Chapter 4: HIV/AIDS, Women and War

War is a strong ally of HIV. It means we say goodbye to our communities and prevention strategies and we say hello to HIV and AIDS.

A Save the Children health worker in Burundi

Marie, a tall and quiet woman of 24, lives with her two-year-old and her baby on the edge of a frontier town in eastern part of the Democratic Republic of the Congo (DRC). The area has changed hands among rebel groups and foreign troops a number of times in the past few years, each time via armed attacks during which civilians were caught in the middle. It is not a town that many of its residents would choose to live in – it is simply a place they have run to in order to escape worse fighting somewhere else. Some come to get access to food, which arrives irregularly from relief agencies. Others hope to find treatment for their illnesses or wounds, or to find work or missing family members.

The three-room health post is pockmarked from mortar fire and nearly empty of furniture and supplies. The one trained nurse can provide advice, but little else. There are only occasional medicines and supplies, brought by charities when it is safe to visit. People coming to the clinic with injuries or wounds – and there are many – can usually be treated only with soap and water. Many infections go untreated. Anyone who needs blood must be transfused from a friend or relative, using inadequate and sometimes unsterilized transfusion supplies. When Marie delivered her babies at home in her hut, she got help from a traditional birth attendant whose razor blade had already been used for many births.

The town is filled with women and children, mostly. Many of the men from the region have fled or been killed or have gone to the bush with rebel groups. A recent Human Rights Watch report has documented frightening levels of violence in the town and the surrounding region.[1] Many of the women that Marie knows have been raped by soldiers from one group or another. Marie also was raped when she was 20 years old but she considers herself "one of the lucky ones – it wasn't gang rape, and I wasn't hurt badly and it was only once." Given the experiences of many women she knows, she is thankful for this.

There are no jobs for Marie or her friends and they have no family left to help them, so quite often they resort to selling sex for money, food or even to 'buy' protection from rebel leaders. Marie is embarrassed about this, but feels she has no choice. "I am only thankful that my mother and father cannot see the way I am living now because they did not raise me to do these things. But what else can I do? There is no one to help. I must take care of my children."

Marie knows that sex with many partners can be unhealthy but she doesn't really know any details and she has no access to information about sexually transmitted infections or HIV. Nor does she have access to basic supplies such as condoms or contraceptives to prevent an unwanted pregnancy. She has no power to negotiate protection with the men who come to her hut.

There is much that Marie is unaware of – and it will probably cost her her life. She does not know that HIV is spread through sex or through contact with contaminated blood. She doesn't realize that many of the soldiers who are deployed in the region, some

of whom come to her hut to buy sex, are infected with HIV. She has no idea that women are biologically more vulnerable to HIV infection than men and that violent sex such as rape makes women especially vulnerable. She would be shocked to learn that the odds of an infected woman passing the infection to her baby during delivery or breastfeeding are one in three and that her children are probably infected. And if she knew these things, there is little she could do about them.

The odds are very much against Marie. Almost 1.3 million adults and children are living with HIV in DRC. In North Kivu, near where Marie lives, a recent study showed infection rates of 54 per cent among adult women, 32 per cent among adult men and 26 per cent among children.[2] Marie will probably live long enough to watch her baby die and maybe even to bury her two-year-old. She will almost surely suffer extended illness and pain and die alone, without any family to care for her. The immediate cause of the deaths in this young and fragile family may be AIDS, but the real causes would be poverty and neglect, war, ignorance, greed, discrimination and exploitation.

Who is to blame for Marie's plight? Is it the men who infected her, knowingly or unknowingly? The birth attendant who used a contaminated blade to cut the umbilical cord? The government that for decades neglected the region, leading to poverty and war – and also never trained the birth attendant? The neighbouring government that supports the rebels but does not support any health care or education in the town? The international community which looked the other way as the conflict got worse? The arms dealers who profit from it? The humanitarian community which doesn't protect or provide basic health care or food to the civilians? The donors who don't provide the resources for the humanitarian community to do so? Well-meaning but naive groups who believe that their support for HIV prevention should focus on abstinence? Marie's church which, even if she could get condoms and get men to use them, would tell her that condom use is a sin? The members of the Security Council who pass resolutions on HIV/AIDS and conflict but continue to sell small arms to anyone who can pay?

