HIV/AIDS AS A SECURITY ISSUE IN AFRICA:

LESSONS FROM UGANDA

16 April 2004

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TABLE OF CONTENTS

APPENDICES

ICG Issues Report N°3 16 April 2004

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

HIV/AIDS prevention and conflict prevention should go hand in hand. They are the two blades of the scissors required to cut the strangler's cord choking Africa. Some 2.5 million Africans will die of AIDS in 2004. One in four African countries presently suffers from the effects of armed conflict.

The correlation of HIV/AIDS and war is difficult to calculate with precision because the data are less than complete, and numerous interacting factors are at play. Nevertheless, the evidence available demonstrates that war can lead to increased risks of HIV/AIDS and suggests that HIV/AIDS can make conflicts worse. While the relationship between these two scourges is too complex to be expressed in simple cause-and-effect terms, it is important to consider how the HIV/AIDS pandemic in Africa contributes to further instability and conflict on the continent and how violent conflict in turn creates conditions favourable to the spread of the virus.

HIV/AIDS, moreover, can make it harder to bring conflict to an end. To ensure a sustainable and lasting peace, it is not enough simply to halt the fighting and implement disarmament and reintegration programs (DR). Law and order and governance have to be re-established quickly, regional and local administrations set up, schools and clinics opened. However, AIDS thins the ranks of trained and experienced personnel required to fill these posts and adds to the complexity of demobilising combatants. Hence, how successfully a country resolves internal conflict may depend in part on how well it incorporates HIV/AIDS into its DR programs and on how successfully it manages national response to the AIDS pandemic.

Too many African governments still fail to recognize that AIDS is more than a public health issue but also threatens their states' stability and potential security. The New Partnership for Africa's Development (NEPAD) pays too little attention, particularly to the pandemic's impact on economic development, stability and conflict. Uganda's more comprehensive approach, which makes the security sector and specifically the army an important focus of its overall AIDS strategy, demonstrates a more integrated response.

Although it is widely accepted that HIV/AIDS has been shown, in most countries, to be more prevalent among uniformed services than the general population, this is not fully reflected in programs and allocation of funding and resources by governments, the UN or NGOs. As a result, opportunities for reducing the disease's spread in the controlled environment of organised militaries are lost. HIV/AIDS technical and financial cooperation programs for militaries in Africa remain limited by inadequate bilateral and multilateral support. Implementation of comprehensive awareness, testing, prevention, counselling and treatment programs for UN peacekeeping forces similarly suffers from lack of resources. Mandatory HIV/AIDS testing and screening should be encouraged for all participants in UN peacekeeping missions and backed up with confidentiality, counselling, access to condoms and treatment to the extent possible. All soldiers in conflict areas should be issued condoms as standard equipment, as some governments do, and given awareness and sensitisation training.

HIV/AIDS should be addressed during a conflict rather than waiting until it has ended. Humanitarian pauses and ceasefires should incorporate the opportunity for prevention

education, distribution of condoms and voluntary testing. Negotiations for peace agreements should include the possibility for the full range of prevention, testing, counselling and, to the extent feasible, treatment programs for all combatants, whether regular or irregular forces, as well as among displaced civilians. It should be on the agenda during peace negotiations, which would require including public health officials on negotiating teams or at least among those providing facilitation. Consideration should be given to offering assistance, as an inducement to stop fighting, to combatants with HIV/AIDS, including treatment for diseases like pneumonia and tuberculosis that attack those whose immune systems have been weakened (so-called opportunistic infections) and, when they are medically indicated and can be sustained, anti-retroviral (ARV) medicines.

For both militaries and populations in the African countries most affected by the pandemic, the greater availability of ARV drugs will lead to a substantial increase in people living with AIDS. It also will require an effective health delivery system to insure proper management of the ARV regimen. It will mean larger numbers dependent upon health care facilities, so that greater priority should be given in DR programs to expanding health infrastructure along with widespread dissemination of the "ABC" package of prevention – abstinence, being faithful to a partner, and using condoms.

This report is the third in a series on HIV/AIDS as a security issue,[1] and draws particularly on the policy experience of Uganda.

RECOMMENDATIONS

To the Donor Community:

1. Allocate a larger percentage of technical and financial assistance programs for militaries to HIV/AIDS prevention and treatment.
2. Provide additional resources to the Global Fund to Fight AIDS, Tuberculosis & Malaria in order to include local militaries in prevention and treatment programs.
3. Provide more funding to the UNAIDS program on AIDS, Security and Humanitarian Response (SHR) to assist national government design and implementation of testing, screening, prevention, counselling and treatment programs for their military and police forces, as part of their comprehensive programs.
4. Provide more funding to the UN Department of Peacekeeping Operations (UNDPKO) so it can significantly expand its capacity for testing, screening, prevention, counselling and, as appropriate, treatment programs for peacekeeping forces.
5. Assure as a condition of support that disarmament and reintegration (DR) programs and reconstruction programs take appropriate consideration of HIV/AIDS, including voluntary testing, counselling and treatment for ex-combatants, internally displaced persons (IDPs), and returned refugees, and provide increased funding for those programs.
6. Incorporate more support for HIV/AIDS prevention and treatment within cooperation assistance to NEPAD development programs, particularly in relation to AIDS and conflict resolution.

To the United Nations:

7. Direct all UN agencies to cooperate more closely with UNAIDS on its AIDS, Security and Humanitarian Response (SHR) program.
8. Provide adequate funding within peace operations budgets to incorporate HIV/AIDS awareness, prevention and treatment programs for all military forces and, at a minimum, enforce and monitor current DPKO policy that all members of peacekeeping forces, including civilian police, should be offered Voluntary Confidential Counselling and Testing (VCCT) prior to deployment.
9. Change current policy to encourage, through DPKO and UNAIDS, all countries contributing troops to UN peacekeeping missions to carry out mandatory HIV/AIDS testing and screening prior to deployment and on return from conflict areas, and require those

[1] ICG Issues Report No. 1, *HIV/AIDS as a Security Issue*, 19 June 2001; ICG Asia Briefing, *Myanmar: The HIV/AIDS Crisis*, 2 April 2002. See also ICG Asia Report No. 25, *Central Asia: Drugs and Conflict*, 26 November 2001.

countries to notify the UN whether this has been done and whether HIV/AIDS awareness training has been given to these troops.

10. Introduce, through DPKO, condom pouches as part of the standard military equipment for all members of UN peacekeeping missions.

11. Ensure that HIV/AIDS prevention and conflict prevention activities go hand in hand, including by:

    (a) exploring with the governments of the affected countries how all those engaged in fighting in conflict areas, including rebels, can benefit from HIV/AIDS awareness and sensitisation programs; and

    (b) ensuring that HIV/AIDS is fully taken into consideration as part of humanitarian accords, peace negotiations, and DR programs.

To the Governments of Affected Countries:

12. Collect and provide more statistical information regarding the prevalence of HIV/AIDS within their military and security forces.

13. Adopt a multi-sectoral approach to tackling HIV/AIDS, including the security and defence sectors, in order to take full account of the impact of AIDS upon security and conflict.

14. Allocate more resources to HIV/AIDS programs that benefit members of their military and other uniformed services, including provision of ARVs.

15. Provide condoms as part of the standard equipment for all members of the armed forces, and accompany this with HIV/AIDS awareness and sensitisation programs.

16. Encourage, where this is not already the case, mandatory AIDS testing and screening for all members of the military and other uniformed forces before and after deployment to conflict areas.

To NGOs and Other International Organisations:

17. More NGOs involved with HIV/AIDS programs should, with the agreement of the host authorities, work with the uniformed security services.

18. International bodies and other organisations able to work in conflict zones, in particular those with access to "rebel-held" areas such as the International Committee of the Red Cross (ICRC), should include HIV/AIDS awareness and sensitisation programs in their activities.

Kampala/Brussels, 16 April 2004

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HIV/AIDS AS A SECURITY ISSUE IN AFRICA: LESSONS FROM UGANDA

I. INTRODUCTION

AIDS in Africa is more than just another obstacle to development. The realisation is growing that it is an epochal event that is changing demography, family structure and social relations, weakening economies and undermining governance. It has effectively thrown the process of political and economic development into reverse in a number of countries.[2] The only comparable impact may have been the introduction of new diseases by early European settlers in the Americas that caused the transformation of entire societies.

ICG's concern has led it to explore the relationship between AIDS and conflict in Africa. Its initial report, published just prior to the UN Special General Assembly on HIV/AIDS in summer 2001,[3] concluded that AIDS can make nations more vulnerable to both internal and external conflict. It also noted that AIDS can prejudice attempts to resolve conflicts by undermining countries' abilities to participate in peace operations, including those established by the United Nations.[4] The issue has also been addressed periodically by ICG in its country or regional specific reporting.[5] ICG has continued to advocate greater national and international response to the pandemic in Africa as well as in second wave countries whose large populations and regional and global importance raise additional potential security concerns.

