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Linking HIV/AIDS, Conflict and National Security
A Colombian Case Study

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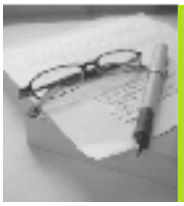

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Linking HIV/AIDS, Conflict and National Security
A Colombian Case Study*

Caroline Törnqvist**

Abstract
An estimated 33 million people are today infected with HIV. The majority of these people live in developing countries, and many in countries experiencing armed conflict or instability. This paper examines the linkages between HIV/AIDS, conflict and national security applying existing theories to the Colombian context and asking whether HIV/AIDS should be securitized in order to reduce the negative cause and effect relationship. It finds that the linkages are definitely present in Colombia and concludes that HIV/AIDS should be politicised at the national level and securitized at international level.

Resumen
Aproximadamente 33 millones personas están hoy en día infectadas con el VIH. La mayoría de ellos viven en países en vía de desarrollo y muchos de estos países están sufriendo conflictos armados o inestabilidades políticas. En el presente documento se examina los vínculos entre VIH/SIDA, conflicto y seguridad nacional, aplicando las teorías existentes al contexto colombiano y haciendo la pregunta si se debería tratar el VIH/SIDA como una cuestión de seguridad nacional para reducir la relación causa y efecto negativa. En el documento se descubre que estos vínculos están presentes en Colombia y concluye que a nivel nacional se debería buscar un reconocimiento político del tema VIH/SIDA, mientras a nivel internacional sería pertinente tratarlo como una cuestión de seguridad.

* This is a revised and shorter version of the Master Thesis 10p/15 ECTS. NOHA – Network Of Humanitarian Assistance. Masters programme Department of Peace and Conflict. Uppsala Universitetet. Supervisor: Kjell-Åke Nordquist. October 2007.

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EXECUTIVE SUMMARY

An estimated 33 million people are today infected with HIV. The majority of these people live in developing countries, and many in countries experiencing conflict or instability, including post conflict settings. The international community is increasingly recognising the affect HIV/AIDS can have on national security and conflict, both exacerbating conflict and being an obstacle to peace. Security Council Resolution 1308 reflects this recognition. The purpose of the paper is to investigate the value of including HIV/AIDS as a securitized concept in conflict resolution and the provision of humanitarian assistance. The research question it poses to answer this is: "*Should HIV/AIDS be securitized? If so, what would be the consequences for humanitarian assistance?*" Colombia is used as a case study. The paper approaches national security from the narrow definition whilst applying the discursive reasoning from the Copenhagen School of Security Studies. Within this framework four main theories have been concluded on the links between HIV/AIDS, national security and conflict. These are 1) Uniformed personnel as a vector of HIV, 2) National security threatened by HIV/AIDS affected state institutions, 3) Increased vulnerability to HIV infection in conflict and post-conflict environments, and 4) HIV as an obstacle to peace building. These four theories are explored in the Colombian context. Colombia is a pertinent country to look at given that it has experienced a protracted internal conflict lasting over 40 years, which has still not been resolved. Its HIV epidemic is characterised as concentrated and prevalence rate is comparably low. However prevalence is increasing, especially amongst the vulnerable population, pointing to the importance of targeted interventions in order to prevent a generalised epidemic. The interpretations of the Colombian conflict and the national and international response to the conflict (both political and humanitarian) both have an impact on the HIV epidemic. Of the four theories investigated it was found that 'uniformed personnel as a vector of HIV' and 'increased vulnerability to HIV infection in conflict environments' presented the strongest linkages between HIV/AIDS, national security and conflict. The theories 'national security threatened by HIV/AIDS affected state institutions' and 'HIV as an obstacle to peace building' were less strong, mainly due to the relatively low HIV prevalence rate in Colombia. The provision of humanitarian assistance in this context also impacts on the HIV epidemic and resultantly on the conflict. The illegal armed groups party to the Colombian conflict play an important role in the spread of HIV and as such must be targeted in any intervention to reduce HIV transmission. However the policies of the Uribe government do not permit this. The question of response is of utmost important when answering the question on whether HIV/AIDS should be securitized. The paper argues for the securitization of HIV/AIDS at international level, though concludes that politicisation of the issue would be more appropriate in the Colombian context.

Research question: *Should HIV/AIDS be securitized? If so, what would be the consequences for humanitarian assistance? A Colombian case study*

Purpose: To investigate the value of including HIV/AIDS as a securitized concept in conflict resolution and the provision of humanitarian assistance.

Reason: The magnitude of the HIV/AIDS pandemic.

Based on: The growing body of evidence linking HIV/AIDS and national security and conflict, and the international commitments and resolutions made on the issue in recent years.

1. ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral
AUC	Autodefensas Unidas de Colombia
DDR	Disarmament, Demobilisation and Reintegration
DRC	Democratic Republic of Congo
ELN	Ejército de Liberación Nacional
FARC	Fuerzas Armadas Revolucionarias Colombia
FFAA	Fuerzas Armadas (the Colombian Nacional Army)
HIV	Human Immunodeficiency Virus
ICG	International Crisis Group
IDP	Internally Displaced Person
IOM	International Organisation for Migration
MDG	Millennium Development Goals
NGO	Non-governmental organisation
OAS-MAPP	Organisation of American States – the Mission to Support the Peace Process in Colombia
PLWHA	People Living With HIV/AIDS
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on AIDS
UNDPKO	United Nations Department of Peacekeeping Operation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

2. DEFINITIONS

AIDS - Acquired Immunodeficiency Syndrome. The later stage of a continuum of HIV infection and disease. The interval between HIV infection and AIDS varies.

Armed Conflict – contested incompatibility which concerns government and/or territory where the use of armed force between 2 parties, of which at least one is the government, results in at least 25 battle-related deaths per year.

Complex emergency – a humanitarian crisis where a significant breakdown of authority has resulted from internal or external conflict, requiring an international response that extends beyond the mandate of one single agency.

Concentrated epidemic - an HIV epidemic in a country in which 5% or more of individuals in groups with high-risk behaviour, but less than 5% of women attending urban antenatal clinics, are infected.

Emergency – a situation that threatens the life and well-being of large numbers of a population, extraordinary action being required to ensure the survival, care and protection of those affected. Emergencies include natural crisis such as hurricanes, droughts, earthquakes and floods, as well as situations of armed conflict

Generalised epidemic - an HIV epidemic in a country in which 5% or more of women attending urban antenatal clinics are infected. Infection rates amongst individuals in groups with high-risk behaviour are also likely to exceed 5% in countries with a generalised HIV epidemic.

HIV- Human Immunodeficiency Virus. A virus attacking the cells that are part of the body's immune system. By weakening the body's defence against diseases HIV makes the body vulnerable to a number of potentially life-threatening infections.

HIV prevalence – the proportion of people living with HIV in a defined area or amongst a defined population group.

Human security- developed by the UNDP in its 2004 Human Development Report, which increases the scope of global security to include threats in 7 areas: economic security, food security, health security, environmental security, personal security, community security, and political security.

Opportunistic infections – an infection that affect people with low immune system

Pandemic – an epidemic occurring simultaneously in many different countries

War – armed conflict which results in at least 1000 battle related deaths per year

3. INTRODUCTION

Since first detected in 1981 HIV/AIDS has infected 65 million people worldwide and killed more than 25 million. Every day the pandemic kills three times as many people as those who died during the September 11 terrorist attacks and in the decades ahead HIV/AIDS is expected to kill ten times more people than conflict[1]. HIV/AIDS has been declared as one of the greatest threats to development and poverty reduction. Almost all countries in the world have committed themselves to stop and reverse the spread of HIV/AIDS by the year 2015 through the adoption of the Millennium Development Goals (MDGs) at the UN Millennium Development Summit in 2000. World leaders went further in their commitment to the fight against HIV/AIDS when at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001 189 countries declared HIV/AIDS a national and international development issue of the highest priority. UNGASS also took the progressive step of considering HIV/AIDS as a threat to international security, like the UN Security Council had done in Resolution 1308 the year before. In passing Resolution 1308 the Security Council recognised that the HIV/AIDS pandemic is exacerbated by conditions of violence and instability and stressed that, if unchecked, may pose a risk to stability and security. Since the adoption of Security Council Resolution 1308 a number of regional and sub-regional initiatives on HIV/AIDS and security has been established, such as the African Union Peace and Security Commission, the Pacific Regional Police HIV/AIDS Initiative, the Latin American and Caribbean Armed Forces and Police Forces Committee for AIDS Prevention and Control (COPRECOS), to name just a few. Research increasingly points to the link between HIV/AIDS, national security and conflict, demonstrating how conflict accelerates the spread of HIV and how HIV/AIDS in itself is a potential threat to national security.

Based on the above developments the following *research question* was developed– "Should HIV/AIDS be securitized? And if so, what would be the consequences for humanitarian assistance?" Colombia is used as a specific case study, applying the stated links between HIV/AIDS and conflict to the Colombian context. Colombia is a relevant case due to its protracted conflict and comparatively low HIV prevalence rate. It is of particular value for two reasons. First, the majority of existing research is based on evidence from conflict-affected African countries, which suffer from much higher HIV prevalence rates. Secondly, Colombia is also an example of an internal conflict, which is the most common type of conflict. The findings are therefore relevant for other countries experiencing internal conflict and with low to medium high HIV/AIDS prevalence rates.

The paper is based on the narrow definition of national security and does not therefore examine the links between the demographic and economic threats to national security caused by HIV/AIDS. Whilst these links are also likely to be important they have been excluded in order to permit more comprehensive and qualitative research on the theories which are of direct relevance to national security based on the narrow definition. Likewise, there are many other factors that contribute to an increased HIV/AIDS epidemic independent of the existence of armed conflict. If HIV/AIDS was to be taken into account in conflict resolution processes and integrated into the Disarmament, Demobilisation and Reintegration (DDR) programmes, such factors would also need to be taken into account. These factors are crucial for fully understanding the causes and affects of an HIV/AIDS epidemic in a country.