All are to blame. And in too many of the places we visited, even if peace comes, HIV/AIDS will continue to kill.

The Link Between HIV and Conflict

HIV transmission occurs in a number of ways: through exposure to infected blood; exposure to body fluids during unprotected sexual relations; or from mother to child during pregnancy, delivery or breastfeeding. Over 40 million people were living with HIV at the end of 2001, and more than 20 million have died since the virus was first identified.[3] Although 70 per cent of those infected right now are from sub-Saharan Africa, the epidemic continues to grow in other parts of the world. Transmission is influenced by a complex set of social factors, including gender inequality, economies of labour migration which separate families, levels of commercial or 'survival' sex, dangerous traditional practices, intravenous drug use and unsanitary medical procedures. Although many countries with high infection rates have not been in war, there is evidence that conflict conditions exacerbate the epidemic.

If the virus exists within any of the populations involved, the risks of all of these modes of transmission can increase during wars and displacement. Women are at special risk since they are already biologically more vulnerable to infection and their place in

social structures increases this vulnerability. In most places where the main form of transmission is sexual, women are infected in greater numbers than men and at younger ages.

The surest way to contract HIV is to be exposed to infected blood. During armed conflicts, civilians and combatants suffer torture, wounds and injuries requiring medical treatment. If they are exposed to infected blood, or if they receive medical care with contaminated instruments or get transfusions of unscreened blood, then their risks are magnified. In many war zones, the damage to health systems results in inabilities to maintain even basic 'universal precautions' of sterilizing instruments or cleaning hospital linen. Equipment and supplies for screening blood may be destroyed or unavailable at the same time that the need for transfusions increases dramatically. An International Committee of the Red Cross (ICRC) study has documented that the farther they are from health centres, the longer individuals bleed before getting treatment and the more blood they will need to survive. Those who are injured by antipersonnel mines require very large amounts; burn patients require even more.[4]

In Sierra Leone, a country with one of the highest maternal mortality rates in the world, a woman from the north who haemorrhages at delivery will face a dramatic gamble – the blood she needs to survive cannot be screened in any of the regional hospitals and it will take too long to get to Freetown. One maternal health worker told us, " We can train the staff to do emergency deliveries, we can supply the hospital with the obstetrical equipment, we can even provide an ambulance to get women in difficulties to the hospital quickly enough to save her life – but without a blood banking system, without the ability to test blood for HIV, we may be sentencing her to death."

Sexual violence and exploitation, all too common in conflict and post-conflict settings, contributes to transmission as well, both directly and indirectly. Rape by an infected man directly exposes women to the virus, and the abrasions or tearing of vaginal tissues which may result increase the risk of infection dramatically. Indirect effects are also insidious. Sexual violence often has lasting psychosocial consequences, including depression, stigma and discrimination, which can lead women into further cycles of exploitation and also contribute to other high risk activities such as drug use or prostitution. Tragically and most cruelly, in some conflicts (such as Rwanda), the planned and purposeful HIV infection of women has been a tool of ethnic warfare.

The mixing of civilians and combatants (either regular military forces or rebel forces) can increase the chances of infection since military forces almost always have much greater rates of sexually transmitted infections (STIs) and HIV than civilian populations.[5] In many conflict settings combatants are involved in sexual exploitation of women, regular relations with sex workers and, in some places, high levels of sexual violence.

STIs spread quickly in situations of poverty, powerlessness and social instability – and all of these epitomize conflict situations. The disintegration of communities and family life can lead to the break-up of stable relationships as well as the disruption of social norms governing men's and women's sexual behaviour. Forced migration mixes groups with varying HIV infection rates and can increase risks of infections in groups less aware of HIV/AIDS and of means of prevention. A clear example is that of Rwanda, where 1992 infection patterns were high in urban areas (27 per cent of pregnant women infected) and low in rural areas (just over 1 per cent) but where urban and rural rates

became almost the same by 1997 due to the huge population movements during and after the years of ethnic conflict. Since rates of infection in most countries are higher in urban areas, rural people who flee to cities are especially vulnerable. The economic destitution and the psychological trauma of war-affected populations also increase their risk behaviours, while at the same time access to information and modes of prevention are diminished.