The prominence of AIDS as a security issue was taken up most directly by the UN Security Council in Resolution 1308:

> The HIV/AIDS pandemic is exacerbated by conditions of violence and instability, which increases the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care…If unchecked, the HIV/AIDS pandemic may pose a risk to stability and security.[6]

The UN General Assembly subsequently called for the convening of a special General Assembly session on HIV/AIDS,[7] which in turn produced the Declaration of Commitment on HIV/AIDS in 2001.[8]

In short, the Security Council and the UN more generally have recognized that AIDS can exacerbate conflict and that conflict can lead to increased risks of AIDS. However, the statistical data needed to develop this hypothesis are scarce. By its very nature conflict leads to a breakdown of law and order, which disrupts governments, international organisations and NGOs, impeding them from operating in conflict zones. Not surprisingly, therefore, the collection and collation of data in these areas is more than usually problematic.

Another accepted assumption is that the rates of HIV are higher among military and other uniformed forces than among the general population. UNAIDS has found that the rates of sexually transmitted diseases among such forces

[2] Alex de Waal, "How will HIV-AIDS transform African governance?", *African Affairs*, vol. 102, No. 406 (2003), pp. 1-23.

[3] ICG Issues Report N°1, *HIV/AIDS as a Security Issue*, 19 June 2001.

[4] ICG also entered into a cooperative agreement with UNAIDS 23 August 2002 to explore HIV/AIDS and security and to undertake related advocacy activities.

[5] See fn. 1 above.

[6] UN Security Council Resolution 1308, 17 July 2000.

[7] UN General Assembly Resolution 5/13, 3 November 2000.

[8] UN General Assembly Declaration of Commitment on HIV/AIDS, June 2001.

even in peacetime tend to be two to five times that of the general population and can rise even higher in times of conflict.[9] Available but limited data suggest the same patterns generally apply with respect to HIV/AIDS. Most governments, however, consider information about the rate of HIV among their armed forces to be sensitive. It is not usually collated separately, and if it is, governments are wary of disclosing it for fear of prejudicing national security.

This report explores the relationship further using such limited data as are available for one country, Uganda, with a view to developing insights that could be applied more widely. Uganda has been chosen because of its recent involvement in the Great Lakes conflict, the ongoing fighting in its north, and its positive domestic record in dealing with AIDS. Uganda is regarded by UNAIDS and the World Health Organisation as being in the forefront in addressing the AIDS pandemic, with some commendable successes, and it has been more willing than most countries to disclose information. Nevertheless, it is clear that, even with vigorous government attention, twelve UN agencies and around 1,300 international and local NGOs working on AIDS in the country,[10] very few of the studies produced relate to the impact on conflict or deal directly with the armed forces. This report is an initial attempt to fill that gap.

II. HIV/AIDS IN AFRICA

In 2003 another 3 million people died of AIDS around the world.[11] Of these, 2.3 million were Africans – 6,300 per day. In other words, on any one day in Africa, more people died of AIDS than in any terrorist attack or in all but the very worst earthquakes, famines, floods, or conflicts. While there were 100,000 fewer deaths from AIDS than the previous year, that is no grounds for believing the worst is over. Vast numbers of people were continuing to become infected – another 3.2 million in Africa, out of 5 million worldwide, bringing the estimated total of persons living with HIV/AIDS in Africa to just under 27 million out of an estimated worldwide total of 40 million at the end of 2003. Nearly one in ten of the Africans, 2.5 million, can expect to die this year.[12] Between now and the end of the decade, the number of people dying from AIDS in the continent is likely to double.

However, figures for the number of people infected with AIDS in Africa have to be treated with particular caution because of changes in the ways they are gathered. Figures for national estimates are derived mainly from ante-natal clinics. During the 1990s, epidemiologists worked on the assumption that national prevalence was a product of prevalence in urban and rural areas. It has become growingly apparent that the clinics that provided statistics in rural areas were mostly situated close to main roads or in small towns and did not accurately represent the situation in small or isolated villages. More recent surveillance done in villages has shown that rural prevalence is generally lower. Hence, national estimates were revised downwards by UNAIDS in 2002-2003. The current estimates are the best to date, and the picture is clearer. When like is compared with like (that is, figures from individual sites over time sequence), the evidence is that rates of infection are still rising. Hence, the following figures do not actually indicate a decline in either infections or deaths:

[9] UNAIDS Executive Director Peter Piot, at UNGA High Level Meeting on HIV/AIDS, New York, 22 September 2003.

[10] According to the United Nations Development Programme, quoted in Uganda Aids Commission, "The Story of AIDS in Uganda", September 2003.

[11] UNAIDS "Epidemic Update 2003".

[12] Ibid.

Figures for Africa in:	2002	2003
New Infections	3.5m	3.2m
Living with AIDS	29.4m	26.6m
Died of AIDS	2.4m	2.3m

Source: UNAIDS

Although figures on individual countries remain woefully inadequate, Uganda has a relatively long history of combating HIV-AIDS, including in its armed forces. Since AIDS was first recognised there in the early 1980s, 1 million Ugandans have died out of a population of over 25 million. During a crucial initial period, the existence of an HIV/AIDS problem was almost entirely unknown to or unaccepted by its people. Some observers note that the event that did most to open the eyes of the public was the testimony of the popular singer Pilly Bongoley Lutaaya. After returning to Uganda from Sweden, he declared publicly in 1989 that he was HIV positive, causing much wider appreciation of the problem.

It is estimated that some 550,000 Ugandans above the age of fifteen are living with HIV/AIDS. However, this is more encouraging than in most of Africa. The average prevalence rate of HIV/AIDS among the adult population in Uganda was just over 6 per cent in 2003,[13] which, although slightly higher than in 2002, is a significant drop from 18 per cent ten years earlier. Some observers are sceptical about Ugandan statistics[14] but generally this "success" against AIDS has been widely acknowledged. According to the UN Special Envoy for AIDS in Africa, "Uganda has been overwhelming and stunning with its achievements with AIDS, on every level, and in every way".[15]

This accomplishment is based in part upon an early recognition of AIDS' effects upon development and security, leading to adoption of a multi-sectoral approach to management of the disease.[16] This is a lesson not yet fully accepted by many other African countries. Even the NEPAD[17] plan for the future of Africa "includes scant reference to HIV/AIDS as a public health problem and none at all to its development impact – or the impact upon conflict and security".[18] As a result, the goals NEPAD has set are less likely to be realised, e.g. to raise domestic savings from 19 per cent to 33 per cent of GDP. In recent statements, the NEPAD Steering Committee has acknowledged HIV/ AIDS as one of the region's major challenges but programmatic focus on the development impact of the pandemic remains limited.[19] AIDS cuts the life expectancy of those who are reaching adult life, removing incentives for saving and other types of forward planning. From the point of view of governance and development, the most disastrous consequence may be the effect on bureaucracies, which will need to train far higher numbers merely to keep staffing at present levels, as AIDS victims are so often adults in the prime of life. When more teachers or police die in a given year than graduate from teaching colleges and police academies, fundamental changes need to be made in sectors far beyond health to cope with the impact of AIDS on national and regional stability.

[13] Uganda AIDS Commission, National AIDS Policy document, August 2003.
[14] Justin O. Parkhurst, "The Ugandan Success Story? Evidence and Claims of HIV-1 Prevention", *The Lancet*, vol. 360, No. 9326 (2002).
[15] Stephen Lewis, UN Special Envoy for AIDS in Africa, cited in Uganda AIDS Commission booklet, "And Banana Trees Provided The Shade", September 2003.
[16] Uganda AIDS Commission – National AIDS Policy, August 2003.
[17] New Partnership for Africa's Development.
[18] De Waal "How will HIV/AIDS transform African governance?".
[19] "NEPAD Dialogue," 19 February 2004, No. 35, http://www.touchtech.biz/nepad/files/newsletter 35.html.

III. CONFLICT IN AFRICA

The number of states in sub-Saharan Africa at war or with significant lethal conflicts doubled between 1989 and 2000.[20] One in four African countries presently suffers from conflict.[21]

Since UN Secretary General Kofi Annan called for a "culture of conflict prevention" in 2000, the number of UN peacekeeping missions also has increased. Of the fifteen such UN missions around the world, five are based in Africa: UNMIL (Liberia), MONUC (the Great Lakes), UNMEE (Ethiopia/Eritrea), UNAMSIL (Sierra Leone) and MINURSO (Western Sahara). Out of 48,590 soldiers and police officers under UN command, nearly three quarters are on that continent, including 10,866 with MONUC, the peacekeeping mission based in the Democratic Republic of the Congo (DRC). UNMIL in Liberia, is set to become the UN's largest mission in 2004, with some 15,000 peacekeepers.[22]

The Great Lakes conflict has involved seven African nations including Uganda.[23] Since the outbreak of fighting in August 1998, it is estimated that 3.3 million have died and more than 2.2 million Congolese have been displaced.[24] Uganda withdrew its forces from Ituri Province in the eastern DRC in May 2003 under international pressure. In that province alone, 50,000 Congolese are estimated to have died, with 500,000 displaced.[25] However, Uganda continues to give political support to some Congolese militia leaders, on the grounds that this is necessary to help its army guarantee border security.[26]

The conflict in Uganda's north, centred on Acholi Province, has lasted eighteen years. The insurgency of Joseph Kony and the Lord's Resistance Army has claimed thousands of lives and displaced an estimated 400,000 Ugandans.[27] Women and children have especially suffered. In 2003 alone, 8,500 children were abducted by the rebels.[28]

[20] United States Institute of Peace, Special Report No. 75, "AIDS and Violent Conflict in Africa", October 2001. The numbers of sub-Saharan states at war or with significant lethal conflicts increased in that period from eleven to 22. In contrast, the number of conflicts between and within states is declining globally, a trend that will be documented in the first annual Human Security Report, produced by the University of British Columbia Human Security Centre, directed by Andrew Mack, and to be published by Oxford University Press in 2004.