PART I: THEORETICAL FRAMEWORK

4. SECURITY DISCUSSION

The paper in exploring the link between HIV/AIDS, national security and conflict, approaches security from the narrow perspective but in recognition of the shortcomings of the narrow definition adopts the theory developed by the Copenhagen School on Security Studies. This theory explores the logic of security and how an issue becomes securitized. Its main authors are Barry Buzan, Jaap de Wilde and Ole Weaver and it is considered one of the most controversial contributions to the field of security studies in recent years.

The *narrow* definition of security limits security to that of military security, and military conflict is the key denominator to security. Security therefore is determined by studying the threat, use and control of military force. The military-political understanding of security is that of survival, with international security firmly rooted in the traditions of power politics. An issue becomes a matter of international security when survival is threatened. This happens when an issue poses an existential threat to a designated referent object, which most often is a state (consisting of a government, territory and society). The invocation of security is key to legitimise the use of force and justify the use of extraordinary measures by the state. As argued by the Copenhagen theory, by saying "security" the state representative declares an emergency condition, thus claiming the right to use whatever means necessary to block the threatening development. The *wide* definition of security also takes into account other non-militarised sources of threats, such as economic, environmental and social issues. It is a response to the growing dissatisfaction with the focus on military issues only in the light of the increased importance of economic and environmental agendas in international relations in the 1970s and 1980s, and issues of identity and cross-border crime in the 1990s. The wide definition of security has been criticised for endangering the intellectual coherence of security by including such a range of issues that the essential meaning of security becomes void. The Copenhagen theory proposes a solution to this debate which is to keep the security agenda open to many different types of threats, and to seek coherence not by confining security only to the military sector but exploring the logic of security itself.

The cornerstone of the Copenhagen School security concept is the importance it places on the utilisation of the concept by governments and policy makers, and its discourse. It argues that "the use of the security label does not merely reflect whether a problem *is* a security problem, it is also a political choice, that is, a decision for conceptualisation in a special way."[2] The way issues end upon the international security agenda is through speculative predictions about future developments, prioritising between competing claims, and also deciding whether an issue is best addressed under a security framework rather than under other competing frameworks. This is particularly so when the discussion refers to wider social issues where considerable elements of politics are involved in its determination and presentation in the public debate. They warn against the danger of securitization as basically security should be seen as negative, as a failure to deal with issues as normal politics which ideally should be able to unfold according to routine procedures without such extraordinary elevation of specific threats. The theory gives three options on how an issue is determined, depending on how it is presented in the public debate. It remains non-politicised if the issue is not put forward to the public debate or discussion. Alternatively, it becomes politicised when it is made part of public policy and subject to a public discussion. Finally, it becomes securitized if presented as an existential threat requiring emergency measures and justifying actions outside the normal bounds of the political procedures.

For an issue to become securitized it must be taken out of its non-politicised or politicised status and elevated to the security sphere by being presented according to the particular logic of the security speech act. The security speech act has four components through which the issue must pass: i) *securitizing actors* (such as political leaders, intelligence experts etc) declaring ii) *a referent object* (such as a state) to be iii) *existentially threatened* (e.g. by an imminent invasion), and who make a persuasive call for the adoption of iv) *emergency measures* to counteract this threat (e.g. declare war or impose a curfew)[3]. The theory seeks to ask with some force the value in presenting an issue as a security issue, and to enable an analysis to determine whether the issue is better dealt within normal politics.

5. BACKGROUND

5.1 A Growing Recognition of the Link between HIV/AIDS, National Security and Conflict

In the first two decades since the discovery of HIV/AIDS the disease was conceptualised primarily as a public health and development issue. A small number of analysts in the US CIA and some other think tanks sporadically explored the linkage between HIV/AIDS and security in the 1990s. The major international turning point was in the year 2000 when the issue was for the first time discussed at the UN Security Council, which declared HIV/AIDS in Africa a threat to international peace and security. The same year the US National Security Council formed an inter-agency working group and pronounced HIV/AIDS a security danger. For US development practitioners this has meant that support for HIV prevention can also be given to military institutions. This is justified by the fact that soldiers in many developing countries have been flagged as a population with very high levels of HIV, and ignoring them would compromise civilian HIV/AIDS initiatives. Further UN Security Council Resolution has since been issued on HIV/AIDS and security, such as S/Res/1325

on "Women, Peace and Security", A/Res/S-26/s and A/Res/60/262 which establish targets and strategies to reduce the spread and impact of HIV. They call for HIV/AIDS components to be included in international assistance programmes in crisis situations and for member states to establish strategies to address HIV among national uniformed services. Since 2001 UNAIDS together with the US Department of Defence has been chairing the international task force for strengthening and co-ordinating implementation of AIDS strategies among uniformed services worldwide. With close co-operation with the UN Department of Peacekeeping Operations (UNDPKO) AIDS prevention has been integrated into the pre-deployment training of UN peacekeepers and there are AIDS Advisors Focal Points in all 18 peacekeeping missions worldwide. In 2004 a UN Inter-Agency Working Group was established to develop clear and practical policies, guidelines and procedures for the planning, implementation and monitoring of HIV/AIDS in DDR programmes.

5.2 The HIV/AIDS Pandemic

In the coming decade HIV/AIDS is expected to kill ten times more people than conflict. According to UNAIDS Global Epidemic Report 2006 11,000 people are infected with HIV every day and 8,000 people die from HIV/AIDS on a daily basis. HIV/AIDS is clearly a health issue, but its far-reaching impact makes it a development problem threatening human welfare, socio-economic development and productivity, social cohesion and national and international security. In 2001 the Special Session of the UNGASS declared HIV/AIDS as a national and international development issue of highest priority and the resulting Declaration of Commitment on HIV/AIDS called for innovative responses, co-ordinated efforts and accountability for progress against the epidemic. The World Bank estimates that per capita growth in half of the countries in sub-Saharan Africa is falling by 0.5%-1.2% each year as a direct result of AIDS, and by 2010 per capita GDP in some of the hardest hit countries may drop by 8%. The sheer number of people infected has overburdened national health systems, social systems and hinders educational development, placing an extremely high financial cost on countries while at the same time depleting human resources. When infection rates among adults reach 5% the spread of the disease will accelerate at a much faster rate, and thus become increasingly difficult to control. In 2001 25 countries had infection rates of more than 5%.[4]

In 2007 an estimated 33 million people were living with HIV/AIDS worldwide and 2.2 million became infected. The same year AIDS caused 2 million deaths. In the last 25 years 25 million people have died of HIV/AIDS.[5] 95% of people living with HIV/AIDS (PLWHA) live in developing countries, of which nearly two-thirds in sub-Saharan Africa. AIDS is the leading cause of death in Africa and the fourth leading cause worldwide. More than 15 million children under the age of 15 have been orphaned by HIV/AIDS, with the number projected to double by 2010.[6] The Caribbean is the second worst affected region in the world, where the HIV prevalence rate averages 2.3%[7]. It is the leading cause of deaths amongst adults aged between 15 and 44 years. Eastern Europe and Central Asia is experiencing one of the fasted growing HIV/AIDS epidemics, with the number of PLWHA increasing 20-fold in less then 10 years. Asia being home to almost half of the world's population will determine the scope of the future HIV/AIDS pandemic. If prevalence rates in China, Indonesia and India increase to 1% the number of people infected with HIV/AIDS globally will double.[8]

Groups identified as being most vulnerable to HIV/AIDS include young people (in particularly young girls), women, homosexuals, men-having-sex-with-men, sex workers, displaced populations and uniformed personnel. Vulnerability is influenced by a number of variables, and the interactions and relationships between them, including:

initial infection rates

patterns of sexual behaviour

the frequency of rape

infectivity and viral load

the presence of sexually transmitted infections (STIs)

age, and in particular the age of female partners

the presence or absence of economic or social pressures on women to be sexually active

the extent to which condoms are available, affordable and socio-culturally acceptable

whether the male partner is circumcised

service and programme factors such as the cultural appropriateness (or inappropriateness) of HIV/AIDS prevention programmes; the accessibility (or inaccessibility) of services due to distance, cost and other factors, and the capacity of health systems to respond to growing demand

5.3 HIV/AIDS as a security issue

Applying the Copenhagen School securitization theory to the resolutions adopted by the UN Security Council HIV/AIDS it can be argued that HIV/AIDS has already been securitized. As demonstrated by Elbe, arguments around HIV/AIDS "have shifted from humanitarian and public health ones to officials in international organisations, governments and NGOs (*securitizing actors*) increasingly arguing that beyond these humanitarian considerations, the survival of communities, states and militaries (*referring objects*) is now being undermined (*existentially threatened)*, unless drastic measures (*emergency measures)* are undertaken by national and international actors to better address the global pandemic."[9]

Whilst the increased attention given to HIV/AIDS by world leaders is arguably welcomed, there are certain dangers in making HIV/AIDS a security issue. It could potentially push national and international responses away from civil society towards state institutions such as the military and the intelligence community, which have the power to override human rights and civil liberties. Of greater concern are the consequences of the "threat-defence" logic part of the security language. Viewing HIV/AIDS as a security threat would push the response to be based on narrower national interests rather than as a global multidimensional problem, and thus risk adverting international efforts made in countering the HIV/AIDS pandemic. As pointed out by Susan Peterson, responding to HIV/AIDS as a security issue transforms the logic of international action into one of narrow self-interest. This can create the impression that global health issues are only worth addressing if they touch upon the core security interests of states and may end up absolving states from any moral responsibility to react to a disease in the developing world that do not engage their essential national interests. Portraying the disease as a security threat can also reverse the advances made by grassroots AIDS activists to normalise social perceptions regarding PLWHA. Finally, it allows states to prioritise AIDS funding for their armed forces and elite. Securitizing HIV/AIDS therefore risks removing the issue from being dealt with through routine democratic procedures to less democratic and transparent echelons of state power, and shifts the responses from civil society to military and intelligence organisations. It places HIV/AIDS within a state-centric framework, where states are primarily concerned with maximising power and security rather than addressing wider humanitarian concerns. On the other hand, securitizing HIV/AIDS brings with it a number of benefits, such as focus, attention and mobilisation of resources to fight the pandemic. In many of the countries most affected by HIV/AIDS it is not excessive state mobilisation that poses the main problem, rather the utter absence of a meaningful state response to the disease. The approach taken by the UN Security Council is an attempt to increase political pressure on governments to address the issue in a way that would help ensure the survival of millions of PLWHA. The ability of states to override certain legal provisions is also an advantage in the struggle to weaken the grip of patents on life-saving medicines, as such patents could potentially be overridden in the light of national security considerations. Art 73(b) of TRIPS notes that nothing contained in the agreement should be construed to prevent a member from taking any action which it considers necessary for the protection of its essential security interests. In terms of normalising HIV/AIDS to reduce stigma and discrimination, as pointed out by Elbe "there is a crucial difference between arguing that people with HIV/AIDS are a security threat and arguing that AIDS is a security threat."[10]

Efforts to fight the pandemic are unlikely to succeed if they do not involve the security sector. However, as argued by Elbe, HIV/AIDS should be presented as a security issue in addition to also being a health issue, development -, economic -, social-, political-, and gender issue, etc. It should be framed as an issue with important security dimensions, rather than as a dangerous and overwhelming security threat. Such issues are included in the broader framework of human security.