In Sierra Leone, the Women in Crisis Movement has established support for young women driven into the sex trade in Freetown. The women are provided with literacy and vocational training, HIV prevention skills and treatment for STIs in participating clinics. However, despite the sense of belonging that the group has provided, and the new skills that the women are learning, until the local economy can provide more jobs, or the women can establish sustainable businesses, they will remain at risk of exploitation and of HIV/AIDS. As one member stated, " We are trying to rebuild our lives after so many bad experiences and this project is helping us do that. But so much depends on being able to get food, transport and housing – most of us don't even have the basic things so many still do sex just to survive."

Normal medical procedures, such as childbirth, become more dangerous during conflict, as do unsafe abortions or treatment for abortion complications. Some traditional practices, such as female genital mutilation (FGM), also contribute to HIV vulnerability among women, especially when women are subject to violent sex. In Somalia, where the culture places a high value on chastity for women, there was very little STI transmission among women before the civil war. However, the disruption of communities and families and the decline of traditional protections for women have changed patterns of relations among women and men.

Dire poverty has driven many women to have sex for survival and, as we learned from many Somali women we met, sexual violence has increased dramatically. Since most Somali women have experienced genital mutilation, including infibulation, rape is very likely to damage their genital tissues, increasing their risk of STIs including HIV/AIDS. Since the HIV/AIDS epidemic is growing so rapidly in the neighbouring countries where many Somalis are living as refugees, there is widespread concern that the epidemic will reach crisis proportions in Somalia as well. The low rates reported for the country may have more to do with lack of good data than with the actual disease patterns.

Conflict also often disrupts food production and markets, and leaves poor people unable to meet basic food requirements. Poor nutrition hastens the onset of AIDS among HIV positive people, thereby weakening families and communities in a never-ending downward spiral.

In many countries, refugee camp situations are insecure for women. Men who have lost their status in their communities or family may resort to drinking or abuse and engage in unprotected sex with multiple partners. Young people who have lost role models engage in sex early. Some refugees bring STIs with them; others contract them in the camp or in nearby towns. If camps do not have active STI treatment services and HIV prevention programmes, they can become dangerous places for residents. A study in Rwandan refugee camps in Tanzania showed that women and men reported frequent experience with STIs. Over half of women receiving prenatal care were infected, with 3 per cent having gonorrhea and 4 per cent syphilis. Six per cent of males had syphilis. Since, as noted above, STIs greatly increase the risk of HIV infection, and given that the

HIV prevalence in Rwanda and Tanzania is already high, these refugees are in great danger.

All of these factors contribute to increased exposure to HIV among women in war zones. They are exacerbated by the already low status of women and girls in most regions of the world that are experiencing armed conflict. Women in the places we visited were powerless to control their sexual relationships or to negotiate safe sex. They are at the mercy of their partners or of strangers even in peacetime; as we have seen, they become even more vulnerable during conflict.

Even in settings where HIV prevention programmes have been well established and where women have reached a level of equality, the onset of war can severely disrupt such programmes, causing a breakdown in access to health information, damage to health infrastructure, lack of access to services and shortages of supplies such as STI treatment drugs or condoms. This lack of services, combined with poverty, can severely limit women's abilities to control their exposure to HIV. As one refugee told us, " I know all about AIDS because we had a big prevention programme back home. All of us here know how you get it and how to keep from getting it. Lots of people started using condoms back home. But here in this camp, they aren't always available and in the city they are expensive – so what should we do? Sometimes my husband and I are together without protection even when we know better."

Even as conflicts subside, extremely difficult economic and social conditions often leave many people unemployed and unable to resume their normal community or family lives. Where AIDS and opportunistic infections are already a problem, women bear the largest burden of care for family members.[6] This responsibility can keep girls from going to school and prevent women's involvement in the work force, thus amplifying the low status of women. In this regard, HIV is a direct threat to both human and national security since the epidemic undermines the economic and social participation of the population during a critical time of national rehabilitation and recovery. As a senior Congolese official told us, "We have the beginnings of peace in our country now and we have so much to do to recover. We need everyone to participate and we need them to be healthy to do that. If we let this epidemic go on, then we will jeopardize everything. We have to stop it now."

