal gangs, warlords and terrorists. This could be called the ‘drier kindling’ argument: when a flame is lit by an entrepreneur of violence, a society impacted in this way is more likely to catch fire. Not only is there more kindling (young men) but it is drier (they are more ready for recruitment). This is plausible, but again begs the question of ‘who strikes the match?’ It points to the policy and programmatic importance of education and employment in poor and conflict-prone societies, and the need to adjust the provision of both in the context of HIV/AIDS.
- An even stronger version of this is claim that people living with HIV, or living in a society blighted by an AIDS epidemic, become so alienated, fatalistic and angry that they initiate violence or willingly follow violent leaders because they simply don’t care about the future, or want the world destroyed with them. This can be called the ‘loose molecules’ argument after Robert Kaplan’s ‘Coming Anarchy’ thesis. (Note that this need not be specific to AIDS: any bulge of desperate youth will do. Kaplan himself was writing about west African countries with low HIV prevalence in the early 1990s.) Direct evidence for this is non-existent. However, there is evidence for HIV/AIDS being integrated into a short-term, risk-infused and fatalistic worldview among marginalized youth in many different cultures. The existence of such alienated youth is a concern in and of itself, and exposure to HIV can be a significant element in this mix. Whether or not it can lead to conflict is another issue, as yet without investigation. There is also a danger that identifying PLWHA as possible criminals, guerrillas or terrorists will further stigmatize them, and encourage a view that the AIDS epidemic needs to be policed as well as healed. It is important to counteract this.
- The ‘poverty fuels conflict’ argument. There is statistical evidence from Paul Collier and others that links poverty, especially economic downturns, and risks of conflict. The association is small but robust. Insofar as HIV/AIDS contributes to poverty, inequality and economic downturn, it also increases the risk of conflict. As with the ‘security demographic’ argument, this is a provable if small correlation. It does not demonstrate the causal pathways and the question remains, who lights the match? Once again, this argument points to the importance of finding mechanisms for sustaining democratic governance in poor countries, and adapting these to the specific challenges of countries ravaged by AIDS.
- The ‘AIDS accelerates state collapse’ argument. This is perhaps the strongest argument, and will be treated in more detail in Issue Paper two. The loss of

human resources in key government departments to HIV/AIDS, on top of existing capacity constraints and losses, means that some governments are simply unable to sustain departments of health, education and justice. This collapse in basic government services is already occurring in several countries. This is a new form of state collapse: going out with a whimper rather than the more familiar bang associated with civil war in a capital city. The experience of governance vacuum in remote regions such as Darfur in the west of Sudan indicates that, over time, this is an extremely serious risk factor for conflict. In order for an ungoverned province to transition from merely being unserved to being prone to violence, additional preconditions need to be in place, including the presence of armed groups and governmental manipulation of local tension. We don't know what it means for government services and administration to quietly evaporate on account of AIDS, without accompanying militarized manipulation. But even if we remain sceptical about AIDS actually *causing* state collapse, there are very serious questions about how to handle HIV/AIDS policies and programmes in a state that is fragile or collapsing for any reason. It is highly plausible that, even if AIDS is not the major cause of a state collapse, it will be one of the major impediments to a collapsed state getting back on its feet. For these reasons, we need to be even more alert to the dangers of state collapse in the era of AIDS.

In summary, there is reason to be concerned that HIV/AIDS is exacerbating existing social pathologies and thereby incrementally adding to the factors that increase the risk of conflict. The 'security demographic' is a real factor in risk of crime and conflict, whether arising from population growth alone (as in north Africa, the Middle East and parts of south and central Asia) or population growth combined with HIV/AIDS (as in southern and eastern Africa). The economic decline factor is also real. But these causal linkages are all based on surmise rather than demonstration and it is easy to exaggerate these threats.

Even though HIV/AIDS does not appear to directly contribute to conflict, the *concurrency* of conflict and an AIDS epidemic creates special problems and demands special humanitarian instruments. How to sustain HIV prevention and treatment programmes in the midst of a conflict, complex humanitarian emergency or collapsed state is a difficult question that has yet to be answered. Existing instruments to use in these circumstances may prove ineffective or have unfortunate side-effects. For example, normal measures against an abusive dictatorship include economic sanctions, on the rationale that even if ordinary people suffer, this can be justified by the longer-term good. If the sanctions undermine an AIDS programme, this rationale may need to be revised. Similarly, emergency relief interventions usually focus on life-saving measures for children including food aid, water supplies and relatively cheap standard health interventions. In the context of AIDS, should ARV provision to adults be added too? Should attention be paid to how relief measures such as relocating conflict-affected populations away from war zones might inadvertently increase risks of HIV transmission? Finally, how is state reconstruction to be attempted in a country that is ravaged not just by conflict and misgovernment but by AIDS as well? These are areas demanding research and policymaking.