6. THEORIES LINKING HIV/AIDS, NATIONAL SECURITY, CONFLICT

The body of evidence linking HIV/AIDS, national security and conflict can be grouped into four different categories: 1) uniformed personnel as a vector of HIV; 2) national security threatened by HIV/AIDS affected state institutions; 3) increased vulnerability to HIV infection in conflict and post-conflict environments; and 4) obstacles to peace building. The theories are strongly interlinked and will as such inevitably overlap.

6.1 Uniformed personnel as a vector of HIV

Uniformed services include national militaries, police forces and international peacekeepers. This group, which are at the forefront of maintaining national and international stability, is particularly affected by HIV/AIDS. Uniformed personnel have a heightened vulnerability to infection, as well as acting as an agent for spreading HIV within the communities where they serve and live.

Military personnel have an elevated risk of HIV infection compared to the surrounding civilian population. Research show that uniformed services personnel display an HIV infection rate on average 2-3 times higher than the comparable civilian population[11]. For example, Southern African military authorities have reported HIV prevalence rates of 20-40% and even as much as 50-60%. STI rates, which greatly increase the risk of HIV infection, are generally 2 – 5 times higher among armed forces. In times of conflict the difference can be up to 50 times higher[12]. According to the World Bank countries with big armies have higher HIV prevalence rates[13]. For the average developing country, reducing the size of the military from 30% to 12% of the urban population will reduce seroprevalence among urban adults by 4%.

The military is considered one of the three core transmission groups of HIV/AIDS, alongside sex- and transport workers[14]. A number of factors making men and women in uniformed services particularly vulnerable to HIV infection include:

Age – Most personnel are within the age group 15-24, which is the group at greatest risk for HIV infection.

Postings – the posting of personnel far from their accustomed communities and families for varying periods of time has been identified as the single most important factor

leading to high HIV rates in the military[15]. As well as the emotional stress placed on the individual, this practice also encourages use of commercial sex as soldiers are removed from traditional social controls and spouses or regular sexual partners.

Attitudes and behaviour – attitudes, either purposely indoctrinated by the armed forces or learnt informally as part of military 'culture' encouraged through peer pressure, include willingness to accept risk and aggressiveness. This has been found to lead to increased willingness to engage in high-risk sexual practice, such as unprotected and/or purchased sex, and an increased likelihood to have multiple partners. The fact that soldiers have a steady income often make them considerably better off than those in surrounding communities, encouraging the growth of sex industries around military settings. The sense of prestige of being part of the services, reinforced by bonding within units, has encouraged soldiers to view civilians (especially women) as people over who power can be exerted, with increased incidents of coercive sex. Rape by soldiers is systematic in some conflict-affected countries such as DRC, where 60% of the armed forces are estimated to be HIV positive. The sharing of razors and skin piercing instruments used in tattooing and scarification are additional high-risk behaviours found to be comparably common within uniformed services.

Selected examples

In Namibia and Zambia AIDS related illnesses are now the leading causes of death in the army and police forces, accounting for more than 50% of in-service and post-service mortalities[16]. In badly affected countries AIDS patients occupy 75% of military hospital beds and the disease is responsible for more admissions than battlefield injuries[17].

Africa's first national HIV/AIDS epidemic occurred in Uganda and coincided with a foreign invasion (Tanzania) after which followed a gruesome civil war. It is believed that Ugandan and Tanzanian militaries provided a bridge population whereby a concentrated epidemic was spread to the general population. The spread of HIV in Uganda has been linked to the movement and especially the demobilisation of armed forces.

A KAP survey by the UN among peacekeepers deployed to Liberia which showed that approximately 25% had sexual intercourse within the mission area, 31% had 2 or more partners, and 21% reported not using condoms despite their availability

Other studies on sexual behaviour of uniformed personnel include: a study of Dutch sailors and marines on peacekeeping duty in Cambodia which found that 45% had sexual contact with sex workers or other members of the local population; findings that 10% of US naval personnel and marines contracted a new STI during trips to South America, West Africa and the Mediterranean during 1989-91[18]; and that increased infection rates were reported among Nigerian peacekeepers returning from deployment in neighbouring countries.

6.2 National Security threatened by HIV/AIDS affected State Institutions

HIV/AIDS has the greatest impact on national security when combined with and/or exacerbating other factors that threaten livelihood, and can in this way lead to the erosion of the state's law and order and welfare functions. Applying the narrow security definition, the state which consists of a government, territory and society, is the main agent exposed to security threats. Its survival becomes threatened when key government institutions which make the state run and resolve disputes peacefully cease to function. Competing powers may take advantage of the resultant security vacuum in order to seize power.

Reduced functioning of national militaries

As the threat, use and control of military force is a central matter pertaining national security, the impact of HIV/AIDS is of particular concern for national security when affecting the national military. As seen, the military is one of the most vulnerable groups to HIV infection. HIV/AIDS seriously impedes the operational functioning and readiness of the military reducing combat effectiveness and deployment of troops. Sick leave and leave to care for dependants have led to increase absenteeism, to the point that some commanders from high prevalence countries worry about being able to field a full contingent for deployment on relatively short notice. According to public statements in Malawi, troop strengths have decreased by 40% due to AIDS related deaths[19]. In South Africa it was found that up to 50% of soldiers aged 23-29 were HIV positive in 1999, raising immense human resource challenges. In all likelihood there will be a shortage of qualified and experienced personnel and a hollowing out of the institution, since most soldiers infected with HIV are expected to die before they reach the age of 35. Additionally, in some countries demographic, health and socio-economic factors are already putting pressure on the pool of recruits, a situation exacerbated, or even caused by, an HIV epidemic. Even if new recruits can be found, readiness and smooth teamwork are compromised if absences are filled in by people who have not served together previously. The impact on continuity of command, as well as loss of cohesion, disruption of schedules, and loss of respected personnel pose a serious threat to morale and discipline within national militaries. Quality may be further reduced when younger and less experienced personnel take on more responsibility and are brought in to replace infected personnel. A weakened national military is per se a risk for increasing instability inside a nation, and with its neighbours.

Reduced effectiveness of other key state institutions

AIDS poses a further threat to national security by reducing the ability of the state to govern, i.e. ensuring the effective operation of the institutions and people. With the death of large numbers of experienced workers, AIDS is decimating civil services, police forces and national institutions, thus posing a fundamental threat to community and social cohesion. HIV/AIDS also has an adverse affect on a country's attempt to establish or maintain democracy and equality as the next generation of political leaders is being wiped out.

At the most basic level HIV/AIDS has a profound impact on national policing. In South Africa HIV/AIDS reportedly permeates the police and military to such an extent that neither are permitted to donate blood. The Kenyan police said in year 2000 that AIDS accounted for 75% of all deaths reported in the force in the last two years[20]. Teachers and health care workers are other heavily affected sectors of public employment. UNESCO has estimated that Africa is expected to lose 10% of its teachers to AIDS by 2005, setting back education levels by 100 years. The World Bank has noted that as education levels drop, the standard of living follows, leaving people with less of a stake in the system, ultimately increasing the risk of violence[21]. These dynamics it has been argued can both singularly or in combination exacerbate and in some settings provoke social volatility and political polarisation. The increasing inability of governments to respond effectively to HIV/AIDS contributes to instability in a restive citizenry. As pointed out by International Crisis Group (ICG) South Africa is a test case of how a perceived mishandling of the HIV/AIDS epidemic can feed internal tensions and drain political legitimacy. AIDS has become a persistent legal and political issue in South Africa. The epidemic is creating military uncertainty, splits in the ruling ANC, and deep disillusionment among citizens who believe their government has failed to provide for them. The AIDS crisis will add greater burdens to a society already struggling with economic and political reforms and persistent dangers of civil conflicts. Russia illustrates as an example where there already exists widespread public discontent with the hardships of transition and where relatively fragile democratic institutions are extraordinarily poorly positioned to deal with a major health crisis.

The creation of a security vacuum

The impact of AIDS may as such intensify the struggle for political power to control scarce state resources and contribute to the growth and attractiveness of extremist movements, as actors attempt to fill the vacuum left by the weakened state. As pointed out by ICG domestic and foreign sources of unrest (political, military or criminal) are likely to fill the vacuum left by weakened military and police forces. In weak states with divided societies, opposition groups may exploit the situation by instigating civil unrest or toppling the ruling elite. In some countries the military may themselves become a threat to law and order. Anything that weakens a state may create an environment in which a state poses outside aggressors a more tempting target. When major state powers are weakened the effect is less likely to present itself as invasion and war but instead increased turbulence and minor violence in the international system. The larger the country, the larger is the potentially destabilising impact on the international area. What happens in Russia, India and China, with their huge populations, large militaries and historic rivalries, matters a great deal elsewhere. Even the perception that a neighbour's military is suffering from an AIDS epidemic may trigger wars, and similar perceptions may trigger coups d'état at home.