As reported in Guatemala and Bosnia and Herzegovina, as well as other settings, levels of sexual violence and exploitation may actually increase after war is over. It is common in many post-conflict situations for traumatized individuals to turn to drugs or alcohol, which is strongly associated with gender violence and increased exposure to HIV. The socio-economic collapse in Tajikistan has led to heavy drug trafficking from Afghanistan, and it is estimated that that 30 per cent of the national economy depends on the drug trade.[7] These drugs permeate the society, and school children as young as 12 have begun to inject drugs, leaving a wide-open door for HIV.[8]

Sexual Violence and Exploitation

"In February 1994 at my parents' house, seven men raped a widow who was staying with the family. The men said, 'at least one of us must be HIV positive.' The widow contracted AIDS and she has already died."

A survivor of the Rwandan genocide

Sexual violence and exploitation are inexcusable under any circumstances, but in the face of HIV/AIDS and conflict they take on new menace. Of all the things we saw or learned about during our visits, one of the most cruel occurred in Rwanda during the genocide there, when Hutu men who knew that they were infected with HIV purposely attempted to infect Tutsi women as a strategy of war. The Interahamwe leaders directly encouraged their militias to rape Tutsi women in order to dilute Tutsi ethnicity; infecting the women with a virus that would eventually kill them seemed an even more effective means of genocide. AVEGA, a support group for Rwandan women, has documented that many rape survivors were infected with HIV. Veronica, an AVEGA member, told us, "The genocide was planned for a long time. Arms were brought in from outside the country for that purpose. They started killing everyone including unborn babies. They would kill a mother after killing her own children in front of her. Men in groups of between 30 and 50 would rape a woman. They would all wait their turn. This was the beginning of the spread of HIV/AIDS. Today many of us are infected because of rape."

Even in the relatively wealthier places we visited, war had taken such a toll on the local economy that women were selling sex to men who had resources of some kind – money, housing or food. From East Timor to Bosnia, Colombia to Liberia, girls and women were forced into such work to survive. In none of these places did women have adequate access to HIV protection. East Timor, for example, had very low HIV prevalence for many years, but there is increasing infection today. The high incidence of sexual violence during the war and the new patterns of relations between East Timorese women and foreigners, including peacekeepers, businesspeople and aid workers seem to be factors. When sex is used as a commodity, women and girls have little negotiating power over the use of condoms – and an offer of more money from men who don't want to use protection is all too difficult to refuse. In Bosnia, Myanmar, the Ukraine and other sites, economic and social disarray have fed a burgeoning sex industry, including trafficking. In the Ukraine, in a ten-year period, rates of syphilis infection increased by a factor of twenty, and will undoubtedly lead to an increase in HIV infection rates.

Many countries are on the brink of more severe epidemics. Now is the time to take action, but the resources are rarely available. Sierra Leone is one such country and has a fighting chance to stop the epidemic if action is taken now – yet few donors seem interested in funding HIV prevention activities. "It seems strange, " said one UN agency representative, " that donors only seem to want to fund governance projects here – courts, elections, tribunals, civil service training, police training – and no one wants to support HIV prevention. If we don't work on stopping HIV now, there won't be people left to govern. Already, the military is very concerned about preventing infection among soldiers in the new army and they see it as a serious security issue. But there is only one UN agency that brings condoms into the country (UNFPA) and they don't have the resources to meet the national demand."[9]

Military-Civilian Interaction

The Joint UN Programme on HIV/AIDS (UNAIDS) has noted that "Military personnel are a population group at special risk of exposure to sexually transmitted diseases (STDs) including HIV. In peacetime, STD infection rates among armed forces are generally 2 to 5 times higher than in civilian populations; in time of conflict the

difference can be 50 times higher or more."[10] The circumstances of military service make soldiers both more vulnerable to HIV infection and more likely to pass it on. Troops are usually young, sexually active and separated from their normal partners. They often have greater access to resources than the civilian population and may frequent commercial sex workers. The military ethos of risk-taking can undermine HIV prevention even when soldiers are aware of risks. The 'macho' attitudes that are part of military socialization may also lead to carelessness about protection and even to exploitative abuse of power, including sexual violence. Military camps also attract sex workers and other risk-prone 'camp followers'.