[21] ICG *Crisis Watch* N°5, 1 January 2004. The countries are Angola, Burundi, Central African Republic (CAR), Comoros, Congo, Cote d'Ivoire, DRC, Eritrea, Ethiopia, Guinea, Liberia, Mauritania, Nigeria, Rwanda, Sierra Leone, Somalia, Sudan, Uganda and Zimbabwe. Whilst ICG notes improvement in Burundi and Ethiopia/Eritrea, it warns of deteriorating situations in CAR, Cote d'Ivoire, Sudan and Zimbabwe

[22] ICG Africa Report, No. 75, "Rebuilding Liberia: Prospects and Perils 30 January 2004. ICG Interview, UNDPKO official, February 2004.

[23] ICG Africa Report N°4, *Africa's Seven-Nation War*, 21 May 1999; ICG Africa Report No. 26, *Scramble for the Congo: Anatomy of an Ugly War*, 20 December 2000.

[24] "Conflicts in Africa", webpage October 2003.

[25] *Africa Confidential*, June 2003.

[26] ICG interviews with UPDF officers.

[27] Conciliation Resources, "Initiatives to End Violence in Northern Uganda", *Accord*, issue No. 11, 2002. See also ICG Africa Report N°77, *Northern Uganda: Understanding and Solving the Conflict*, 14 April 2004.

[28] Jan Egeland, UN Under Secretary General for Humanitarian Affairs, December 2003, cited in *Africa Confidential*, 5 December 2003.

IV. THE IMPACT OF CONFLICT UPON AIDS

Conflict not only causes death and destruction. It can disrupt development in general and produce a breakdown of governance that ends in state collapse. Basic education and health care are seriously affected. Conflict displaces families and whole communities, forcing individuals to flee as internally displaced within their own country or beyond the borders as refugees. The population movement adds to social breakdown, to mobility and frequently to vulnerability to sexual assault. In conflict areas it is very difficult for either governments or NGOs and international organisations to carry out programs to meet basic needs, including those relating to AIDS awareness, sensitisation and treatment. Not only are the programs disrupted and schools and health facilities frequently pillaged, but those running them may curtail operations because of risks to the safety of their personnel. In short, programs aimed at combating HIV/AIDS become less effective and do not receive priority. As UNAIDS notes, "conflict and displacement is associated with increased risk of HIV transmission among affected populations because of behavioural change due to interruption of social networks and economic vulnerability (particularly among women and adolescents) as well as sexual violence and disruption of preventive and curative health services".[29]

Existing research suggests that as a result of the general withdrawal of both state and non-state welfare services and the conduct of soldiers engaged in combat, there will usually be a higher prevalence of HIV/AIDS in conflict zones.[30]

In Uganda, figures based upon antenatal attendees at Lacor Hospital show that, next to the urban concentration in the capital, Kampala, the second highest prevalence rate for HIV/AIDS is in and around Gulu, the conflict area in the north. The rate there is 13 per cent, compared to the national average of 6 per cent.[31] Health officials working in the southwest close to the Rwandese and Congolese borders estimate a prevalence of 10 per cent, again based upon attendees at antenatal clinics.[32]

In line with the generally higher prevalence in conflict areas, it is reasonable to suppose that there may be more HIV/AIDS within the armed forces.[33] For example, ICG reported in June 2001, data from a variety of published and unpublished sources, including UNAIDS, the U.S. Defence Intelligence Agency, Jane's Intelligence Review and the U.S. Congressional Research Service, that estimated HIV prevalence in sub-Saharan militaries as high as 60 per cent in Angola and 40 per cent in South Africa.[34] Recent reports indicate that the South African National Defence Force (SANDF) could lose 25 per cent of its majors and lieutenant colonels, leading to what one scholar termed, a "hollowing out" of its operational midlevel officer ranks.[35] It may even be that more soldiers are dying from AIDS than from conflict in Africa.[36] Such assertions, however, are based on the sparsest statistics, not least because governments are usually reluctant to reveal casualty details in wartime or to release information that might indicate their forces were weakened in any way.

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[29] UNAIDS Fact Sheet No. 2 "HIV/AIDS AND CONFLICT", http://www.unaids.org/html/pub/Topics/Security/FS2conflict_en_doc.htm.

[30] UNAIDS, "Accelerating Action against AIDS in Africa", 2003. There also appear to be some important anomalies, however, such as areas of the eastern Congo that are reported to have a strikingly low prevalence of AIDS, certainly lower than might be expected from the intensity of conflict experienced. A prevalence rate for eastern Congo of 4.9 per cent is based upon UNAIDS/UNICEF/WHO Epidemiological Facts Sheets on HIV/AIDS and Sexually-Transmitted Infections: Update 2002. This may be attributed to the fact that these areas have been cut off as a result of the conflict so there has not been the same mobility and inter-relationships as elsewhere. A different kind of factor in the lower than expected rate may be the absence of data on rural villages. Similar lower than expected prevalence rates have been shown in initial CDC [Centre for Disease Control] research in parts of post-conflict Sierra Leone. Vera Bensman, "HIV/AIDS and Conflict: Research in Rwanda, Burundi and Eastern DRC", report for Save the Children, UNICEF and UNAIDS, May 2003. ICG interview, UNAIDS official Washington, D.C., February 2004.

[31] "HIV/AIDS Surveillance Report", Ugandan Ministry of Health.

[32] ICG interview, official in Kabale, November 2003.

[33] UNAIDS, "HIV/AIDS and the Uniform Services", 2003.

[34] ICG Report, *HIV/AIDS as a Security Issue*, op. cit.

[35] Lindy Heinecken, deputy director, Centre for Military Studies, South African Military Academy, in *Armed Forces &Society*, vol. 29, No. 2, Winter 2003, pp. 281-300.

[36] Interview with Pamela Machipanja, Department of Peace and Conflict Studies, University of Bradford, BBC Network Africa, November 2003.

Notwithstanding the absence of detail, it is generally accepted that the prevalence rate for HIV/AIDS is higher within armed forces operating in conflict areas for several reasons. Soldiers, including rebels, are usually young and sexually active. They often turn to alcohol and sex as relaxation from the stress of fighting, or an antidote to the boredom of being away from home for long periods, sometimes years on end. They attract commercial sex workers because they have money. There is anecdotal evidence that officers are more prone to HIV/AIDS because they are paid more and have greater status and mobility, although this is balanced by the belief that they are more likely to understand HIV/AIDS programs and abstain from unprotected sex. There are, it should be noted, few definitive studies.[37]

Armies in war zones operate in environments where HIV/AIDS sensitisation and awareness programs are difficult to carry out, given the breakdown of law and order, local administration, and health and education services. Condoms are not as widely available as in non-conflict areas. Moreover, some reports indicate that soldiers may be less inclined to use condoms in conflict areas. For example, a study conducted by the Rwandan army showed that although a high percentage of its personnel had knowledge of HIV/AIDS, only 36 per cent of those surveyed reported using a condom the last time they had sex. This was partly attributed to drunkenness.[38] Most of these forces had been deployed in combat in the region. Rwanda recently has expanded HIV/AIDS prevention programs directed at its military.[39]

There are no published figures for prevalence rates specifically among the uniformed and fighting forces in the Congo, Rwanda or Burundi. Equally, although there is much more data on AIDS in Uganda, it is still insufficient to determine the exact extent of the pandemic within the Ugandan forces due to insufficient or unavailable data. There are also conflicting anecdotal reports. The first indication of a high prevalence rate within the Ugandan armed forces was in 1986, when eighteen of 60 soldiers sent to Cuba for training tested HIV positive.[40]

Up to 10,000 Ugandan troops served in the Democratic Republic of Congo at any one time in the late 1990s, with more than that number deployed on rotation. Prior to deployment, those who failed a general medical examination were left behind, but specific HIV/AIDS screening was not carried out either before deployment or on return. Officials of the Uganda People's Defence Force (UPDF) claim this would be discriminatory and contrary to Article 21(2) of the Ugandan Constitution as well as the Universal Declaration of Human Rights. The high cost of screening, (approximately U.S.$5), is also cited as a factor. Thus, the government does not know how many of its troops had AIDS before they went to the Congo, and, more importantly, how many returned with the disease.

The Uganda AIDS Commission, established in 1992 to oversee and coordinate the fight against the disease, claims that the prevalence rate within the UPDF is no different than in other sectors of the population. A voluntary survey of 3,000 soldiers completed in 2001, however, showed a prevalence rate of 23 per cent, [41] a figure that has now dropped to around 20 per cent and is generally accepted by most outside observers, including the U.S. Department of Defence,[42] although some estimates are as high as 70 per cent. All new applicants for the UPDF are now screened for HIV/AIDS as part of a general medical. In 2003 the infection rate for all applicants was 4.7 per cent, slightly less than the estimated rate in the general population of 5 to 6 per cent.[43] Nevertheless, the continuing concern about AIDS in the Ugandan military is best expressed by President Yoweri Museveni's statement on 30 November 2003 to UPDF recruits undergoing military training that the biggest danger to the army is not war but HIV/AIDS.[44]

[37] The studies that do exist, such as Heinecken, op cit., and P.W. Singer. "AIDS and International Security", *Survival*, 44, 1 (Spring 2002), pp. 145-158, cite significant impacts on the officer corps. Whether these impacts are disproportional to the armed forces as a whole, however, remains ambiguous.