6.3. Increased vulnerability to HIV infection in conflict and post-conflict environments

Conflict zones provide ideal conditions for the accelerated spread of HIV/AIDS, as most risk indicators for HIV vulnerability sharply rise. The disruption of social structures, mass movements of people (armies and refugees), breakdown of healthcare infrastructure and increased poverty caused by conflict have often showed to cause greater casualties than military action, and are factors highly conducive to HIV infection. The nature of a conflict will significantly influence the likelihood of an epidemic. Short wars that depend on "distance" tactics such as aerial bombardment are less likely to spread HIV/AIDS than conflicts that lead to long-term fighting on the ground and to mass movements of soldiers and civilians. Conflict also increases the number and power of two groups at the highest risk of contracting HIV/AIDS: soldiers and sex workers. UNAIDS reports that throughout North Africa and the Middle East HIV is spreading fastest in war torn Somalia and Sudan. Cambodia, Thailand and Myanmar also have large epidemics and have all been affected by conflict. The damage to health infrastructure caused by conflict, the behaviour of conflict affected populations, and the policies pursued during times of conflict have been identified to increase vulnerability to HIV infection.

Damage to the health infrastructure

Healthcare infrastructure is repeatedly attacked in conflict zones, which is also one of the main systems to respond to an HIV epidemic. This creates three significant problems. First, demand for healthcare services increases substantially as war-casualties increase and civilians find themselves at increased vulnerability to violent (combat-related injury) and non-violent (infectious diseases) health problems. Secondly, the supply of healthcare services will rapidly contract as services are redirected to battlefield surgery and emergency medicine.[22] Conflict-affected populations often lack access to sexual and reproductive health services, including access to antenatal services, voluntary HIV counselling and testing (VCT), and prevention of mother-to-child transmission, denying the most basic protection against HIV. In addition, there is often an acute lack of ARV provision and treatment for opportunistic infections. During conflict there is an increased need for blood transfusions though there is often a shortage of

resources to screen the blood, thus increasing the risk of HIV transmission through infected blood. Lastly, the breakdown in monitoring and surveillance systems prevents accurate estimates of HIV prevalence and the behaviour of the epidemic, thus preventing targeted high-impact interventions.

Changed behaviour of conflict affected populations

Conflict and militarization tend to exacerbate gender inequality. This manifest itself in the lowering of status of women, which in turn reduces their ability to protect themselves against HIV, either through the fidelity of their partners or through condom use. Women often become reliant on transactional sex as their lives are disrupted and impoverished. As men's lives become disrupted by conflict, either through joining armies or migrating, new sexual relations are facilitated. Conflicts are also associated with increases in rapes, which on some occasions have been used as a weapon of war and genocide, such as in Rwanda. Almost all female survivors of the Rwandan genocide were raped, giving rape epidemiological significance as a direct transmitter of HIV, as well as a cause of physical trauma leaving them considerably more vulnerable to HIV transmissions. In Bosnia between 30,000 and 40,000 women were raped and faced being infected and risk transmitting HIV to their partners and children[23]. The medical conditions arising from rape, such as internal bleeding and tearing of genitalia, make women further vulnerable to HIV infection. The acute lack of HIV/AIDS knowledge in many conflict situations is another main factor increasing vulnerability to infection. This is partly caused by the undermining of awareness raising and prevention efforts, and partly because even where awareness is high the daily realities of life under conflict can diminish the perceived risk of HIV infection. It has also been found that people become more sexually active during times of conflict as a result of increased uncertainty over the future. Lastly, alcohol and drug use often increase as a reaction to trauma, and with it lower perceptions of HIV infection risk and behaviours change. The above factors have led to increased rates of HIV and STIs in conflict environments.

Refugees and IDPs

Displacements caused by conflict place people at a heightened risk for HIV infection, and refugees and internally displaced persons (IDPs) have been identified as a group highly vulnerable to HIV/AIDS. Refugee and IDP movements from high prevalence areas to low prevalence areas, or vice versa, have been found to accelerate increases in HIV rates, as refugees/IDPs interact with the host populations (in many instances as a mean of survival) or with their home communities on their return. A number of factors contribute to their vulnerability, including uprooting and movement, poverty and lack medical services or the inability of existing services to cope with the additional increase in demand. Refugees and IDPs are also particularly vulnerable to sexual violence and exploitation. Adequately monitoring and surveying the health situation, including HIV prevalence, amongst displaced populations is extremely difficult due to relocation, loss of medical records and the difficulty to access these populations. This is particularly a problem amongst non-camp based refugees and IDPs.

Wartime policies and priorities

States in conflict are making slow progress in implementing plans to fight HIV/AIDS. Given the long incubation period of HIV, monitoring its spread has not been a priority under emergency conditions. The threat of HIV/AIDS is widely underestimated in conflict affected countries and insufficient national resources are directed at tackling the problem, with social services starved of funds which instead are redirected to armies and armament. In addition, the breakdown of epidemiological surveillance caused by conflict has devastating effects on targeted interventions. International financing to fight HIV/AIDS is almost entirely absent from the countries most affected by conflict.

The post-conflict environment

The post conflict period is also a time of high societal vulnerability to HIV. The ending of conflict often leads to substantial population movements, reunification of families, opening of roads, increased flow of commerce, demobilisation of combatants and deployment of peacekeepers and aid workers. This environment could provoke an explosive spread of HIV. As evidenced in Cambodia peacekeepers have significant physical, moral and economic power, which frequently enables them to have sexual relations with locals and sex workers, either consensually such as commercial sex or through coercion. South Africa is another credible example as the early stage of the epidemic coincided with the opening of the country's borders and the return of troops who had been staged in Namibia.

6.4 Obstacle to Peace building

High rates of HIV/AIDS have in some instances been found to be an obstacle to peace, creating disincentives to end conflicts. As members of the uniformed services international peacekeepers are particularly vulnerable to HIV infection as well as acting as agents for transmission. This is beginning to impact on both states' commitments to supply peacekeepers for international missions and acceptance to receive peacekeepers. Finally, HIV/AIDS can have a detrimental effect on post-conflict recovery and reconstruction.

HIV/AIDS as a disincentive to end conflict

HIV/AIDS can result in disincentives to end conflict. Where soldiers come from low prevalence countries they have often facilitated the spread of HIV in their home communities once they return from duty[24]. Returning combatants act as Trojan horses when they enter a low-prevalence area and transmit the virus to members of the civilian population surrounding military bases. Some analysts have reported that one of the reasons for why the Rwandan Government has been slow to end its involvement in the DRC is that it fears the return of potentially highly infected troops will increase HIV/AIDS prevalence rate in Rwanda. On the other hand military officials in the DRC and Nigeria have confirmed that high rates of HIV/AIDS encourage risk taking and inappropriate behaviour among soldiers who believe they have already received a death sentence. Soldiers infected, or expecting to become so, have their time horizons shortened dramatically and in DRC it has been shown that they will choose continued fighting, plunder and short-term enrichment over the prospect of peace.

Reduced willingness by states to provide or receive peacekeepers

HIV/AIDS affects peacekeeping operations both in terms of a country's willingness to contribute troops and its willingness to receive international peacekeepers. The USA and South Africa are two countries that are becoming increasingly unwilling to contribute national contingents to high-risk zones. In 2000 the then US Ambassador to the UN Richard Holbrook stated that in the future the US will never again vote for a peacekeeping resolution that does not require action by the UNDPKO to prevent AIDS from spreading to peacekeepers. India, Pakistan and Bangladesh, which are major troop contributing countries and with low HIV prevalence rates, have expressed concern over the risk their troops face of contracting HIV while deployed abroad. An increased HIV prevalence rate amongst their troops would in turn have a negative impact on the operational functioning and readiness of their own national armies. Peacekeepers have also been found to spread HIV, particularly so in Cambodia, Liberia and Sierra Leone, with the result that countries are becoming increasingly unwilling to accept peacekeepers from high-prevalence countries. During the Balkans conflict of the 1990s, there was an effort by Zagreb to keep African peacekeepers out of Croatia in case they became a vector of the HIV virus. South Africa's Institute for Strategic Studies[25] has warned that unless the spread of AIDS among African armies is stopped soon, it is possible that many countries, including South Africa, will be unable to participate in peacekeeping operations. This would be a serious blow for peacekeeping operations as soldiers from countries with high HIV/AIDS prevalence make up 11% of the UN force total, whilst countries nearing such high prevalence yield 37% of all UN peacekeepers.

Obstacle to reconstruction and recovery of national security

Post-conflict reconstruction and recovery in countries with high HIV prevalence rates may also be further complicated by the epidemic. Strengthening governments in post-conflict societies has been one of the chief preoccupations of development planners for decades. The burden HIV/AIDS places on human and financial resources puts institutions of governance under threat just as they are needed the most. Demobilising and reintegrating combatants may be threatened by combatants returning to villages and families heavily affected by the virus, and by breakdown of government, police and civil society and by overall AIDS-caused economic decline. The space left behind by deteriorating national institutions can all too easily be occupied by forces of destruction and conflict, either within the country with the rise of criminal activity and communal violence, or from outside as neighbouring states take the advantage of a state's weakness. Failure to rebuild and reintegrate post-conflict countries is a main cause for a relapse of violence and conflict.

6.5 Critique against theories

The critique towards the theories linking HIV/AIDS and conflict wishes to bring to the debate a critical view to the increasing acceptance of the link between HIV/AIDS and national security by arguing that the loss of national security can act as decelerating factor. In a similar manner neither will the presence of high prevalence rates automatically pose a threat to national security.

The main arguments presented against the linkages are:

HIV rates in armies and uniformed services are highly variable, in some instances considerably higher than in corresponding civilian populations, whilst in other the same or lower. In the early days of the African pandemic, several armies seemed to have very high rates. Now most armies seem to have rates comparable to or lower than the general population. In Asia it is possible that the rates are higher than the low background rates in the population. This variability is also the case for peacekeepers.

Fears that militaries would collapse on account of HIV/AIDS have not materialised. There is strong anecdotal evidence that at a very early stage of the east African pandemic some militaries were hard hit by the loss of officers to AIDS giving rise to fears that armies would be hollowed out by the disease. AIDS however cannot overtake a division or garrison in a matter of weeks, like influenza or malaria.

