

AIDS, Security and Conflict Initiative

Speaking Notes on Themes and Evidence

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Introduction

The state of the evidence consists of: what we know, what we need to know, and the policy implications that follow. This will be presented under four main themes or clusters, each of which corresponds to a proposed Working Group for the ASCI. These are:

1. AIDS in the military and other uniformed forces
2. AIDS, conflict, humanitarian emergencies and post-conflict phases
3. Gender
4. AIDS and fragile states

Two basic cross-cutting themes:

- calibrating concern
- variability according to local circumstance

In summary, what we face is not a single monster problem. Rather it is a cluster of more specific problems, some severe, some less so. Some problems have immediate remedies. Some unfold over a long time, with consequences that are complex and difficult to predict. Some have been exaggerated and are in fact smaller and more tractable than we may have feared.

One: AIDS and the military

This will work on research themes 1 and 2 (in the research document): HIV in the military/uniformed services and implications of HIV/AIDS for national and multi-lateral security institutions and policies. This is a mix of empirical research and policy analysis.

What do we know about HIV in the military and other uniformed services?

- We know that HIV rates armies and other uniformed services are highly variable. In some instances they appear to be considerably higher than in the corresponding civilian population. In other circumstances they are the same or lower. In the early days of the epidemic in Africa, several armies seemed to have very high rates. Now, most armies seem to have rates comparable to or lower than the general

population. In Asia and the FSU, it is possible that the rates are higher than the low background rates in the population.

- We know this variability is also the case for peacekeepers. There are documented cases—for example Nigerians in ECOMOG—in which deployment on a peacekeeping mission is a significant risk factor. There are other cases where this is not the case.
- We know much more about armies than about other uniformed services such as the police.
- We have good reason to suppose several factors determining HIV prevalence in armies and uniformed services. These include:
 - The age composition of the army, which in turn reflects whether it is chiefly a conscript army, or a professional force with an older age distribution.
 - The pattern of deployment of the army: whether it is in small or large garrisons, how long soldiers are stationed in one locality, the type of operations it mounts.
 - The morale, discipline and ethos of the force, whether it is well-paid or not.
 - The kind of epidemic to which the army is exposed, whether it is generalized or concentrated, the stage of maturity of the epidemic, the main means of transmission.
 - Attitudes and policies in the institution towards individuals who may engage in high-risk practices, including MSM, IDUs etc.
 - The AIDS policies adopted by the military.

What do we need to know? And how will it be useful?

- We need to know how these patterns play out among different militaries. We need to know if we can cluster or categorize armed forces into different types according to the criteria identified.
- This will be useful for designing HIV/AIDS policies and programmes appropriate to the circumstances of specific militaries. It will allow for the concentration of effort on the most serious problems and where the greatest impact will be felt. It will be useful for advocacy purposes.

What do we know about the policies and programmes adopted by armies and other uniformed services?

- We know that most armies and police forces have been secretive about the level of HIV they experience. This is partly because it is considered a national security issue. It is also because what has been presented as the norm—extremely high

rates of HIV—is usually not what these militaries find, so that they are worried that they will be accused of covering up if they publish their results.

- We know that armies face a number of policy dilemmas, which they handle in different ways. These include whether to treat soldiers and their families within the military medical system, or discharge them to the civilian health system. How are they to budget for the impact of AIDS on medical bills, recruitment and training, etc? Should they adopt harm-reduction measures, for example with respect to IDUs? How are they to handle women serving in the armed force? What are their obligations to the orphans of military families?
- A particular dilemma is over the issue of mandatory testing. Most armies have decided firmly in favour of mandatory testing, both on recruitment/conscription and on promotion or sending an officer for specialist training. This is open to challenge on human rights and legal grounds in many cases, but armies still do it. The question is no longer whether to test, but how to handle the implications of a policy of testing. What are the obligations of the army to a conscript who tests positive? To a serving soldier who tests positive? To his family? How is a testing policy to be sustained?
- In the case of police forces, we have not only the questions of their own internal institutional practices, but also how they relate to civilian communities. Given that many of the groups at high risk of HIV are stigmatized and/or criminalized, and some of the actions that contribute to HIV transmission and vulnerability are crimes (e.g. rape), police and judicial authorities face a range of significant policy and implementation choices.

In short: armies and police forces can be categorized according to (1) the level and nature of the HIV threat they face and (2) the political, social, economic and policy environment in which they have to make key choices. The diverse circumstances in these two sets of frameworks will lead to a great range of policy and programme recommendations.

What do we need to know and what implications will it have?