[38] Rwandan Patriotic Army Military Project, "Results of Focus Group Discussions", September 2001.

[39] ICG interview, Rwanda military officer, March 2004.

[40] Uganda AIDS Commission booklet, "And Banana Trees Provided The Shade", op. cit.

[41] ICG interview, UPDF director of health, November 2003.

[42] ICG interview, USAID Kampala, 17 November 2003.

[43] ICG interview, UPDF director of health, November 2003. The general population estimate is from the Uganda AIDS Commission.

[44] Radio Uganda, Kampala, "Uganda: President Museveni Says AIDS Posing Danger to Army", 30 November 2003.

V. THE IMPACT OF AIDS UPON CONFLICT

The question can be put both ways: if conflict can lead to an increased risk of AIDS, does AIDS lead to an increased risk of conflict? Some, including ICG, have raised this issue. The International Institute for Strategic Studies (IISS) stated, "The general security problems of the continent [Africa] are being exacerbated by widespread poverty, the general availability of weapons and the continuing spread of HIV/AIDS".[45]

There is no instance where AIDS can be identified as the sole cause of conflict. One only has to take the example of Botswana, which is "conflict free" but whose prevalence rate for HIV/AIDS has more than doubled in the last decade to approach 40 per cent, one of the highest in Africa.[46] Like poverty, however, AIDS is a frequent corollary of conflict and can have a substantial impact upon it, although the relationship is far from simple. According to the U.S. Institute for Peace (USIP):

> The relationship of the AIDS pandemic to violent conflict in Africa is far too complex to be expressed in simple cause-and-effect terms. Instead it must be addressed in terms of (i) how the explosion of HIV/AIDS may contribute to further instability and conflict on the continent in coming years, and (ii) how instability and violence encourage conditions favourable to the spread of the HIV virus.[47]

Emerging evidence suggests that the most damaging impact of AIDS in the long term is upon governance and the social fabric.[48] Hence, AIDS does not just cause deaths among soldiers, it also profoundly impacts how armies perform and even how they are organised. It can reduce the ability of the armed forces to contain and resolve the conflict. UPDF commanders claimed that HIV/AIDS affected the fitness of their troops both in the Congo and in Northern Uganda.[49] Those who were HIV positive became more easily tired and lethargic. One commander claimed that the absence of proper medication, notably ARVs, led to some soldiers becoming irresponsible, not only sexually but also in their general discipline. If they were HIV positive, they no longer saw need for caution.

This view, however, was challenged by the Director of Health of the Ugandan armed forces, to some degree not surprising given his position. He noted that the UPDF's sensitisation program emphasised that even those soldiers who tested HIV positive could still function reasonably normally but if they had unprotected sex, they risked accelerating HIV into full blown AIDS and an early death. He claimed that this message was heeded. In any event, one reason sometimes given for the army's inability to put down the long running insurgency in the north, in contrast to its success in defeating the former Ugandan army in 1986 when President Museveni came to power, is that many experienced commanders had died of AIDS and been replaced by younger, less experienced officers.

This last point illustrates the corrosive effect that AIDS can have on bureaucracies generally, which includes those instrumental in resolving conflicts. To ensure a sustainable and lasting peace, it is not enough just to stop the fighting and implement disarmament and reintegration (DR) programs.[50] Law and order and governance have to be re-established. Regional and local administrations have to be set up, including education, health care, communications and employment schemes. These are all undermined by a high prevalence of HIV/AIDS.[51] As with military officers, it takes time to train public servants, teachers, nurses and doctors. AIDS lowers average life expectancy. In Uganda it is 42,[52] with AIDS the

[45] International Institute for Strategic Studies, "2003 Annual Strategic Survey", as quoted in the press release issued in October 2003.
[46] UNAIDS, "Accelerating Action against AIDS in Africa", September 2003.
[47] United States Institute of Peace, Special Report No. 75, "AIDS and Violent Conflict in Africa", October 2001.
[48] Alex de Waal, "How will HIV/AIDS Transform African Governance?". Also see, Mark Schneider and Michael Moodie, "The Destabilizing Impacts of HIV/AIDS", Center for Strategic and International Studies HIV/AIDS Task Force, May 2002.
[49] ICG interview, former UPDF commander, November 2003.
[50] For greater simplicity and in the hope that the usage will become more common, ICG employs in its reporting the abbreviation DR, to include, as appropriate to individual situations, the concepts of disarmament, demobilisation, repatriation, resettlement, and reintegration that are elsewhere often abbreviated as DDRRR or DDR.
[51] De Waal "How will HIV/AIDS transform African governance?", op. cit.
[52] UNAIDS, "Uganda National Response Brief", 2003.

leading cause of death. For every three teachers trained, only two remain alive long enough to teach for a number of years. The state's ability to govern and provide the services required by its population is constantly eroded, leading to what has been described as "social involution".[53] These are the kinds of wrenching blows to the social fabric which threaten stability and security.

VI. UGANDAN ARMY EFFORTS TO COMBAT AIDS

Uganda was among the first countries in Africa to recognise and try to address these problems. The UPDF has been running HIV/AIDS awareness programs since 1989 based upon three objectives, which follow the national guidelines:

- to prevent further transmission, through health education, raising awareness, sensitisation seminars, film shows, lectures, discussions, and so forth;
- to mitigate the impact of HIV/AIDS on those who have contracted the illness through pre-test, post-test and on-going counselling and home care (ARV drugs are not yet available to UPDF members but there are plans to arrange this, subject to funding, through army centres at Bombo and Mbuya); and
- to strengthen capacity building in running the programs, with central planning directed from defence headquarters at Bombo and programs implemented at division level by army doctors and health educators.

Such programs were conducted during the UPDF's involvement in the Great Lakes conflict. In addition to the pre-deployment medical, the troops sent to the Congo were vaccinated against yellow fever, hepatitis B and tetanus. Notwithstanding the high prevalence of HIV/AIDS, the UPDF considered its forces to be at greater risk from the ebola virus than AIDS.

A health educator was attached to each battalion during the conflict. That position was at the point where HIV/AIDS and conflict came together. Although the job was to sensitise the troops about the dangers of AIDS, the educator was also a serving soldier who, if his unit came under attack, would fight. He oversaw the HIV/AIDS awareness programs in the field, which took the form of talks, literature and film shows produced by the government and the military. The film shows were considered to be especially effective. The troops were issued with condoms, but only when requested.

The UPDF is presently considering whether to follow the lead of some other countries, such as Ghana, Eritrea, Ethiopia and Indonesia, and make

[53] Alex de Waal, "HIV/AIDS and the threat of social involution in Africa", in Camilla Toulmin and Ben Wisner (eds.), *Towards a New Map of Africa* (Earthscan, London, 2004).

the condom pouch part of the standard military equipment for every serving soldier. As one Ugandan commented : "A soldier must be taught as a matter of routine that having sex without cover can be as deadly as not taking cover when under fire".[54]

If a soldier became HIV positive, the health educator would report this to the Director of Health at headquarters in Uganda. The soldier would be ordered to withdraw. His commanding officer could not overrule this, notwithstanding his concerns over the reduction in his unit. Soldiers diagnosed with HIV/AIDS must leave military service, either with a pension or gratuity depending upon the years of service.

The ministries of defence and finance say they estimate that the cost of these UPDF programs added 5 to 10 per cent to the overall expense of the deployment.[55] Undoubtedly there was a cost factor but given that personnel expenses were covered within the normal army budget and did not include medication (i.e. ARV drugs), this estimate appears somewhat high.

The UPDF has stated that it does not have statistics on the number of its personnel infected by HIV/AIDS, and that its policy is to allow personal discretion over whether such information is divulged.[56] Although Ugandan forces were not automatically screened for HIV/AIDS when they returned from the Congo, they were quarantined before joining other units and the community. UPDF troops withdrawn from Congo were kept isolated from other units and from the local community for a short period while they were given a routine medical examination that did not include an AIDS test. If a soldier showed signs of illness, he would be given further medical treatment that included an AIDS test. If this test was positive, he would be required to leave the military, which would appear not only to stigmatize the individual but also to be counterproductive in terms of control the spread of the disease. Since much time may elapse before an HIV-positive individual displays symptoms, there would be great reluctance to undergo voluntary testing if a positive finding resulted in dismissal and discrimination.

A feature of the Ugandan experience in the Congo was that some 1,000 "Congolese wives" accompanied the soldiers home. Their arrival in Uganda created complications for army commanders concerning the stationing and support of the returning soldiers and their spouses.[57] Many returning soldiers were sent to the conflict in the north, where polygamy is more accepted. The wives were entitled to the same medical assistance as other Ugandan wives and family members.