Conflicts can at times protect against HIV/AIDS. In some prolonged conflicts in Africa HIV prevalence has remained relatively low compared to other countries that have not been affected by emergencies. Investigations in Sierra Leone, DRC, Southern Sudan, Angola and northern Ethiopia fail to show increases in HIV. In northern Uganda HIV rates are higher than in the south, but appear to follow much the same patterns and trends.

The main conclusion therefore is to avoid a one-size-fits-all approach as the reasons will be different in different cases. Alex De Waal has illustrated this by arguing that, for example, in Angola the outbreak of war pre-dated the emergence of an HIV epidemic. The war kept the national population isolated from its neighbours and should therefore not have had the effect of driving up HIV rates. In southern Sudan the 'isolation' argument may also hold true but this is not the case in the IDP camps in northern Uganda. The fact that camps are heavily policed and allow little privacy may mean that there is a reduction in sexual activity. In northern Ethiopia drafted soldiers were mainly rural youth which in addition were screened for HIV. Moreover the army also had an unusually good HIV programme. This may explain why HIV prevalence did not significantly increase.

In comparison with the body of research supporting the linkage between HIV/AIDS and conflict the above critique, although valid, appears rather weak. In the examples given above, many organisations and researchers argue the opposite. For example, in Sierra Leone peacekeepers were found to be the main agents for spreading HIV/AIDS (claimed by amongst others the ICG, the CSIS and Save the Children) thus pointing to the risks posed by the post conflict environment. Save the Children has further concluded that rates are expected to be high and growing rapidly in conflict countries such as Angola, DRC, Liberia and Sierra Leone, whilst UNAIDS say HIV is spreading fastest in war torn Somalia and Sudan out of all North African and Middle Eastern countries. UNAIDS also reported that although it is believed that prevalence amongst new recruits to the Ethiopian army were lower than that of the civilian population due to the exclusion of recruits testing positive, infection rates are expected to increase with age and time spent in service.[26] The CSIS estimates high HIV prevalence rates within the Ethiopian army, partly as a result of the high prevalence rate amongst the general population.

Whilst it is arguably important to recognise the uniqueness of each conflict and to base any response (being HIV/AIDS or any other issue in resolving conflicts) on case-specific information and evidence, it is equally important to recognise that different situations can lead to the same effects. For example, there may be many different reasons for why HIV infection rates are higher in national armies than in the corresponding population, but as a result they act as a vector of HIV infection. Analysis on both sides conclude that the lack of reliant surveillance systems to monitor HIV prevalence accurately in conflict settings makes it impossible to know what the actual rates are in these countries and how fast the epidemic is accelerating.

PART II: CASE STUDY COLOMBIA

7. COLOMBIA

7.1 The Colombian Conflict

The origins of the 40 year long Colombian conflict can be traced back to the period called "La Violencia", between 1948 and 1958 when a civil war raged between the conservative and liberal parties. The Armed Revolutionary Forces of Colombia (FARC) was formally created in 1966. By the late 1970s there were a dozen guerrilla groups active as well as the newly formed self-defence groups, which were the private armies of rich landowners. For a period in the 1980s FARC observed a cease-fire and ran candidates for political office, though it returned to armed opposition following the assassination of a number of leaders of its political party the Union Patriota. During the 1980s and 1990s drug trade and kidnapping were lucrative business for the illegal armed groups. The Colombia United Self-Defences (AUC), was formed in 1995 as an umbrella group consisting of several local paramilitary groups. The AUC referred itself as a special pro-state group. When Alvaro Uribe came to power in 2002 he vowed to fight the illegal armed groups, both on the left and the right of the political spectra. A ceasefire was signed with the AUC in December 2002 and in 2006 more than 30,000 paramilitaries had officially demobilised, which caused the government Peace Commissioner to declare that the AUC no longer existed. However violence continues, the demobilisation process has only been partly successful, and new illegal criminal groups continue to emerge. The impacts of the conflict have been profound. According to the Small Arms Survey 2006, over 38.800 people have died as a direct consequence of the conflict since 1998, translating into 2,221 deaths per year.

The *direct actors* to the Colombian conflict include:

The Colombian Government and the National Armed Forces: according to government figures, the national military counts with 254,259 troops[27], and the national police with 136,230[28]. The government's approach is a military defeat of the illegal armed groups, in particular FARC.

FARC: a peasant based organisation though recruitment mainly targets unemployed youth in rural areas. With an estimated 16,000 to 20,000 members, FARC is one of the largest guerrilla forces in the world[29].

ELN: founded by academics and priest taking inspiration from the Cuban Revolution. It has approximately 4000 to 6000 members[30] though it has been hit hard by both the national armed forces and the paramilitaries.

The paramilitaries*:* an alliance of various self-defence groups united as the AUC. The AUC has enjoyed a quasi-legitimate status in some parts of the country, in particular in their strongholds of Antioquia, Córdoba and parts of the Caribbean coast. The paramilitaries began as an anti-guerrilla federation but with the formation of the AUC they evolved into a drug federation in which traffickers from across the country used the paramilitary network to make deals, pool shipments and share routs.

The USA: Colombia is of particular interest to the USA in its post-9/11 war against terrorism policy, which makes direct links between drug trafficking and the financing of international terrorism. The primary aim of US policy towards Colombia is improving the state's military capacity to combat the illegal armed groups. In 2006 US military support to Colombia (Plan Colombia) was valued at $602.6 million[31].

Issues pertaining social justice were of main concern when FARC and ELN were formed, though the quest for economic and political power have come to dominate the motivations of the guerrilla groups in recent years. Both FARC and ELN state that they want to overthrow the state. The current government under Uribe has stated that there is no war or armed conflict in Colombia instead the government is engaged in a fight against terrorism. Uribe seek to align other governments in the region in the fight arguing that terrorism in Colombia is a potential threat to democracies throughout South America. FLASCO (the Latin American Faculty of Social Science) has distinguished four threats to the region as a consequence of the Colombian conflict: neighbouring countries risk the presence of armed actors of the Colombian conflict in their territories; a humanitarian crisis and social conflict resulting from Colombian refugees; an ecological catastrophe due to the effects of the fumigation policy to combat coca cultivation; the spread of illegal crops to other Latin American countries[32]. Ecuador, Venezuela and Panama have expressed concern over the considerable number of Colombian refugees they are receiving, and the presence of Colombian armed groups in Brazil and Peru has been reported. The Democratic Security Policy of the Uribe government identifies terrorism and drug-trafficking perpetrated by the narco-terrorist groups as significant threats to national security. The Policy describes the security challenge as an essentially criminal one and the government has assigned high priority to fight the emergence of new illegal armed groups following the AUC demobilisation process. The government has stated that these new groups will not receive any kind of recognition, such as AUC did, but will be pursued as criminals. Nevertheless, the State's presence in many regions is still precarious, making it more difficult to control these groups.

Successive governments have attempted several *DDR processes* with the various rebel groups. Since 1990 some 7,300 former guerrilla soldiers have disarmed of which 4,715 have entered reintegration programmes. The majority of paramilitary groups initiated a cease-fire with the government in December 2002, although this was not always observed on the ground. By the end of 2006 some 32,000 ex-combatants had been demobilised[33]. The process however has been fiercely criticised,

in particular by human rights organisations for being initiated without an adequate legal framework for its implementation, and for being excessively lenient on the paramilitaries. The process has also failed to reintegrate the ex-combatants into civil society in a sustainable manner. Many of the demobilised AUC combatants involved in the new armed groups joined because these groups offer more lucrative employment than the government stipend for the demobilised combatants. Both the ICG and the Organisation of American States' Mission to Support the Peace Process in Colombia (OAS-MAPP) have reported an increase in the reorganisation of demobilised AUC combatants into new criminal gangs. There is a consensus that such micro-rearming could present a more difficult challenge to reintegration than the re-emergence of large armed groups.

7.2 The HIV/AIDS Situation in Colombia

The HIV pandemic is spreading rapidly in Latin America and the Caribbean. New infections continue to linger around 140,000 per year and the number of AIDS deaths at around 65,000. Two thirds of all PLWHA live in the four most populous countries: Argentina, Brazil, Colombia and Mexico, whilst HIV prevalence rates are the highest in the smaller Central American countries. Honduras has a prevalence rate of 1.5% and Belize 2.5% in 2005. Transmission of HIV in the Latin American region occurs in a context similar to most of the countries: widespread poverty and migration, insufficient information on the epidemic trends outside major urban areas and rampant homophobia. UNAIDS has concluded that the severe economic and social inequalities present in the majority of Latin American countries constitute a favourable environment for the rapid growth of the HIV/AIDS pandemic the coming decades[34].

HIV prevalence rate in Colombia 2005 stood at 0.7% and is estimated to reach 1.5% in 2015[35]. The majority of new infections 2000-2004 occurred amongst the age group 25-34, followed by the age group 35–44. Although there continues to be an underreporting of deaths from AIDS, AIDS mortality as a proportion of total mortality has risen from 0.86% in 1997 to 1.22% in 2004.[36] HIV/AIDS is considered a high-cost disease within the Colombian health system, in particular due to the high cost of ARV treatment. Access to services is greatly limited by the conflict, but also because of the high cost of services, long waiting periods, minimum payment within the contributory health scheme, geographical access etc.