## **Conflict, Gender Relations and AIDS**

The level of gender-based violence in conflict, long a neglected subject, has belatedly received political, advocacy and scholarly attention in the last decade. Advocacy on the issue of conflict and gender based violence has followed the snowball pattern and tended to assume the worst case as the general reality. In addition, some advocates assumed that these factors, singly and in combination, are highly significant for HIV infection. Without in any way lessening the criminality of gender-based violence and the horrific realities of rape in wartime, the overall epidemiological significance of these factors for HIV remains uncertain. The case of Rwanda is at present the only instance that demonstrates both very high HIV prevalence on account of systematic rape and also deliberate HIV transmission as a weapon.

Quantitative investigation of gender relations and rape is extraordinarily difficult. Developing robust methodologies in this area is important. In the meantime, we can refine the hypothesized causal pathways whereby conflict can lead to an increase in gender inequality and gender-based violence and, in turn, HIV.

Hypothesis one: conflict and militarization exacerbate gender inequality. This is manifest in lowering the status of women, which results in their reduced ability to protect themselves against HIV, whether through the fidelity of their partners or through using condoms. Leftwing revolutionary militarism may provide some limited opportunities for women to emancipate themselves, but this is typically rare, selective and brief. It is also manifest in the construction of a militarized masculinity, which values command, authority and power, and discourages seeking consent or consensus.

Hypothesis two: conflict disrupts women's lives and impoverishes them, leaving them more reliant on transactional sex. During conflicts, a greater economic and social burden falls upon women. This may on occasion be liberating for women who can join the labour force, but more often it simply increases their workload and vulnerability. Poor and vulnerable women may have no alternative but to engage in commercial sex work, seek out partnerships with men who may also have other partners, or resort to survival sex. Men's lives are also disrupted: some join armies and others migrate to look for work and safety. This disruption may facilitate new sexual networks. Some men may relish the freedom they obtain.

Hypothesis three: conflict places special pressures on women's health. Disruption of services leaves women less well educated about HIV, and with less access to health services and prevention methods, and hence more vulnerable to HIV. The collapse of STI services for both men and women leads to greater prevalence of untreated STIs and hence greater vulnerability to HIV.

Hypothesis four: many wars are associated with an increase in rape, and on some occasions rape has been used as a weapon of war and genocide. In these circumstances, rape is not only a criminal act but may have epidemiological significance, first as a direct

transmitter of HIV, and second as a cause of physical trauma to women which may leave them more vulnerable to HIV transmission in subsequent sexual encounters.

These are important subjects warranting careful examination and policymaking. In all areas, action is warranted irrespective of the epidemiological significance for HIV transmission.

## **Conclusion**

The overall picture that emerges from this analysis is that the issues surrounding HIV/AIDS and security are less extreme and more manageable than the literature might imply, but that there are nonetheless a number of significant and severe problems in specific areas. There are major gaps in data and analysis which, if filled, could allow better targeted interventions to address these specific challenges. We can focus our concern in more manageable ways, while still sounding the alarm about the consequences that will follow if AIDS epidemics are allowed to proceed unchecked.

A major theme that emerges is that HIV/AIDS makes existing problems more difficult and less tractable. Armies that have problems of discipline, command and control, will find these exacerbated by HIV/AIDS. Although AIDS may not directly fuel conflict, it may make the impacts of conflict more long-lasting, and impede the rehabilitation of a fragile state. HIV/AIDS adds to the existing horrors of large-scale gender-based violence in conflict.

A few years ago, the field of AIDS and security was dominated by conjecture, with little empirical evidence on which to base policies and programmes. Research and understanding has now moved on, and it is possible to crystallise the state of knowledge, to identify the key areas of concern. In this context, countries that are on the cusp of serious epidemics have important lessons to learn from those that have suffered generalized epidemics for some years, and a new set of finely-tuned best practices can be distilled from what has been learned.

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