The U.S. Agency for International Development (USAID) funds a project for soldiers' wives in Mubende. The UPDF is expected to benefit from a so-called CRD (Community, Resilience, Dialogue) project operated in sixteen districts by a consortium of donors led by the AIDS Information Centre (AIC), with a budget of U.S.$12 million over five years. (The AIC is the first clinic for voluntary counselling and testing set up by the ministry of health in Kampala, in February 1990. There are now 80 such AICs in 28 districts in Uganda).[58] An HIV/AIDS Working Group has been established with the UPDF, funded and supported by USAID, to look at the special needs of the Ugandan military.

A. THE ALLOCATION OF RESOURCES

The acceptance of a higher prevalence of HIV/AIDS within the uniformed services has not, hitherto, been reflected in the allocation of resources to the UPDF. For example, it receives only a very small percentage of the World Bank's HIV country program. Out of U.S.$47.5 million over five years, the UPDF received in 2001/2002 U.S.$55,000; and in 2002/2003 U.S.$27,000. For 2003/2004, U.S.$285,000 has been requested.[59] The Uganda AIDS Commission says that this is as

[54] ICG interview, Major Rubaramira Ruranga, National Coordinator for Network of People Living with HIV & AIDS, November 2003.
[55] ICG interview, deputy minister of finance, November 2003.
[56] ICG interview with UPDF director of medical services, Colonel Dr Musinguzi.
[57] ICG interview, former chief of personnel UPDF, November 2003.
[58] Uganda Aids Commission, "And Banana Trees Provided the Shade", op. cit.
[59] World Bank HIV/AIDS Control Project, Appraisal Report No. 21350-Ug, December 2000.

much due to absorption capacity within the UPDF as it is reflective of overall priorities.[60]

The allocation of resources is part of a more fundamental issue that governments face over spending on AIDS. This centres upon the debate between the health and finance ministries. The former argues that the HIV/AIDS pandemic is of exceptional gravity and that, as with national emergencies such as wars, spending limits must be waived. The latter replies that because HIV/AIDS is a long term spending proposition, it cannot be regarded as an emergency measure, and that exceeding spending limits threatens the prospects for growth and poverty reduction, without which there is no chance of tackling HIV/AIDS or any other social problem.[61]

This dilemma was illustrated by a proposed three-year grant in 2002 of U.S.$52 million from the Global Fund to Uganda for HIV/AIDS. It would have taken ministry of health expenditure through the ceiling of U.S.$107 million that had earlier been agreed with the ministry of finance. Finance instructed health either to refuse the grant or to accept it but stick to the spending ceiling and return the balance of the health budget to the treasury.[62] Fortunately, a compromise was reached which permits additional AIDS funds to be expended since extra funds coming from external sources would not alter the fiscal deficit, even if they would alter previous bureaucratic and political agreements on internal budget allocations.

Underpinning the arguments on both sides is an acceptance of the reality that countries such as Uganda are simply too poor to be able to spend the money needed to keep all their citizens alive. It is an issue of significance to the production and distribution of ARVs.

B. ANTI-RETROVIRAL DRUGS (ARVS)

Access to existing and future anti-retroviral drugs is expected to have a major impact upon the fight against AIDS throughout Africa as well as worldwide. Reportedly, some UPDF personnel receive ARV treatment paid for from the army budget and on the personal authorisation of President Museveni. It is unclear what criteria are applied in deciding which officers may be treated at public expense, while others receive no treatment.[63]

ARVs are also available to some other branches of government, such as ministry of works employees. Wider availability was apparently precluded because of the high costs involved, initially estimated at around U.S.$500 per person per year. Three firms have been cleared by the ministry of health to apply to produce anti-retroviral drugs locally, which is expected to bring this figure down to U.S.$200. Informed sources in Uganda suggest that the overall cost of providing the drugs to all in the country who have AIDS, at U.S.$200 per head, would be no more than is currently being spent on AIDS awareness and prevention programs.[64] However, a full ARV program would still need to be accompanied by prevention programs and in all likelihood an expansion of the health infrastructure to assure proper administration of the ARVs and to cope with more people living longer with AIDS. The development of ARVs shifts the AIDS problem back towards the health and social sectors but it also will require conscious efforts to ensure that both civilian sectors and military forces have access to treatment.

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[60] ICG interview, Professor John Rwomushana, Director, Research & Planning, Uganda AIDS Commission. Very little foreign international HIV/AIDS cooperation by bilateral or multilateral donors is dedicated to help militaries. The U.S. Department of Defence has begun providing technical and some financial assistance on HIV/AIDS to 27 countries, including Russia and India. China has recently expressed interest. Nevertheless, the minimal resources devoted to technical support are evident in the sums involved: U.S.$10 million in FY2001; $14 million in FY2002; $7 million in FY2003 and $4.25 million in FY2004, as well as some $2 million each year that could be used to cover HIV/AIDS-related testing and other equipment. Most of those funds were initiated by the Congress. It is anticipated, but by no means certain, that some of the new Global AIDS initiative funds requested by the U.S. administration and approved by the Congress – some $2.4 billion for FY2004 – will be used to support such military to military AIDS cooperation efforts. UNAIDS' SHR program has opened important assistance programs with some 50 militaries; however, its financial resources also are limited.

[61] De Waal, "HIV/AIDS and the threat of social involution in Africa", op. cit.

[62] Eventually a compromise was reached. C. Wendo, "Uganda Agrees to Increase Health Spending Using Global Fund's Grant", *The Lancet*, Vol. 361, No. 9354, January 2003.

[63] ICG interview, March 2004.

[64] ICG interview, Major Rubaramira Ruranga, National Coordinator for Network of People Living with HIV & AIDS, November 2003.

For ARV treatment to be effective, the individual concerned must follow a disciplined health and social regime.[65] There are now thousands worldwide who are HIV positive and have lived full and productive lives for many years. This was apparent at the eleventh annual international conference for People Living with AIDS, held in Uganda in 2003. The conference welcomed this development but delegates noted the need for strengthened health care systems. More clinics and hospitals will have to be built, and more doctors and nurses will have to be trained and paid for.

The full response package also involves more than just providing ARVs. It includes voluntary counselling and testing, prevention of mother-to-child transmission, treatment of opportunistic infections, nutritional support and healthy living assistance, even micro credit and other financial support so that those with HIV and AIDS can sustain livelihoods. And it means a vast expansion of social safety net programs for the orphans of those who have died of AIDS.

This will impose great demands on African economies. At a special summit in Abuja in 2001, leaders called for the mobilisation of both national and international resources to combat HIV/AIDS. Their domestic target was for 15 per cent of national budgets to be allocated to health, a target only Botswana has met. Internationally, Kofi Annan's call for a Global Fund to Fight AIDS, Tuberculosis and Malaria was endorsed by the UN General Assembly's Special Session on HIV/AIDS in June 2001.[66] It began disbursing its first money in January 2003. By April 2004, it had multi-year pledges of more than U.S.$5.4 billion, contributions of U.S.$2.4 billion, commitments for approved projects of some U.S.$2.1 billion and disbursements of U.S.$285 million. HIV/AIDS constituted some 60 per cent of all of the approved projects, and approximately 60 per cent of all projects were designated for countries in Africa.[67] Nevertheless, the funding gap, both directly for meeting health needs and for meeting the indirect costs of HIV/AIDS on other sectors, including security sectors, remains substantial.

C. REDUCING AIDS IN CONFLICT ZONES: LOCAL COMMUNITIES AND REBELS

While the Ugandan army did what it could to reduce the risk of HIV/AIDS to its troops in the Congo (and continues to do so in the conflict with the Lord's Resistance Army in the north), it has not seen it as its role to sensitise the local communities. Nor has anyone else been able or willing to accept responsibility for insuring that the opposing forces in the conflict areas are aware of the threat of HIV/AIDS.

Women in conflict areas, both as displaced persons and in refugee camps, have been the victims of rape. While there is no firm evidence that AIDS has been used as a weapon of war by the fighting forces, UNIFEM reported that charge.[68] One example has been cited to ICG of two wives of rebels who surrendered to the UPDF in the north, were deliberately raped, and subsequently became HIV positive.[69] Amnesty International in 1999 criticised Ugandan troops for engaging in rape in the Congo, although there has been no repetition of that charge in subsequent reports nor any suggestion that rape was used as a systematic means of spreading AIDS to weaken the fighting efficiency of the opponent. Rape is a capital offence in the UPDF, dating from its early days in the bush as an insurgency itself. Generally, senior Ugandan military officials claim that its incidence has lessened as a result of AIDS awareness.[70]

Women are victimised in other ways as well in conflict situations, including forcible recruitment into competing irregular forces and being lured or

[65] Ibid.
[66] UN General Assembly Declaration of Commitment on HIV/AIDS, June 2001.
[67] Global Fund to Fight AIDS, Tuberculosis and Malaria, "Funds Raised & Spent", at http://www.theglobalfund.org/en/funds_raised/commitments/ and http://www.theglobalfund.org/en/files/grantsstatusreport.xls. Bilateral donors also have increased funding substantially, with the U.S. promising $15 billion over five years, and first year funding of some $2.4 billion approved by the U.S. Congress in late January 2004, most of which will be in the form of bilateral grants. Member states of the European Union also have increased their spending for HIV/AIDS, the bulk of that increase through the Global Fund.
[68] UNIFEM, "Independent Experts Assessment On the Impact of Armed Conflict on Women and the Role of Women in Peace Building", http://www.unifem.org/index.php?f_page_pid=41.
[69] ICG interview, ICRC representative, Kampala, November 2003.
[70] ICG interview, UPDF director of health, November 2003.

driven into prostitution, all of which increase their vulnerability to infection with the AIDS virus.[71]

Several persons consulted by ICG commented upon the difficulty of getting the message about HIV/AIDS across to the rebels. Their forces obviously are not part of AIDS awareness and sensitisation programs of the uniformed forces, while whatever programs run by NGOs and international organisations in the conflict areas are focused upon local communities, internally displaced persons and refugees, and exclude the armed insurgents. In fact, all too frequently, as the head of UNHCR, Ruud Lubbers, has complained, displaced persons and refugees are also excluded from HIV/AIDS national programs.[72]

HIV/AIDS awareness programs aimed at the general population have included some useful attempts to deal specifically with women and children. A report on HIV/AIDS and children in Northern Uganda[73] identified the conflict in the north as the single most important factor which increases the contextual and behavioural risks of exposing children and youth to HIV/AIDS. It noted especially the increased risks of HIV/AIDS for children who are abducted by the rebels but did not focus upon the rebels themselves.