The dynamics of the HIV/AIDS epidemic in Colombia can in many ways be explained by Colombian culture, which also plays a vital role for the prevention and control of the epidemic. Fears, myths and taboos associated with sexuality and HIV/AIDS could play a part in the low request for VCT and the discrimination and exclusion towards PLWHA. Engaging in unprotected sex cannot be explained only by lack of sexual education or condom access, it also has to do with beliefs, attitudes and practices integrated in Colombian society. Sexual education continues to be based on moralistic values and does not offer a wider understanding of sexuality. Despite an increase in condom promotion efforts, condom use remain low and sectors within society opposing the use of condoms still exercise strong influence amongst the Colombian population. Machismo, which has strong influence in Colombian society, further contributes to the spread of HIV as it condones or even promotes high-risk behaviour such as zoophilia, anal sex between men, sexual initiation with sex workers amongst young men. Sexual and domestic violence, closely correlated to machismo and which incidence has increased in the last 5 years, continue to be an important factor in the increase in HIV prevalence. Poverty, unemployment and forced displacement have lead to an increase in commercial sex. Two types of commercial sex have been reported to be of particular concern by UNAIDS. Firstly, sex in exchange for money or food in conflict affected zones, areas with a high number of displaced people and in communities which lack opportunities and capacities for income generating activities. Secondly, related to consumerism where sex is offered in exchange for access to social benefits and services such as clothes, acquisition of electrical goods or payment for higher education. Of the reported cases of HIV/AIDS in Colombia between the years 1983 – 2005, 24% were in Bogota, 22% in Valle, followed by 16% in Antioquia. These are also the departments that first counted with a system of registration. Of the reported cases, 40% pertained the age group 25-34, 25% the age group 35-44, and 18% 15-24 year olds.[37]

PART III: ANALYSIS & CONCLUSION

8. ANALYSIS

The analysis is based on the interviews conducted in Colombia, supplemented by published materials. Some unpublished material has also been used. Only published material that can be traced is referenced. Interviews were conducted with the Cerac Foundation, La Fundación Seguridad y Democracia, the Government Collective Demobilization Programme, the Organisation for International Migration, the Ministry of Defence, the National Police, the Presidential High Commission for the Social and Economic Integration of ex-combatants, the Organisation of American States, UNAIDS, UNFPA and the World Health Organisation,

8.1 The Security Situation

The intensity of the Colombian conflict has fluctuated and has at times been elevated to the status of civil war as battle-related deaths per year reached 1000 or above (as in 2001, 2002, 2004 and 2005)[38]. The decision by the Uribe government not to classify the Colombian conflict as armed conflict or civil war has serious implications for the provision of humanitarian assistance and the response to the HIV/AIDS epidemic.

Interpretation of the Colombian conflict

How a conflict is defined is crucial to the response from both a humanitarian and political perspective, and will determine whether international humanitarian law becomes applicable. In a clear break from his predecessors Uribe takes the view that there does not exist an armed conflict or civil war in Colombia. Instead the government interprets the conflict as a fight between the legitimate state and terrorist groups, placing the local challenges in the global war on terrorism framework advocated by the USA. Uribe supported the US invasion of Iraq and the subsequent sidelining international humanitarian law in his quest for stronger US involvement in the Colombian conflict and the continuation of Plan Colombia. Uribe went as far as asking the USA to treat terrorism in Colombia in the same manner as in Iraq, something which would very much run the risk of foreign invasion[39]. The Bush administration recognises Colombia as a security problem but very much as a secondary issue[40]. There is some inconsistency in the interpretation taken by the Colombian administration, with the police and military defining the conflict as an armed conflict/civil war, as well as inconsistency in the language and actions by president Uribe.

Response

The government policies emphasise military defeat over the guerrilla, the recuperation of state authority and monopoly of coercive force. By viewing the guerrilla and paramilitaries as terrorist groups the government has prohibited humanitarian organisations accessing these groups and has broken with the line taken by the Pastrana government when the guerrilla groups participated openly in peace negotiations with the government. In assuming the presidency in 2002 Uribe increased the military force and national defence expenditure, imposed a war tax and sought the direct involvement of the USA in the conflict. Uribe has called for a revision of the Pan-American Treaty on Reciprocal Assistance of 1947 for it to incorporate threats deriving from internal situations of the countries party to the treaty as a regional threat. Although denying the existence of an armed conflict/civil war the Uribe government has stated that the *war* cannot be won with the existing institutional guarantees of democratic, civilian and political rights in place. Such guarantees are seen as obstacles to winning the war and Uribe has openly stated that antidemocratic measures are required to defeat the illegal armed groups.

Demobilisation of the paramilitaries

By the end of 2006 35,000 paramilitaries had gone through the demobilisation process and as a result the government announced that the paramilitary no longer exist. This is in clear contrast to what is happening on the ground where violence and corruption by paramilitary or paramilitary-style groups continue. Whether it is paramilitary violence becomes a question of definition. In the sense that the paramilitaries are the same as the AUC, it could be argued that they do no longer exist. Approximately 30 different paramilitary structures were merged to form AUC. This structure has now been demobilised, and all the ex-combatants are registered and identified. The problem lies in that many of the demobilised ex-combatants have continued within different criminal structures, although with different motivations and purposes. Fighting the guerrilla is no longer their main aim, instead it is focused on drug trafficking, lottery, casinos, counterfeits etc. and as such it has become a public order problem rather than a military one. The new groups are much less structured, have no clear line of command, and operate in much smaller groups. In this aspect paramilitarism continues, though it raises the question whether or not this is as such paramilitarism. The UN concluded that that rather than wresting control from the paramilitaries and restoring it to the state, demobilisation has been accompanied by "progressive penetration and control by paramilitaries over municipal and departmental administrations in various regions of the country, as well as over illicit economic activities."[41]

Implications on the provision of humanitarian assistance and the HIV/AIDS epidemic

Policies being pursued under the cover of fighting terrorism may well be laying the groundwork for a worsening humanitarian crisis. A significant consequence deriving from classifying the Colombian conflict as a fight against terrorism is that it prevents application of international humanitarian law. A crisis perceived as an internal armed conflict triggers the provisions of international humanitarian law, which creates space for traditional assistance and protection activities and opens up a role for UN facilitation and mediation. By interpreting the conflict as terrorism the Colombian government is instead invoking the military and police powers of the state to maintain public order, whilst circumscribing the functioning of international humanitarian and human rights organisations. It also prevents these organisations, as well as other NGOs and agencies, to approach the illegal armed groups in the fight against HIV/AIDS. State provided HIV/AIDS prevention and treatment services in the conflict affected areas are at best limited and in many instances non-existent. As such, humanitarian organisations, NGOs and other non-state actors play an important role in providing such services to the Colombian population though they face major obstacles in accessing the population. A further consequence of overriding human rights and civil liberties is that it denies the human rights of PLWHA and other minority groups. It prevents proper investigations into the crimes perpetrated by the illegal armed groups against these groups, including the assassination of PLWHA. Interviews with the national police confirmed that such investigations were not a priority, and that in any case there does not exist a system to establish the proportion of reported crimes collated at police central headquarter which relates to breaches of human rights of PLWHA and other minority groups. The approach also tacitly permits the state to commit human rights abuses, a practice which has been reported by many human rights organisations such as Human Rights Watch and the UN Committee Against Torture. Even where cases are brought before the national judicial system infiltration by the illegal armed groups into the legal system and the corruption of judges presents a serious obstacle to ensuring human rights.

The war policies adopted by Uribe have led to increased fighting and destruction on the ground. Under the Uribe government the status of the Colombian conflict has been elevated to the level of civil war three times; in 2002, 2004 and 2005. This impacts on the HIV/AIDS epidemic as it produces more battle related injuries which treatment requires the strict adoption of universal precautions[42] in order to prevent HIV transmission. Protocols on universal precautions are good but implementation in the rural conflict affected areas is believed to be inadequate at times. It also places a heavy burden on the national healthcare system, which is the main system to respond to HIV/AIDS.

The increase in violence has prevented the repatriation of IDPs as well as led to new displacements. The United Nations High Commissioner for Refugees (UNHCR) estimates that there are currently up to 3 million IDPs in Colombia and approximately 10% of the Colombian population has been displaced once or more by the conflict. An estimated half of the IDPs are children under the age of 18. IDPs are particularly vulnerable to HIV infection and transmission due to limited or no access to healthcare services and intimidation by the illegal armed groups to access HIV/AIDS prevention and treatment services where they do exist. The Representative of the UN Secretary General for the Human Rights of IDPs reported after a visit to Colombia in 2006 that "Colombia is a country with commendable legislation and a far-reaching policy framework on internal displacement /…/ However, there is a clear gap affecting the human rights of many among the up to 3 million displaced persons between what the law says and what is implemented at the regional and local level."[43]

As concluded by Minear "The picture of the Colombian state that emerges is an ambiguous one. On the one hand, the state uses its authority and acts forcefully when it deems it necessary. On the other, it has acknowledged difficulties in delivering essential human services and orchestrating effective relationships with the international community."[44]

8.2 Uniformed personnel as a vector of HIV

This section considers the Armed Forces of Colombia (Las Fuerzas Armadas, FFAA), and the main illegal armed groups FARC and the AUC. The decision to include the illegal armed groups under uniformed personnel is due to the important role they play in the conflict, their considerable size and because they are structured and function in similar manners as a conventional army. It is therefore important to analyse their potential role as a vector of HIV infection. Analysis on the paramilitaries is based on the force as it was up until the demobilisation process came to an end in late 2006.

8.2.1 Las Fuerzas Armadas – the Armed Forces of Colombia

The FFAA includes the army, the air force, the navy and the police. They currently number 400,000 and are due to increase, with the largest increase destined for the police force. The army has changed from being a predominantly conscript army (although military service is still obligatory) to one composed of mainly professional staff.

Age

The main age group within the police is 20 – 24 years old, followed by 25 – 29 years, of which the majority pertain to the lower to middle ranks. The main age group within the military is 19 – 24 year old. Since 1997 there have been 357 reported cases of HIV within the police. In 2007 (up until August) 57 new cases were reported. The majority of these cases are amongst 18-24 year olds pertaining to the lower ranks. These soldiers are believed to adopt more high-risk behaviours such as promiscuity, in addition to having lower levels of education. The army reported 411 accumulated cases of

HIV/AIDS in 2003.The age and ranking is a factor increasing vulnerability to HIV/AIDS within the FFAA.