- We have not categorized military policies on all these issues and examined their consequences, both for national militaries and for regional and international peacekeepers. We don't have a set of best practices. We don't know the position of HIV/AIDS policies in security sector reforms.
- We know far less about other uniformed services including police forces. Police forces engage with the general population in much wider range of areas, with far-reaching implications for HIV/AIDS vulnerabilities and possibilities for HIV/AIDS policies and programmes. There are some important experiences that have yet to be properly documented, analyzed, compared or publicized. This area is wide open for research and policy engagement.

- We know little about irregular forces including guerrillas. We have two stereotypes: the drug-crazed teenage Liberian street fighter, whose whole way of life seems to indicate a high risk of HIV, and the austere rural freedom fighter, respectfully living among the people, who represents the reverse. (The Eritrean and Tigrayan guerrillas had longstanding no sex policies during their liberation wars.)

Overall, our interventions can move away from a ‘one size fits all’ approach into much smarter and more targeted policies and programmes.

Two: AIDS in conflicts, humanitarian emergencies and post-conflict situations

This proposed working group is also a combination of the search for hard data and rigorous analysis of that data, and policy engagement. It will focus on the determinants of HIV in conflict and post-conflict situations, and integrating HIV/AIDS policies and programmes into security sector reforms, conflict prevention and emergency responses, including grassroots and cross-national initiatives.

What do we know?

- We know that most of the risk indicators for HIV vulnerability rise sharply in situations of conflict. Families are disrupted and impoverished, women are vulnerable, health services deteriorate, and we suspect that the likelihood for sexual violence increases. Flows of refugees out of relatively high-prevalence countries may have adverse consequences for HIV/AIDS in their neighbours: Cote d’Ivoire may be an example of this.
- We have remarkably little evidence that HIV rates have risen during most specific conflicts. Investigations in Sierra Leone, DRC, Southern Sudan, Angola and northern Ethiopia after the Ethio-Eritrean war all fail to show increases in HIV. In northern Uganda, rates of HIV are higher than in the south, but they appear to follow much the same pattern and trend.
- We have remarkably little evidence to suggest that refugees are consistently at higher risk of HIV infection. In some cases this may be so, in other cases it appears not to be. We may speculate that camp life, with its lack of privacy and close policing by the refugees themselves and camp authorities, is a low-risk environment for HIV.
- We have plentiful anecdotal evidence for an increase in vulnerability to HIV during complex emergencies and food crises, including an increase in young women resorting to survival sex.
- We have very good reason to fear that post-conflict situations involve heightened risk of HIV transmission. The increased mobility of people, the opening up of areas formerly left isolated by conflict, the return of refugees and exiles, the

demobilization of combatants, the arrival of truck drivers, business people, aid workers, peacekeepers and others, may all increase a population's susceptibility to HIV.

What do we need to know and what impact will it have?

- We need to know if these patterns are consistent, if these anecdotes hold true, if these hypotheses are borne out by the data.
- What we suspect is that the different components of conflict, humanitarian emergency and post-conflict phases have different and selective impacts, and that these depend upon local circumstance. For example, the destruction of health facilities may be very adverse, but forcing people to live in remote groups in rural areas may be a positive factor limiting HIV transmission.
- If we can disaggregate the component factors contributing to lesser or greater vulnerability to HIV, we can design much smarter policies and interventions.

On the policy side, we know that governments, international organizations and NGOs are all struggling to adopt the right approaches. We can tabulate policies, programmes and principles. We can find out who is doing what and who believes what. But we know that the evidence base for constructing these best practices is rather slender. We can explore the opportunities for using innovative approaches in responding to the challenges of HIV programming in these difficult circumstances.

Three: Gender

This working group will focus on refining the gender analysis of AIDS, security and conflict. Again, there is a combination of obtaining data and analyzing policy.

The gender dimensions of conflict have belatedly received much-warranted attention in the last decade. But the systematic evidence base is still poor.

- We know that sexual violence is very common in many conflicts. We know that in some conflicts rape is a weapon of war, or even genocide, and that it has therefore been recognized as a war crime. We know that women bear the greater social and economic burdens during conflict. These are all valid concerns in and of themselves.
- What we don't know is the epidemiological significance of women's increased vulnerability for HIV transmission. The only case in which it has been credibly claimed that women were deliberately infected with HIV during conflict has been the Rwanda genocide of 1994. In other cases, we simply can't say whether rape has had that outcome, either directly through HIV infection during rape, or because of the stigmatization, exclusion, impoverishment and general vulnerability of a rape survivor in the longer term.

- We know that military institutions and conflict situations tend to promote specific cultures of masculinity. We suspect that these have implications for gender relations, including the status and treatment of women, and also the treatment of men who have sex with men and transgendered individuals. We don't know the implications of this heightened and distorted masculinity for HIV transmission.