In Ethiopia and Eritrea the deployment of national armies to the borders during the war was reputed to have been followed closely by the movement of sex workers to the area. The months of inactivity between battles left plenty of time for troops to take leave and spend their time drinking and visiting local brothels. In Eritrea women made up a significant proportion of the armed forces and many young people who might not have become sexually active at home, became involved in relationships at the front. The National Union of Eritrean Youth and Students, concerned about these young people, quickly mobilized an HIV awareness and prevention programme in camps.

For young soldiers (men and women) who are in the midst of a war and have seen their fellow soldiers die in combat, fatalism becomes a risk factor. As one young Eritrean soldier stated, "I have seen so many of my friends die at the front and I know that I might die. Why should I worry about a disease that would take years to kill me when I might die tomorrow?"[11] Combatants who return to their homes and communities may bring whatever behaviours they have adopted as well as any STIs, including HIV, that they may have contracted. This is another way in which HIV spreads back into civilian society. The Director of an HIV/AIDS programme in the Ethiopian military has observed that HIV issues were neglected during the 1991 demobilization after the government was overthrown and that it may have been one of the major transmission factors for the epidemic there. He noted in 2000 that, "If HIV awareness is not paid attention to this time, uncontrolled demobilization will be catastrophic."[12]

The risks of infection are even higher among non-state combatants (rebels and insurgents) who often have very little military discipline and no access to health information or services. Such groups have been responsible for very high levels of rape and sexual abuse in many conflicts, including many of the places we visited. The levels of STI/HIV infection in some of these groups have been estimated at up to 50 per cent; one can imagine the impact on transmission to women within the civilian population.

Multiple troop movements and population displacements in the DRC, and to and from neighbouring countries with high HIV prevalence rates, have left the DRC well set for "an explosion of HIV/AIDS", according to a WHO official in a report on HIV in the region. "I can hardly think of a better vector than tens of thousands of young men with hard currency roaming around the country," noted another relief worker.[13] HIV prevalence among the uniformed services is high in places where the epidemic has most raged. Although the data is not very reliable, it is believed that rates range up to 30 per cent in Tanzania and 40-60 per cent in Angola and the DRC. Zimbabwe, which has troops deployed in the DRC, may have up to 70 per cent infected.[14]

Although military services present exceptional opportunities to prevent HIV through awareness and training of troops in organized hierarchical settings, and even

through use of uniformed services to raise awareness in civilian populations, very few of the militaries in the countries we visited have the resources to establish strong prevention and care programmes. As one general told us, "The war now is with AIDS – but it was easier to get guns than it is to get the tools to fight AIDS."

Peacekeeping Troops: Vectors or victims?

Peacekeeping forces can also have an impact on HIV transmission. These forces are composed of a variety of national troop contingents who have widely varying levels of knowledge about HIV as well as different patterns of interaction with the local population. Such forces can become a part of the problem or part of the solution, depending on their training and their behaviours. When the recent war between Ethiopia and Eritrea came to an end, the two countries agreed to receive peacekeeping forces to monitor the border areas until they were demarcated. As the negotiations for the UN Mission in Eritrea and Ethiopia (UNMEE) proceeded, the Eritrean Government expressed serious concern about the possibility that there might be HIV infected soldiers among the peacekeeping troops and asked that all troops be tested. The Eritrean military screens for HIV, the Government noted, and so should any other military force on its territory. This point has remained in contention for over a year, and Eritrea has yet to sign the agreement.[15]

The Department of Peacekeeping Operations (DPKO), however, cannot require testing of military personnel contributed for service with the United Nations, as this is determined by the national policies of each contributing country. A UNAIDS panel of experts has unanimously agreed that HIV/AIDS testing should be voluntary. The UN has decided to accept this policy recommendation and does not require testing for civilian staff going to serve in a peacekeeping mission. While the testing policies of contingents may vary, it is increasingly becoming a national requirement for troops contributed for service with the UN. In addition to testing prior to deployment, some troop contributors also test their troops upon their return home.