By their very nature, rebels are beyond any support from government authorities, and they rarely benefit from assistance from NGOs and international organisations. This poses some important questions. How do rebels obtain condoms? How do they learn about the dangers of unsafe sex? And how do they have access to testing? As a rebel is unlikely to obtain ARV treatment, does he feel that if he is going to die of AIDS anyway, he might just as well die fighting for a cause? Rebels who are HIV positive and know it may be more easily persuaded to stop fighting if they feel that medication will be available to help them live longer.

This absence of attention to rebels is a major gap in the overall efforts to reduce the spread of AIDS in conflict areas. Though admittedly more difficult, ways should be explored to balance efforts made with uniformed services, local communities, internally displaced persons and refugees. Some consideration might be given to replicating the humanitarian truces that have been first employed in El Salvador in 1985 and subsequently in Uganda, Mozambique and other internal conflicts -- so-called "days of tranquillity", when combatant forces agreed to halt fighting to permit the Pan American Health Organization (PAHO) and World Health Organisation (WHO) and UNICEF to conduct polio vaccination campaigns.[74] HIV/AIDS prevention information could be distributed by radio or leaflets and condoms made available.

Clearly screening for HIV/AIDS should be part of all DR programs for all sides in the conflict, along with education, counselling and treatment. ARV treatment and treatment for opportunistic infections such as tuberculosis and pneumonia, which characteristically affect AIDS patients, could be an inducement to rebels to stop fighting, although governments will be sensitive to criticism if they provide ARV treatment to rebels that is not available to victims of the conflict. This is another reason for promoting availability of ARVs as widely as possible.

[71] UNIFEM, "Women, Peace and Security", http://www.unifem.org/index.php?f_page_pid=35.

[72] Ruud Lubbers, "In the war on AIDS refugees are often excluded", 28 November 2003, UNHCR website. Lubbers stated, "Of the 29 countries in Africa that host more than 10,000 refugees, only 35 per cent have outlined activities for refugees in their National Strategic Plans. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Multi-Country HIV/AIDS Programs of the World Bank have funded HIV/AIDS projects in 24 of these 29 countries that between them host millions of refugees. But less than half of those proposals actually included refugees".

[73] Save the Children Denmark, "HIV/AIDS and the Rights of Children in a Conflict Situation", November 2002.

[74] The "days of tranquillity" concept was initiated in El Salvador in 1986.

VII. REGIONAL EFFORTS AT PREVENTION

All the countries involved in the Great Lakes conflict suffer from the AIDS pandemic. The latest estimated HIV prevalence rates for the adult populations are Burundi 11.3 per cent, Rwanda 8.9 per cent, and Congo 4.9 per cent.

Figures for 2002[75]

	Burundi	Congo	Rwanda	Uganda
Total Population	6.5m	52.5m	8m	24.6m
Living with AIDS	390,000	1.1m	500,000	600,000
Deaths from AIDS	40,000	120,000	49,000	84,000
Children orphaned	240,000	930,000	260,000	880,000
Adult prevalence	8.3%	4.9%	8.9%	5%

A recent report on HIV/AIDS in the Great Lakes, commissioned by UNAIDS and UNICEF and undertaken by Save the Children UK, set as its first objective "to identify the reasons for the inadequate response to HIV/AIDS in emergency settings in the Great Lake region".[76] The report highlighted the number of NGOs and international organisations working on AIDS in the region.

Number of NGOs working on AIDS[77]

Area	Local NGOs	International NGOs	UN Agencies
E Congo	15	5	1
Rwanda	40	20	10
Burundi	55	20	8

The author suggested that the effect was more "slow and uncoordinated" than "inadequate" with respect to the emergency situations. Most on-the-ground organisations did not know what others were doing and did not have access to each others' documents, and there was no structured mutual learning regarding successes and mistakes. The UK Save the Children report, focusing on the emergency conflict areas particularly in Eastern Congo, found as of 2003 that although budgets for humanitarian aid have increased significantly, some are still subject to the political views of the donor with respect to the combatants. Funds were disbursed ad-hoc, with short term commitments; certain programs were over-funded, and others were under-funded. Because of the impact of the conflict, nobody had an overall picture of who was funding what, and how much money was being spent.

The picture is changing somewhat with donors, particularly because of the required consultations and coordination for submission of grant proposals to the Global Fund and the coordinating mechanisms of the UN Theme Group on HIV/AIDS and the United Nations Joint Programme on HIV/AIDS (UNAIDS). These also can provide a framework for the assistance programs of bilateral donors.

In 1998 the Great Lakes Initiative on AIDS (GLIA) was started with a grant from the World Bank of U.S.$15 million. Cooperating countries are Uganda, Kenya, Congo, Tanzania, Rwanda and Burundi. It focuses on the needs of the refugees and IDPs resulting from the conflict. There is no involvement of military forces, which have not benefited directly from the initiative. However, it is a useful platform for coordination and exchange of information and appears to overcome political differences in the region. For example, Uganda has recently supported a GLIA grant to Rwanda notwithstanding political differences. It may be hoped this will lead to a closer working relationship between the armed forces.

Military cooperation in the wider region generally is less formalised but efforts are being made. A workshop on HIV/AIDS activities with the Armed Forces of Kenya, Tanzania and Uganda was held in Entebbe in July 2003 under the auspices of UNAIDS. The U.S. and EU recently expanded their own HIV/AIDS cooperation with regional military forces, either bilaterally or in conjunction with UNAIDS, but much more remains to be done. For example, the African Union, urged on by UN DPKO, recently

[75] UNAIDS/UNICEF/WHO Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002.
[76] Bensman, "Report on HIV/AIDS and Conflict", op. cit.
[77] In Uganda, there are 1,300 local and international NGOs and 12 UN agencies working on AIDS. See Uganda Aids Commission, "The Story of AIDS in Uganda", op. cit.

agreed to coordinate establishment of sub-regional African military rapid reaction forces at brigade level for peacekeeping purposes. On 1 April 2004, the EU reportedly offered support, along with the U.S.[78] HIV/AIDS issues should be integrated into that effort.

VIII. THE ROLE OF THE UNITED NATIONS

Until close to the turn of the century, the UN viewed AIDS as primarily a health issue, and its impact upon conflict and security was all but ignored. However, the Security Council's focus on the issue and the General Assembly's Declaration of Commitment (June 2001) were turning points in identifying AIDS as a security issue.

Since then the UN has paid particular attention to the impact of AIDS on uniformed services, including its own peacekeeping missions. Soldiers from countries with high HIV/AIDS prevalence make up 11 per cent of UN force totals. Adding in countries nearing such high prevalence brings this to 37 per cent of all UN peacekeepers.[79] There is no evidence to suggest that governments are reluctant to contribute to UN peacekeeping missions serving in conflict areas where there is a high prevalence of AIDS, perhaps because the economic benefits of UN service appear to outweigh health risks. But this attitude could change if increasing numbers of troops become infected.

At the General Assembly in September 2003, the UN launched a global initiative on "Engaging uniformed services in the fight against HIV/AIDS" designed to expand massively the work of the UNAIDS program on AIDS, Security and Humanitarian Response (SHR). Through it, UNAIDS has facilitated partnerships with some 50 governments around the world and has launched various measures to support activities which address HIV/AIDS among uniformed personnel, including a guide for developing and implementing programs on sexually-transmitted illness, peer education kits, awareness cards and an interactive map. A case study has been carried out on HIV/AIDS prevention among armed forces and UN peacekeepers in Eritrea. A new SHR effort provides countries help with developing strategic action plans for dealing with AIDS in the military.[80]

[78] "Europe Backs African Army Plan", BBC News, Ghananews, 1 April 2004, http://www.nepad.org/ en.html

[79] "Contributors to UN Peacekeeping Operations", UN web site, http://www.un.org/Depts/dpko/dpko/contributors/index.htm.