Compared to the previous two general themes, the evidence base for how the gender dimensions of conflict impact upon HIV is weaker still. Quantitative data are extraordinarily difficult to find and to generate. In conflict, all the lights for heightened gender-based vulnerability seem to flash red. We need be able to calibrate this.

How will this knowledge make us do business differently? Isn't it already the case that we consider gender inequities undesirable and we have added rape to the list of war crimes? How will knowing the implications of this for HIV change policy?

- The answer to this is perhaps disappointing: we won't know until we conduct the research. But we can point to the sorts of recommendations that might arise.
- For example, if it is the case that the principal risk for HIV following rape is the long-term vulnerability of the survivor rather than infection during the act itself, then it makes a lot of sense to focus responses to rape survivors on those long-term psychological and social issues.

Four: Fragile States

The issue of state survival and HIV/AIDS consists of two separate but linked issues:

1. How the epidemic can exacerbate state fragility and contribute to conflict and social breakdown; and
2. How to respond to HIV/AIDS in already-fragile states.

Both are areas in which we know remarkably little. On the first question, a number of hypotheses have been put forward which demand attention. Some are highly implausible, some are plausible, others seem to be occurring right now in front of our eyes. All demand scrutiny. Let me list seven:

1. One of the impacts of generalized AIDS epidemics is the 'security demographic' with a 'youth bulge' that threatens greater levels of crime and political stability.
2. Another impact of HIV/AIDS is slower economic growth, greater socio-economic inequality, greater risks of famine and thus increased risks to the stability of states.

3. The rapid increase in the number of orphans, growing up without adequate socialization and with poor life chances, can make it difficult for a society to sustain its core values and institutions.
4. The drop in life expectancy associated with the AIDS epidemic brings in its wake subtle but far-reaching changes to progress in governance, threatening dysfunctional institutions and societies.
5. Human resource losses due to AIDS, combining with other stresses, imperil the functioning of important institutions for governance. This one is actually occurring in some countries. It can be called the 'fading states' scenario: countries that are going out with a whimper rather than the more familiar bang.
6. AIDS and its impacts may contribute to the growth or attractiveness of extremist movements and ideologies.
7. Rationing, real or perceived, in treatment provision can generate political stresses that can endanger the stability of a state.

In all cases, the evidence needs to be carefully scrutinized. It is important to know whether we should sound the alarm on these scenarios, or whether fears have been exaggerated or misplaced.

And insofar as the fears are real, what kinds of policy instruments will be needed to respond? For example, how are the basic human resource needs for staffing essential institutions to be met, when a country is facing critical shortages of qualified personnel?

A second issue within this cluster is the question of how to respond to generalized HIV/AIDS epidemics that are ravaging countries that are fragile for all sorts of reasons. We need to ask whether the policy and programme instruments that we have are appropriate for responding to the complex challenges posed by a rogue or collapsing state that is also suffering an AIDS epidemic.

The international arsenal for responding to such states includes instruments such as sanctions, humanitarian programmes and in extremis military intervention. The rationale for these instruments changes in the context of an HIV/AIDS epidemic. For example, sanctions that hurt a civilian population are commonly justified on the grounds that short-term hardship will be soon replaced by a better state of affairs. If the country is suffering an AIDS epidemic, however, the hardship may become irreversible. This poses a policy challenge: how to sustain HIV/AIDS programmes in countries in which the state is incompetent, corrupt, tyrannical or absent? At present, there is only a very slender evidence base for making these critical policy choices.

We can examine what is being done in this area and what is contemplated, and consider the kinds of instruments and principles that will be needed for effective responses.

The themes of this final research cluster are the least documented of all. The empirical evidence base is weak for all sorts of good reasons, including the fact that we are mostly talking about what may happen in the future if the AIDS pandemic continues to unfold at its current rate. This is genuinely uncharted territory. That does not reduce us to pure speculation, because we can come to well-informed judgements about what is occurring, what may happen, and how we should respond.

In this field we may need to use innovative research and investigation methods such as scenario exercises and systems modeling.

Conclusion

The agenda we have mapped out is broad and ambitious. It ranges from highly specific questions that can be answered by utilizing data that already exist to charting possibilities for how the future may unfold over the coming decades.

Our basic theme is that the problems are varied, serious, but tractable. Focused efforts informed by empirical evidence and sound analysis can solve real problems.

It is a formidable challenge. It is thoroughly exciting, both intellectually and as an exercise in developing policies based on evidence. It requires a collaborative approach spanning many different institutions across all continents. It needs to be done.