The Eritrean government was responding to concerns that have been in the press ever since the peacekeeping operations in Cambodia, when the presence of international forces was associated with a dramatic growth in the sex industry.[16] Although this has not been empirically proven, there is very good evidence that no matter how the virus gets introduced, situations conducive to unprotected sex with multiple partners – including commercial sex workers – increase vulnerability of HIV infection. A 1998 UNAIDS report, "AIDS and the Military", indicated that 45 per cent of a contingent of foreign troops who had been in Cambodia had had sex with a sex worker or another local woman.

Many troops deployed internationally have mixed with host populations in intimate ways. In Liberia and Sierra Leone, ECOMOG troops are known to have left thousands of children behind with women they had relationships with;[17] many of these women were also exposed to STIs and HIV. The fact that over one third of countries which provide troops for peacekeeping missions have medium or high HIV prevalence levels in their own populations and that they may not screen troops who are deployed has raised concern that while providing protection from armed violence, peacekeepers may also be bringing another deadly risk. As early as 1995, the U.S. State Department noted

that, "Worldwide peacekeeping operations may pose a danger of spreading HIV … Peacekeepers could be both a source of HIV infection to local populations and be infected by them, thus becoming a source of infection when they return home."[18] Increasing concerns about this issue led to an unprecedented discussion in the Security Council in 2000 when U.S. Ambassador Richard Holbrooke introduced discussions on the relationship between HIV, conflict and security.[19] It was the first time that the Security Council had ever discussed a health issue.

Resolution 1308,[20] adopted by the UN Security Council in 2000, recognized the spread of HIV/AIDS and STIs as potential threats to international peace and security and also recommended that HIV prevention be incorporated into all peacekeeping initiatives. The Security Council reinforced this resolution later in the year with the adoption of Resolution 1325, which addressed the issues of women and armed conflict. The Council specifically called for "training guidelines and materials on the protection, rights, and particular needs of women, as well as on the importance of involving women in all peacekeeping and peace building measures, (inviting) Member States to incorporate these elements as well as HIV/AIDS awareness training into national training programmes for military and civilian police personnel in preparation for deployment."[21] Some months later, the UN General Assembly Special Session (UNGASS) on HIV/AIDS unanimously adopted the Declaration of Commitments on HIV/AIDS, which also presented specific objectives related to HIV/AIDS awareness and training among personnel involved in international peacekeeping operations (see box).

Recent studies done in Sierra Leone showed that although most of the 17,000 troops in the United Nations Mission in Sierra Leone were engaged in constructive initiatives in the country, including building schools and roads, rehabilitating services and providing health care in rural areas near their camps; there were however reports that some could be involved in commercial sexual activities, or even in the sexual exploitation of minors. The absence of viable employment opportunities have forced many Sierra Leoneans to resort to commercial sex activities as a means of survival. Thousands of young women walk the streets at night looking for someone who will pay them. In a wide set of interviews with health workers, local officials and women's groups in Sierra Leone, 73 per cent of those interviewed saw indiscriminate sexual activity as a contributing risk factor for HIV.[22]

UNAMSIL has taken a series of measures to further prevent misconduct and to discipline personnel when misconduct has been documented. The UNAMSIL Personnel Conduct Committee has created a dedicated phone line to handle complaints by civilians. There is also an inter-agency Coordination Committee for Prevention of Sexual Exploitation, which UNAMSIL is part of. All cases of misconduct by military personnel are brought to the attention of a Provost Marshal for investigation.

During UN missions in Kosovo (UNMIK) and in DRC (MONUC), as well as in UNMEE, there have also been well-publicized cases of sexual misconduct by peacekeepers with local women or girls. Clearly sexual relations occur in conflict and post-conflict environments; these can be either consensual or forced.

Our discussions with peacekeeping mission personnel and others we consulted were very heated – especially on the issue of mandatory testing. To us, it seemed logical that peacekeepers should be screened before they were deployed, that UN personnel should never bring such a risk with them to a place they were there to protect. Yet we

also realize that peacekeeping missions are made up of individual national contingents, many of which may not have the resources for strong testing and counselling programmes. When we considered a number of issues, such as the fact that detection of the virus takes some time, that pre-deployment screening would not help in cases where peacekeepers contracted the virus after deployment, and the greater effectiveness of voluntary testing and counselling (VCT) programmes for prevention, we determined that we should recommend massive strengthening of such programmes in all militaries of countries that deploy peacekeeping forces.