[80] This help might include cooperation on "awareness and prevention, training through peer education, gender and human rights issues, capacity building and sustainability". See "HIV/AIDS and uniformed services", UNAIDS web site, http://www.unaids.org/Unaids/EN/In+focus/IV_AIDS_

All this commendable activity has led to a closer working relationship between UNAIDS and the UN's Department of Peacekeeping Operations (DPKO), with a view to ensuring that AIDS awareness "permeates every peacekeeping operation".[81] The UNAIDS-DPKO Cooperation framework was formalised in 2001. UNAIDS supports an HIV policy adviser in DPKO headquarters in New York, and AIDS advisers have been placed in peacekeeping missions in Sierra Leone, Ethiopia/Eritrea, East Timor and the Congo. UNAIDS also supports the DPKO's HIV/AIDS Trust Fund, both in resource mobilisation and in providing technical advice on its funded activities. This will include a proposed survey of peacekeepers' knowledge, attitudes and practice in order to establish a comprehensive information base for targeting and evaluating HIV activities. An HIV/AIDS awareness card, which has been produced in ten languages and is being translated into Chinese, includes a pocket for a condom. Around 50,000 cards per year are to be provided to all UN peacekeeping missions and to troop-contributing countries for use in pre-deployment training.

But more still needs to be done by the whole machinery of the UN. As Peter Piot, the Executive Director of UNAIDS, said in addressing the Security Council on 17 November 2003 : "I do note with some regret, however, that the Security Council has not taken the opportunity to expressly address AIDS in a number of recent resolutions establishing and extending UN missions, especially given that some of these missions are operating in regions which already have major HIV epidemics".[82] The absence of specific identification of the need for comprehensive HIV/AIDS awareness in those resolutions diminishes the likelihood that adequate priority will be given to this issue in the disarmament and demobilisation phases as well as in the longer term resettlement, reintegration and reconstruction timeframe.

An issue of particular concern is the screening of peacekeeping troops for HIV/AIDS. An Expert Panel on HIV testing and UN Peacekeeping Missions, chaired by an Australian High Court judge, advised against mandatory testing in 2001,[83] but since then a number of countries hosting missions have called for it. The UN HIV Testing Policy for Uniformed Peacekeepers, finally issued in January 2004, states:

- In line with UN Security Council Resolution 1308 (2000), DPKO strongly supports a policy of Voluntary Confidential Counselling and Testing (VCCT). The UN does not require that individuals at any time be tested for HIV in relation to deployment as peacekeepers.
- The UN is cognizant of the fact that some troop contributing countries (TCCs) have a mandatory testing policy and do not deploy HIV positive personnel. DPKO respects this national requirement.
- The HIV status of an individual is not in itself considered an indication of fitness for deployment in a peacekeeping mission….
- DPKO does require that all uniformed peacekeepers be offered VCCT prior to deployment…
- The mission must insure that all UN personnel, including uniformed personnel, in the mission area have access to VCCT, including pre and post test counselling…[84]

UNAIDS and DPKO have been debating this policy since the panel reported in 2001. The panel based its conclusions on medical evidence/guidelines, focused on concerns about discrimination and stigma, and concluded that individuals with HIV, when acting appropriately and treated appropriately, can contribute without detriment to the peacekeeping mission. Nevertheless, growing numbers of militaries are testing their recruits and established units, the latter particularly prior to external deployments.

Given the special circumstances of peacekeepers in conflict areas, particularly where either or both the

security+and+humanitarian+response/hiv_aids+and+uniformed+services.asp.

[81] Dr Peter Piot, Executive Director of UNAIDS, statement to the UN Security Council, 17 November 2003.

[82] Ibid.

[83] UNAIDS, "Report of the UNAIDS Expert Panel on HIV Testing in United Nations Peacekeeping Operations, 28-30 November 2001," chaired by Australian Justice Michael Kirby. http://www.unaids.org/html/pub/Topics/Security/PeacekeepingReportFinal_en_doc.htm. Also see, UNAIDS, "United Nations Peacekeeping Operations and Mandatory HIV Testing", August 1996 (Revised August 2001), Eric A. Feldman, J.D., Ph.D., Gerald H. Friedland, M.D. http://www.unaids.org/html/pub/Topics/Security/BkgrndpaperMedicalfinal_en_doc.htm

[84] UN Department of Peacekeeping Operations, Office of Mission Support, "HIV Testing Policy for Uniformed Peacekeepers", January 2004. The full document is in Appendix A.

contributing country or the conflict area have high HIV/AIDS prevalence rates, it would appear that mandatory testing and screening, both pre- and post-deployment, would remove concerns about potential spread of the disease. While individual peacekeepers could become HIV positive from sexual contact during their deployment, at the very least pre-deployment testing would help provide individuals the knowledge of their own status and enable them to protect themselves and, by their conduct, protect others. Similarly, post-deployment testing would permit steps to be taken to reduce the likelihood of their "innocently" spreading the disease through unprotected sex on return.

Only three years after the panel report, with the existence of the Global Fund, greater attention and resources are available worldwide to provide treatment to HIV-positive individuals. WHO has launched its "three by five" initiative to insure that 3 million HIV-positive individuals have access to ARVs by 2005. The new U.S. AIDS Initiative Fund also has authority to finance some ARV treatment in fourteen priority countries, most in Africa. Other efforts are underway to pressure the private pharmaceutical industry to reduce the costs of ARVs. All these undertakings address the panel's concern that required testing would stigmatise the HIV-positive individual but very little would be available to assist that individual after determining HIV-positive status. That no longer is the case. In general, the desirability of mandatory testing for specific groups and at specific moments is being debated.[85]

There also still is not even a formal requirement for contributing countries to inform DPKO whether the incoming peacekeeping forces have had AIDS awareness training or means of verification of the information that may have been voluntarily submitted. DPKO, with UNAIDS support, has developed HIV/AIDS standardised training modules for pre-deployment training, and the goal is to insure that all peacekeepers receive that training. However, there are some missions where that training has yet to occur. These issues need to be addressed by the UN and member states. As former U.S. Ambassador to the UN Richard Holbrooke remarked in his final speech to the Security Council: "It would be the cruellest of ironies if people who had come to end a war were spreading an even more deadly disease".[86]

In the Great Lakes, MONUC currently has slightly more peacekeepers than its authorised level of 10,800, with contingents coming from a variety of countries including Uruguay, Senegal, Tunisia, Morocco, Ghana and India. Some, including the Uruguayan and Ghanaian contingents, were screened for HIV/AIDS before deployment. The South African military also now requires mandatory testing prior to deployment. The practice in the Ghanaian army is for a thorough medical examination prior to embarkation; a soldier found to be HIV positive is not allowed to proceed. Ghanaians also carry condom pouches as standard equipment.[87]

The UNAIDS Country Coordinator in Kinshasa is responsible for coordinating the activity of the UN and NGOs in the Congo, through the UN Theme Group; and an HIV/AIDS policy adviser, supported by a qualified UN Volunteer official, works full time on AIDS within MONUC, in addition to the mission's medical staff and chief medical officer. The latter considered malaria a greater health risk to the forces than HIV/AIDS, presumably since malaria can in a short term incapacitate large numbers of the force while HIV positive troops are unlikely to show symptoms for some time, and full-blown AIDS is usually not apparent until much later. According to MONUC's chief political adviser in Kampala, the need to establish the rule of law, eliminate poverty, and create development all warrant a higher priority than tackling HIV/AIDS. That view unfortunately is self-defeating since not acting to halt the spread of the disease will undermine all those objectives. For that reason, the Special Representative of the Secretary General for MONUC, William Swing, hopes to include stronger HIV/AIDS prevention and treatment programs in all DR programs in the region.[88]

[85] See Richard Holbrooke and Richard Furman, "A Global Battle's Missing Weapon", *The New York Times*, 10 February 2004.

[86] Laurie Garrett, "UN Criticized On AIDS Effort / Holbrooke: Peacekeepers Need Testing", Newsday, 19 January 2001.

[87] ICG interview, retired Ghanaian general and former head of UN peacekeeping mission, December 2003.

[88] ICG interview, Ambassador William Swing, MONUC SRSG, February 2004.

IX. CONCLUSION

ICG's aim has been to develop additional insights into the relationship between conflict and HIV/AIDS by examining how the pandemic affected Ugandan troops fresh from military operations in the Congo and Northern Uganda, as well as to advance understanding about the way in which UN peacekeeping forces are being affected by HIV/AIDS and the institutional response.

The correlation between HIV/AIDS and conflict is difficult, complex and poorly documented. Available data demonstrates that conflict can increase the risks of HIV/AIDS and that HIV/AIDS can exacerbate the difficulties of ending a conflict. Studies have shown that HIV/AIDS is more prevalent in the military and other uniformed services than it is in the population as a whole.[89] Notwithstanding the difficulties of working in conflict areas and the inherent reluctance of governments and militaries to offer security-related information, these are compelling conclusions. The UN and the wider international community should support more research in these areas and encourage governments to be more open about the extent of HIV/AIDS within their services.

While AIDS' relationship to violent conflict in Africa cannot be expressed in a simple cause-and-effect manner, the pandemic needs to be addressed in terms of how it may contribute to further instability and conflict on the continent in coming years, and how instability and violence encourage conditions favourable to the spread of the disease.

There is now widespread recognition, thanks in part to the efforts of the UN, that AIDS is more than just a public health issue. However, the recognition that it constitutes a threat to the stability and security of states is not fully reflected in the way African countries are tackling the problem. All governments should follow the example of Uganda and a small number of other countries, including Ethiopia and Thailand, in addressing HIV/AIDS as a priority for security forces as part of a comprehensive government-wide approach, rather than leaving it to the health sector alone to deal with its impact or prevent its further spread. It is disappointing that the NEPAD plan for the future of Africa, while focusing upon conflict, pays scant attention to the relationship of AIDS to conflict, even though recent statements by its Steering Committee chair have acknowledged the pandemic as one of the region's major challenges.