Postings

Within the army the professional soldiers are posted throughout the country without consideration to their home community. Postings last for a minimum of two years and in the majority of cases soldiers cannot bring their families. Conscript soldiers on the other hand are whenever possible posted within their home communities as part of the "Soldados de mi Pueblo" initiative and serve for an average 18-24 months. This initiative is aimed at improving the relationship between the armed forces and the civilian population. As with the professional soldiers, police recruits are posted without relation to their hometowns and postings last for a minimum of two years. Postings can therefore potentially increase vulnerability to HIV/AIDS as it leads to geographical relocations and results in soldiers and officers spending prolonged periods away from their families – two important factors making uniformed personnel particularly vulnerable to HIV/AIDS. An exception is the police who are often able to bring their families, unless they are posted in high-risk isolated areas.

Attitudes and behaviour

Behaviour and attitudes within the FFAA are also found to be conducive to infection and transmission of HIV. FFAA personnel are paid relatively well in regards to their level of education, with the lowest paid ranks receiving well above the minimum pay. This would probably mean that members of the FFAA who serve in rural conflict affected areas are financially considerably better off than the surrounding population. This will place members of the uniformed services at an advantageous position over the local population, which facilitates coerced or purchased sex or sexual relations in exchange for commodities. These are practices which have been reported by UNAIDS to be of increasing concern in Colombia.

In order to maximise resources in the difficult Colombian context the role of the police and the army often overlap, with the police in many instances taking on the role of the army and vice versa. It is mainly the police who have contact with civil society, as the military tend to be stationed outside the communities. A new initiative is being implemented within the FFAA, "Acción Integral", which purpose is to increase the social work carried out by the FFAA. This includes construction of infrastructure and securing access for the state to deliver social services. The police have a Human Rights Office through which it cooperates with NGOs. Relationships with NGOs have improved in the last couple of years and they are now viewed as important partners in ensuring civil and human rights according to the police. Previously they were seen to be mainly leftist organisations working against the state. Nevertheless, the UN and other human rights organisations continue to report considerable concern over state violence. The UN World Committee Against Torture reports that the human rights situation and compliance with humanitarian law in Colombia have deteriorated dramatically since 1996. International protection organisations have indicated widespread and systematic human rights violations in Colombia. Even the USA raised concerns over human rights violations perpetrated by the state in its negotiations on the continuation of Plan Colombia. This includes rape, enforced disappearances and murders of socially marginalised persons. Torture is systematically used throughout the national territory by all combatant groups. This crime is most frequently committed by the military and police forces and by the paramilitary groups who act with their support, tolerance and in many instances active participation. The Colombian State has not taken any effective measures end these violations or to guarantee human rights, and there is practically total impunity towards acts of torture.

Concern has also been reported over blockades on commodities such as drugs, condoms and contraceptives, which civilians are allowed to bring from the municipalities into rural areas. The Ministry of Defence and the National Police confirm there are restrictions in place, but on commodities used for the processing of coca and that restrictions only apply to large quantities of chemicals and certain drugs, but also to some extent on condoms. Other organisations claim there is a deliberate tactic by the FFAA to prevent condoms and contraceptives reaching the guerrillas.

HIV/AIDS information campaigns targeting the FFAA are being implemented, often as a joint collaboration with UN agencies. Prevention is being increasingly recognised by the FFAA as an important factor for the reduction of HIV and as a more cost effective strategy than treatment. This is a recent development as only five years ago HIV prevention was not even considered an issue. Nevertheless, knowledge of HIV/AIDS remains very low within the FFAA and there is a lot of discrimination towards PLWHA. Even at higher levels within the Ministry of Defence there is a lack of knowledge of what HIV/AIDS initiatives are being conducted within the FFAA. HIV tests are offered to members of the FFAA but there is much fear and ignorance surrounding the tests and many do not want to test as they fear the results. Issues include fear of losing their post and social exclusion. HIV/AIDS treatment is available within the FFAA but is mainly concentrated in the major towns. Healthcare provision for the FFAA personnel is generally poor in the rural areas and HIV/AIDS service provision becomes all but impossible in rural and conflict affected zones. HIV/AIDS is not considered a main preoccupation and resultantly few resources are diverted to the issue.

8.2.2 Illegal Armed Groups

It is almost impossible to measure HIV prevalence rate amongst the illegal armed forces. There are a number of reasons for this ranging from their clandestine nature to the prohibition placed on humanitarian organisations to access the illegal armed

groups. Their attitudes and behaviour towards HIV/AIDS makes it further unlikely to be able to survey HIV prevalence rates within these groups. However, looking at the variables for increased HIV vulnerability and the likelihood of transmitting the virus – age, postings, attitudes and behaviours – there are reasons to believe that members of the illegal armed groups in Colombia have a heightened vulnerability to HIV and could play an important role in its transmission to the general population. In addition it can be argued that their structure is a further variable, although this is not part of the theories in section 8.1. The findings suggest some differences between the paramilitaries and the guerrilla.

Statistics collected during the DDR process of the guerrillas and the paramilitary show that the majority of those who belong to the illegal armed groups fall within age group most vulnerable to HIV/AIDS infection. 25-34 is the age group reporting the majority of new infections in Colombia and within this age group the majority of demobilised paramilitaries are found. More than half of all new infections worldwide take place within the age group 15-24, which is the age group where the majority of demobilised guerrillas were found. Low levels of education is another factor increasing vulnerability, within the paramilitary group only 39% had secondary education and within the guerrillas a mere 24%. Amongst both groups 8% were illiterate. UNHCR reports the existence of more than 7000 child soldiers and that the number is increasing.

Age and level of education

Table 1: socio-demographic characteristics of the illegal armed groups

	Guerrilla groups		**Paramilitaries**
Secondary	24%	**Education**	39%
Primary	68%		47%
Illiterate	8%		8%
Married / stable relationship	34%	**Civilian status**	48%
Single	65%		47%
41 and above	3%	**Age**	7%
26 – 40	28%		60%
18 - 25	54%		33%
Minors	15%		*
Female	14%	**Sex**	7%
Male	86%		93%

Source: Alta Consejería para la Integración Social y Económica de ex -combates de la Presidencia. Nov 30 2006

* The source did not report minors. However, the majority of organisations researched reported recruitment of minors by the paramilitaries.

Structure

The paramilitaries

With the unification of the various paramilitary groups into the AUC the paramilitaries significantly strengthened their coercive force, and as such power over local government and communities in many regions in Colombia. As a unified organisation they became sufficiently disciplined and complex to place themselves within the national political arena, acquired a bureaucracy strong enough to govern entire regions and the power to name their congressmen and functionaries to central government. Recruitment was mostly done locally, though in some situations soldiers were recruited from distant societies, either in geographical or cultural terms. This strategy facilitated atrocities and other human rights abuses against the communities they occupied as soldiers would not have any links or identify themselves with the population[45]. The massacres were often committed by a vanguard group which would then recruit local people to maintain control and who would also be more accepted by the local population. The vanguard group would move on to the next village to continue to expand their control. This has two significant HIV/AIDS implications. Because such massacres often involved rape and sexual violence

committed by the vanguard group, which moved from community to community, they became a direct transmitter of HIV. Secondly PLWHA were singled out and assassinated. Whilst this could very crudely be argued to reduce transmission, it fuels discrimination and stigma towards PLWHA, which is a main factor for increasing prevalence rates.

Interpreting the number of paramilitaries that existed is problematic and can affect the conclusion of the analysis. When the demobilisation process started in November 2003 the government estimated the paramilitary had between 12,000 and 15,000 troops. However, as the demobilisation process preceded the number increased significantly. It is believed that many presented themselves to the process in order to access the benefits, without pertaining to any of the paramilitary groups or being only loosely linked. This affects the official statistics on the number of paramilitaries and the average length belonging to the paramilitary forces, and could also skew the statistics in table 1. According to OAS-MAPP there is a rather small hard core group who participated in combating the guerrilla, appropriating territorial control and recruiting local people to the group. They have spent an average 5-10 years with the paramilitary. The larger group constitutes new recruits who once the paramilitary took control over a village participated in maintaining control. Their time with the paramilitaries usually varies between 6 months to a year.

FARC

The structure of FARC is somewhat different. To achieve their aim of overthrowing the government their army must be more cohesive, disciplined and formidable in combat than that of the paramilitaries in order to confront the national army with its sophisticated war machine and expertise in counter insurgency. FARC requires the support and coordination of all their forces to mobilise troops and resources amongst their different fronts, which is very different from the paramilitary blocks which enter in their own separate disputes. The guerrilla tactics results in more injuries than those of the paramilitaries, which is a factor increasing HIV transmission. In addition as the guerrillas have specialised in controlling regions with scarce infrastructure and poorly integrated commercial circuits, access to already limited healthcare services becomes more difficult. Monitoring and surveillance of the actual HIV/AIDS situation becomes all but impossible. On the other hand these regions tend to be vast territories with rather low population density, thus providing a less fertile ground for HIV infection and transmission. However the conflict dynamics such as cultivation of illegal crops and the appropriation of land by the paramilitaries have generated a large population displacement towards remote regions, which has become the social support base of the guerrilla[46]. IDPs are particularly vulnerable to HIV infection and transmission.

As IDPs make up 10% the population nearly every city is a host community to IDPs and IDP neighbourhoods are common recruitment zones for both the paramilitary and the guerrilla.

Behaviour

The general lifestyle differs substantially between the paramilitaries and the guerrilla, with the lifestyle adopted by the paramilitaries being more prone to HIV infection and transmission. FARC adopts strict living rules, tilted towards leftist ideologies with "social living rules" interfering very much with the private lives of their combatants and the villagers which they control. Control within their own forces extends to regulating sexual activity by their soldiers, which could be seen as a factor lowering vulnerability. Based mainly in the mountains healthcare is poor and living conditions are much more difficult than those of the paramilitaries, who are mostly based in villages. Although poor health is linked to an increased vulnerability to HIV infection, isolation from the general population in addition to restrictions on sexual relations are potential reducing factors. However, what has happened is that the economy in guerrilla controlled areas has declined as they prohibit gambling, prostitution, bars etc., which is a strong driving force in the Colombian economy. In contrast, the economy in paramilitary controlled regions has grown as they place no restrictions on such economic activities. The paramilitaries imposes very few or no living rules and pay salaries to their recruits. Their combatants are also based in urban areas, have a greater supply of women and are granted leave to go home on a regular basis – factors identified as increasing HIV vulnerability. The relaxed living rules have resulted in many soldiers pertaining to the guerrilla switching side and joining the paramilitaries. Of the 35,000 demobilised paramilitaries it was found that 20% had been in the guerrilla but converted to the paramilitaries due to the difficult living conditions. These kinds of movements are also a potential factor increasing HIV vulnerability and transmission. In response to such deterioration the guerrilla is becoming more paramilitarised, decreasing the difference between the two forces. The guerrilla is increasingly adopting the methods of the paramilitaries, including entering into business with them over drug trafficking[47]. This has resulted in a loosening of the rigid living rules, which could potentially increase vulnerability to HIV infection and transmission.