United Nations General Assembly Special Session (UNGASS) on HIV/AIDS targets and recommendations (paragraphs 75-78):

- By 2003, 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 person, 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;
- Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;
- By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence forces, and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/ AIDS awareness and prevention activities, including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;
- By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations, while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel.

What Can be Done to Protect Women and Stop the Epidemic?

The issues of HIV and conflict have gained considerable public attention in the past few years. UN agencies, international non-governmental organizations (NGOs) and research and action groups, national organizations and advocacy groups, and academics

have all begun to document the dynamics of the relationship, and a number of guidelines for action have been produced. However, attention to the gender aspects of this relationship have lagged behind, both in terms of documentation and in terms of operational programmes to ameliorate the tragic situations we have reviewed.

Despite the lack of systematic programmes of HIV prevention, care and support in conflict situations and the dismal lack of attention to gender issues in humanitarian response, there are a number of lessons learned:

- ? Making sure that women have adequate access to food, basic health services and protection from exploitation and abuse would reduce their vulnerability to HIV infection.
- ? Protection from sexual violence in all its forms – during war, in camps for refugees and internally displaced persons (IDPs) and in post-conflict situations – can help reduce direct exposure and later risky behaviours.
- ? Provision of basic HIV prevention information and services reduces the risks of infection. Information can be shared in many ways – through media, churches and mosques, community groups and health and social services. To effect changes in behaviours, information must be culturally appropriate and relevant and targeted to specific population groups.
- ? Utilizing gender analysis while designing prevention and care programmes makes them more effective. HIV requires a continuum of care; gender aspects vary according to the position along the continuum.
- ? Educating men and boys about HIV and gender issues is very important for the prevention of HIV in women and girls and can be done even in conflict situations.
- ? Empowering girls with knowledge and awareness of HIV prevention and with the skills to negotiate their relationships is critical to ensuring their later health.
- ? Preventing unwanted pregnancies can reduce the risks of HIV transmission during deliveries as well as during unsafe abortions, which are prevalent in conflict situations. Preventing unwanted pregnancy in HIV positive women will also prevent many cases of mother-to-child transmission.
- ? Reinforcing community support systems can alleviate the burden of AIDS care on women, allowing them to carry on with other productive activities.
- ? VCT reinforces prevention, can help infected women to get the information and services they need and can lessen the stigma of infection. VCT requires skilled counselors in order to be effective.
- ? Uniformed services can be excellent contexts for gender and HIV awareness building, since they have organized structures of communication. In many places, the military is respected and influential and can set the tone for thinking about HIV prevention and care.

The international community has recognized the urgency of the AIDS epidemic and the necessity of HIV programming in humanitarian response and post-conflict programming, as reflected in the UNGASS on AIDS (see box). Both Security Council Resolutions 1308 and 1325 specifically cite the special concerns for women. The UN Consolidated Appeals process has begun to include projects on HIV prevention and care.

Guidelines have been developed and proposals written. But, as we saw so graphically, none of these conferences, resolutions or guidelines have yet been able to help Marie, or the young women on the streets in Freetown, or those taking up 80 per cent of the hospital beds in Burundi or those lost souls injecting drugs in Tajikistan.
Good initiatives are happening: VCT is provided in refugee camps in Tanzania, gender and HIV training is being provided for UNAMSIL troops, youth are being trained as peer educators in DRC and women are getting vocational training and health education in Rwanda. But this is not nearly enough. All of these programmes should be expanded a hundred-fold. This will depend on political will and on resources – and, despite all the global talk about AIDS, both are in short supply. One example: during the past two years, of the HIV-related projects included in the CAPs for 19 complex conflict countries, less than 10 per cent have been funded.