The higher prevalence of HIV/AIDS in the military also is not reflected in the allocation of resources provided by governments, bilateral and multilateral donors, the Global Fund, or the UN and NGOs in their AIDS response programs. For example, the Ugandan army currently receives very little from the World Bank's HIV/AIDS program. More donor funding and a larger percentage of existing funding should be directed towards uniformed services.

AIDS awareness programs, mandatory testing and screening, counselling and treatment should be introduced for all forces involved in areas of conflict, particularly UN peacekeeping missions. At a minimum, the necessary resources should be immediately made available to insure that UN peacekeepers have had access to voluntary and confidential counselling and testing (VCCT) prior to deployment, and that this is available throughout the period of deployment and post-deployment. That would be the best assurance that individuals have access to information that protects them, the communities in which they are deployed, and their own families and communities.

Too little attention has yet been given to the real possibility that the HIV/AIDS pandemic may delay the resolution of conflicts. Infected soldiers become lethargic and irresponsible, and chains of command are broken. As a result, a conflict can drag on, as to a degree may be happening in Northern Uganda. Notwithstanding the difficulties, it is preferable to try to address HIV/AIDS within the conflict areas early on rather than wait until the fighting has ended. Attention also should be given by international, inter-governmental and non-governmental groups to promoting humanitarian accords that permit HIV/AIDS prevention, counselling and treatment to be made available to all those in the conflict region, whether government or rebel combatants, refugees or displaced persons. At a minimum information and condoms can be distributed.

[89] UNAIDS estimates have shown that in Uganda pregnant women had prevalence rates of 20 per cent in 1994 and 15 per cent in 1997, while military recruits were at 25 per cent in 1994 and 27 per cent in 1997. ICG interview, April 2004.

AIDS should be factored into all conflict resolution activities, from peace negotiations to the final accords, and post-conflict DR programs. Teams conducting peace negotiations should include health/AIDS officials. Consideration should be given to offering help with AIDS, including ARV drugs, as an inducement to stop fighting.

HIV/AIDS and conflict pose two fundamental and negatively reinforcing threats to the lives of millions and the stability and security of African nations. Donors as well as regional and international organisations can and should do more to help combat those threats but the primary responsibility resides with the political leadership of the countries themselves.

Kampala/Brussels, 16 April 2004

APPENDIX A

UNITED NATIONS DEPARTMENT OF PEACEKEEPING OPERATIONS HIV TESTING POLICY FOR UNIFORMED PEACEKEEPERS

ACRONYMS AND DEFINITIONS

AIDS	Acquired Immune Deficiency Syndrome, a disease where the body's ability to resist infections and other conditions, for example cancer, is impaired.
Confidential	Information known only to the individual concerned and the persons with whom s/he chooses to share.
Counselling	Formalised system for advice relating to the decision to take an HIV test and the follow up of the result.
DPKO	Department of Peacekeeping Operations.
HIV	Human Immunodeficiency Virus, causes AIDS.
Mandatory	Where an individual has no say in whether or not a test is to be performed.
Medical-in-confidence	Information can only be shared between the doctor and the patient and between treating physicians if deemed beneficial to the patient.
Mission	The peacekeeping mission.
PEP	Post Exposure Prophylaxis, testing and treatment package for use where there may have been accidental exposure to HIV.
TCC	Troop Contributing Country. The nation of a peacekeeper.
Testing	Test to directly or indirectly show HIV infection.
UNAIDS	Joint United Nations Programme on HIV/AIDS.
Voluntary	Where an individual by his/her free will chooses to undergo a test.
VCCT	Voluntary Confidential Counselling and Testing.
WHO	The World Health Organization.

Introduction

1. The transmission of Human Immunodeficiency Virus (HIV) among peacekeepers and host communities is a concern for the UN Department of Peacekeeping Operations (DPKO). Populations already suffering the devastation of war may be especially vulnerable to the virus. HIV is preventable if reasonable precautions are taken, but there is no cure. DPKO has developed pre-deployment 'Standardised Generic Training Modules' as well as in-mission HIV/AIDS awareness training and prevention programmes. Abstinence in the field is encouraged; however, male and female condoms are made available and missions distribute to contingents and UN personnel. Treatment for common sexually transmitted infections (STIs) is also available. This document outlines DPKO's policy with regard to HIV testing of uniformed personnel.
2. The United Nations' HIV testing policy has to conform to international human rights norms, in particular the principle of non-discrimination and the application of the 'least intrusive' means to achieve the demonstrably justified objective of preventing the transmission of HIV.
3. DPKO supports the right of the individual to know his/her HIV-status without fear of personal or professional discrimination. An HIV test should be accompanied by pre and post test counselling. Providing the scope for individuals to make informed and independent decisions to find out their HIV status is a critical component in influencing behaviour and preventing further transmission.
4. In line with UN Security Council Resolution 1308 (2000), DPKO strongly supports a policy of Voluntary Confidential Counselling and Testing (VCCT). The UN does not require that individuals at any time be tested for HIV in relation to deployment as peacekeepers.
5. The UN is cognizant of the fact that some troop contributing countries (TCCs) have a mandatory testing policy and do not deploy HIV positive personnel. DPKO respects this national requirement.

HIV Testing

Pre-deployment

1. The sole medical criterion for the deployment and retention of a peacekeeper is fitness to perform peacekeeping duties during the term of deployment.
2. In accordance with current medical and human rights guidelines, the HIV status of an individual is not in itself considered an indication of fitness for deployment in a peacekeeping mission. An HIV test is therefore not required by the United Nations.
3. Individual fitness must be determined by a thorough pre-deployment medical examination/service medical assessment, which is the responsibility of the TCC. National medical standards are employed to determine fitness, but as a rule UN medical standards, according to the policy of the Medical Services Division and DPKO, are the minimum acceptable for deployment in any peacekeeping operation. The medical examination must exclude those individuals showing signs of active disease, including clinical signs of immunodeficiency, such as Acquired Immune Deficiency Syndrome (AIDS).
4. Individuals in mission who are in non-compliance with the overall standards stated in the guidelines for pre-deployment medical examination should be repatriated.
   (a) Repatriation is at the cost of the UN if the change in medical status has clearly occurred while in the mission.
   (b) Repatriation is at the cost of the Troop Contributor where deployment of the individual has clearly been in breach of the guidelines.
5. The UN does not exclude HIV-positive personnel from serving in a mission because of their HIV-status. DPKO does require that all uniformed peacekeepers be offered VCCT prior to deployment. This should not be interpreted as a requirement for mandatory testing. That VCCT has been made available should be stated in the certificate of health.

In-mission

1. The mission must ensure that all UN personnel, including uniformed personnel, in the mission area have access to VCCT, including pre and post test counselling, at no cost to the individual.
2. HIV testing requires the informed signed consent of the individual and must be accompanied by counselling.
3. Where HIV status is important in the choice of medical treatment, or the patient is unconscious, special provisions will be defined in OMS guidelines on VCCT.
4. In mission areas, confidentiality regarding both the request for a test and the test result must be maintained. Results are 'medical-in-confidence' and may only be shared with the consent of the individual. The national policy of the medical facility provider or that of the individual's nation cannot override the stated rules of confidentiality.
5. The UN strongly encourages that VCCT be available to all peacekeepers upon their return home.

HIV/AIDS Counsellors

1. It is strongly recommended that TCC's deploying more than 200 peacekeepers in a mission include at least one HIV/AIDS focal point in the contingent, certified to provide pre- and post test counselling.
2. Missions should have at least one international and one locally employed counsellor to provide counselling out of UN owned facilities. Both male and female counsellors should be available.
3. All missions must designate one female and one male medical personnel or a female counsellor to be responsible for care, counselling and support in cases of sexual violence or rape. This service must be available at all times.

Exposure to blood

1. In order to avoid unnecessary exposure to HIV and other diseases transmitted through blood and other bodily fluids:
   (a) All blood and blood products must come from sources that meet WHO requirements. Mission hospitals must maintain stocks accordingly.
   (b) Hospitals must maintain quality-assessed sterilisation of all medical equipment. Injection and suture needles must be single use only and disposed of as hazardous waste.
   (c) All UN first-aid kits must acknowledge the need to protect from exposure to blood and other bodily fluids and must include rubber gloves and resuscitation ('mouth-to-mouth') masks.
2. It is the responsibility of the Force Medical Officer and/or the Chief Medical Officer in the Mission to order and ensure that post-exposure prophylaxis (PEP) kits, for occupational exposure and in cases of sexual assault, are available and distributed to UN clinics and level IIs and IIIs (or equivalent). The kits are to be funded through the mission budget.
3. The FMO and/or CMO must ensure that staff, including uniformed medical personnel, are informed about the PEP kits and policy of use.

Review of policy

1. This policy is based on currently available qualitative and empirical data. The DPKO Office of Mission Support shall review it regularly, in consultation with UNAIDS, to take into account any developments in medical treatments and recommendations with regard to HIV and AIDS.