The Global Fund to Fight AIDS, TB and Malaria was created as a public-private partnership in 2001 to combat these diseases in heavily affected poor nations. A trust fund that provides grants for prevention, treatment and care, it has so far only attracted about $2 billion of the estimated $7 billion required to cover needs. It was designed to promote multisectoral planning and to provide flexible and quick support for projects proposed by governments, and has already disbursed a first tranche of funds of almost $400 million for dozens of projects.[23] However, the process shows preference for developed health systems and only two 'conflict' countries received support for programmes in the first tranche: Rwanda and Burundi. We are concerned that the Global Fund may not be very well suited for supporting HIV programmes in conflict for a number of reasons. First, countries in conflict (or without governments at all) are likely to lack the institutions, human resources and skills to develop proposals and submit applications to the Fund. According to requirements, proposals must be submitted based on government and civil society collaboration on a coherent national plan of action to address the three diseases, and on established mechanisms for the management and monitoring of funds and activities. Our experience in conflict areas such as Somalia and Liberia make us question whether these countries can possibly receive support from the Fund, since they could not meet the basic requirements for application. Further, some of the factors which the Fund uses to assess applications are also problematic in conflict situations. These include: "ability to demonstrate measurable results", which would presumably require better health information and data bases than exist in many war zones; political commitment at the "highest" level, which may be hard to come by in countries where the leadership is more focused on security or on ethnic conflict than on health; and prevalence of disease, which may bias the funding to high prevalence countries and neglect those with current low prevalence but where conflict has created conditions suited to rapid transmission. Although the Fund is a very important global initiative we believe that, as currently configured, it cannot take the place of funding for HIV in humanitarian programmes.

With sufficient resources, basic HIV prevention can be provided in emergency situations and expanded as conflicts are settled and access to populations increases. Basic prevention includes protection against sexual violence, provision of HIV information, ensuring universal precautions and a safe blood supply as well as providing female and male condoms. Expanded programmes require treatment of STIs, targeted education and communication initiatives, VCT, treatment of opportunistic infections and prevention of

mother-to-child transmission through prophylaxis. Care and support of those with AIDS is also important, including provision of good nutrition. We firmly believe that all of these are doable with current knowledge, as long as there is strong will. In regards to antiretroviral treatment, resources must be made available so that the world's poor can be treated equally and that their rights to health can be affirmed by the international community.

On HIV/AIDS the Experts call for:

1. HIV/AIDS awareness and prevention programmes to be implemented during conflict and in post conflict situations, with care and support provided whenever there is access to affected populations. National governments, national and international NGOs and UN agencies should incorporate HIV/AIDS prevention into all humanitarian assistance. Donors should strongly support these interventions.

2. All HIV/AIDS programmes and funding in conflict situations to address the disproportionate disease burden carried by women. Mandatory gender analysis and specific strategies for meeting the needs of women and girls should seek to prevent infection and increase access to treatment, care and support.

3. Vulnerability assessments to be carried out in each humanitarian situation to determine links between conflict, displacement and gender. Information and data collection should be strengthened in order to document this relationship and to guide appropriate responses. Governments and agencies should work together to document vulnerabilities.

4. Clear guidelines for HIV/AIDS prevention in peacekeeping operations. All troop-contributing countries should make available voluntary and confidential HIV/AIDS testing for their peacekeeping personnel. Counselling and testing should be provided for all contingent forces and civilian personnel participating in emergency and peace operations before and during deployment on a regular basis.
HIV prevention as well as gender training should be provided in all missions to all personnel.

5. The IASC Reference Group on HIV/AIDS in Emergency Settings to develop clear policy guidelines for HIV prevention and care in humanitarian situations and application of these guidelines to be supported by national authorities, humanitarian agencies and donors.

6. The Global Fund to Fight AIDS, TB and Malaria to make special provisions for support of HIV/AIDS programmes in conflict situations, including in countries without the government capacity to manage the application process. In such cases NGOs and UN agencies should be eligible to submit proposals. Further, we encourage the systematic consideration of gender issues in all programme funding.

7. Regional institutions and organizations to address HIV prevention in conflict situations. In particular, the New Partnership for Africa's Development (NEPAD) should take a leadership role in that region.

8. The development and enforcement of codes of conduct for all UN and international NGO staff to protect against abuse and exploitation of women and girls. All such staff should received training in prevention of sexual and gender based violence, as well as reproductive health information, including STI and HIV/AIDS prevention.