Within the armed groups (FARC in particular) recruits are often subject to mandatory HIV testing and those who test positive killed. During the interviews under demobilisation processes it was claimed that there is a tactic by the enemy group to infiltrate HIV positive women into their counterpart forces as a strategy to infect their enemy. This is an accusation that has been claimed by both the paramilitaries and the guerrilla. Whilst such claims are almost impossible to verify, it points towards viewing purposeful HIV infection as a weapon of war.

Attitudes

The level of intolerance towards HIV/AIDS and homosexuality amongst both the paramilitaries and the

guerrillas is high. There is much stigma and discrimination surrounding HIV/AIDS within the Colombian society in general and within the illegal armed groups in particular. Both groups have adopted a strategy of social cleansing of PLWHA, which is rooted in stigma and a belief that only prostitutes and homosexuals have HIV, people who are not wanted by these groups. UNHCR reported that in field visits it was commonly found that HIV positive persons and homosexuals were killed, while sex workers were commonly taken from the street, raped (sometimes taken to paramilitary camps and raped for 15 days) and then killed. The paramilitaries often force staff in health centres and hospitals to divulge the results on HIV tests, or they place informants within clinics in order to identify HIV positive persons who are then displaced or assassinated. In other instances armed groups subject individuals and communities to mandatory testing. Based on such stigma, discrimination and misbelieves, the armed groups are spreading false information on HIV/AIDS in the communities they control, fuelling discrimination and presenting homosexuality and HIV/AIDS as diseases which need to be resolved through arms. In this environment it is difficult to encourage people to be tested knowing that the results may create more harm. The lack of information, education and communication campaigns on HIV/AIDS is also likely to increase high-risk sexual practice.

Table 2: Uniformed Services and factors increasing their vulnerability to infection and transmission of HIV

	FFAA		**FARC**		**AUC**	
Age	-Main age group: 19-24	IF	-15-24	IF	-25-34	IF
Structure	-Mainly professional: Higher income	 IF	-Highly controlled lifestyle	DF	-Vanguard group committing massacres -Power and monopoly	IF IF
Posting	-Without concern to their home communities, minimum 2 years -Soldados de mi Pueblo	IF DF	-Mountainous and isolated regions	DF	-Urban areas	IF
Pay	-Relatively well paid	IF			-Paid	IF
Behaviour	-Violence against communities -Blockages on goods -Certain cooperation with NGOs	IF IF DF	-Strict living rules -Switching side -Social cleansing of PLWHA -Violence against communities	DF IF IF	-Lax living rules -Supply of prostitutes -Social cleansing of PLWHA -Violence against communities -Occasional leave to go home	IF IF IF IF DF
Attitudes	-HIV/AIDS knowledge low -Stigma and discrimination towards PLWHA	IF IF	-Stigma and discrimination towards PLWHA	IF	-Stigma and discrimination towards PLWHA	IF

IF: increasing factor, DF: decreasing factor

8.3 National Security Threatened by HIV/AIDS Affected State Institutions

While it is difficult to see that the HIV/AIDS epidemic in Colombia has reached the point where functionaries in these institutions are infected to such an extent that the epidemic threatens the effective functioning of the state, what could be argued is the situation in reverse. The territorial weakness of the central state (caused by non-HIV/AIDS related factors, beyond

the scope of this paper to explain) is increasing the risk of an accelerated HIV/AIDS epidemic. It highlights the importance of prevention in order to avoid reaching the stage where HIV/AIDS starts to create a security vacuum and becomes an additional destabilising factor to national security.

Colombia is a country with comparatively strong and solid institutions at central level. The weakness lies in the territorial reach of the government, where the state is extremely weak and in many instances completely absent. In these areas the presence of illegal armed groups is strong and they are disputing the state monopoly, including the monopoly on armed forces. The Ministry of Defence claims that the FFAA is present throughout the country, though in the southern and western part of the country (approximately 50% of the geographical area), and parts of the eastern coast departments (Chocó and Cauca) their presence is mainly limited to the departmental capitals. All other sources investigated outside the armed forces claim that there is a total lack of state presence in large parts of the country, in particular the rural conflict affected zones. Additionally the ICG reports that in most regions it visited there were reports of security forces either tolerating the new armed groups and criminal gangs that have emerged after the demobilisation of the AUC or even actively working with them. Most of the country is affected but in different ways. The state tends to have total or near total control in the large and intermediate cities, while for example Caquetá, Putumayo, Meta and Arauca have seen a large presence of paramilitaries the last 15 years. Other regions profoundly affected are Tumaco, Cauca, Valle, Chocó, and Catatumbo.

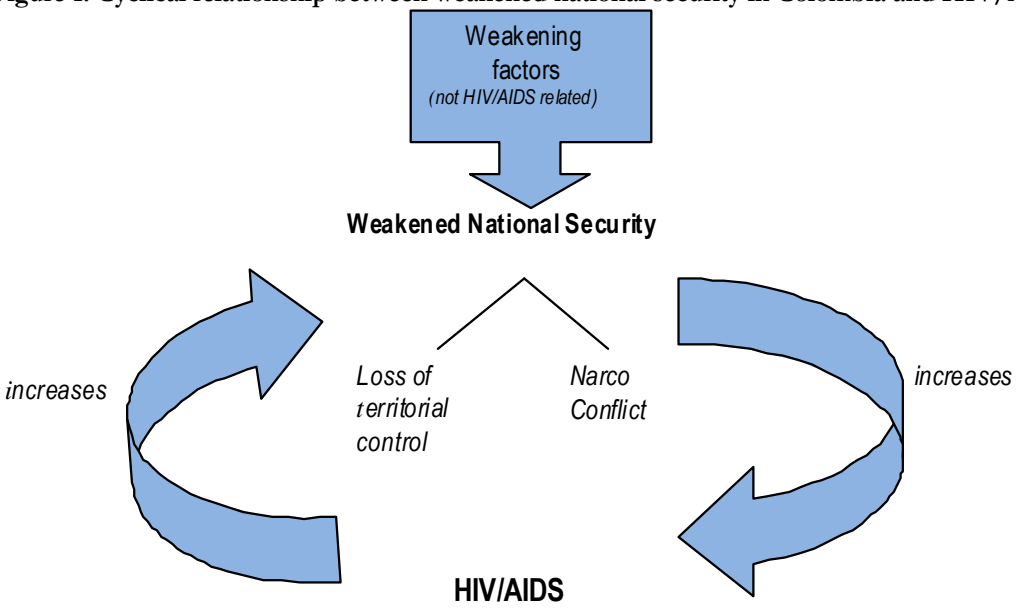
Territorial state weakness

With the AUC a new social order was imposed in many rural and semi-urban regions of the country. The power of some of the paramilitary leaders increased to the extent that a new form of local state was created. Duncan terms these leaders as 'warlords' who imposed a new power relation with new ways of extracting tributes, regulating the economy, administer justice, bring protection, organise the provision of basic services and monopolise coercive force[48]. Any legal business which demonstrated perspective access to competitive markets were subjected to extortion, either obliged to associate themselves with the warlords or be expropriated. The territorial weakness of the state in these areas prevents it from fulfilling its fundamental obligations to its citizens, such as healthcare provision and the upholding of civil and human rights. It enables the illegal armed groups to infiltrate the national healthcare infrastructure and, being the authority administering justice, the rights of PLWHA and other minority groups becomes seriously threatened[49]. The power of the illegal armed groups enables the enforcement of their attitudes and beliefs on HIV/AIDS and acting as the state they have the power to prioritise issues and resource distribution, which would arguably disfavour HIV/AIDS prevention and treatment. Access by humanitarian organisations and other healthcare providers to the populations in these communities becomes increasingly difficult.

Narco-conflict

Drug trafficking and the closely related issue of corruption are other destabilising factors in Colombia, exacerbated by the territorial state weakness. In some instances the national armed forces, judges, governors and parliamentarians conceal the violations committed by the groups involved in the drug trade. Cultivation of illegal crops takes place in rural and isolated areas with limited or no state presence and thus resultantly limited channels for the population to participate in legal economic activities. Cultivation and processing of coca significantly increases the income amongst the population and the dynamics of the industry has been found to produce situations where a significant number of young men with a comparably substantial amount of money have little other stimulation than consumption of drugs and women. An increase in prostitution (both supply and demand) has occurred, and resultantly higher incidents of HIV/AIDS. With no state provided social services there is an absence of healthcare services and risk reducing programmes targeting prostitutes, such as those found in Bogotá and other large cities implemented by the Ministry of Health.

Figure 1: Cyclical relationship between weakened national security in Colombia and HIV/AIDS



8.4 Increased vulnerability to HIV infection in conflict and post-conflict environments

The conflict is characterised by prolonged fighting on the ground, involving more soldiers and movement than short wars that depend on distance tactics. Casualty rates from land mines are amongst the highest in the world, as is the number of IDPs. The dysfunction of the national health system and the barriers to providing and accessing services has led to a worsened health status of the Colombian population. 64% of the Colombian population live below the national poverty line[50] and the coping strategies of the conflict affected population many times lead to high-risk behaviour in terms of HIV infection and transmission.

Damage to the healthcare infrastructure

The main damage to the national healthcare infrastructure caused by the conflict is the dysfunction of the healthcare system. Infiltration by the illegal armed groups into local government and the healthcare infrastructure has caused major difficulties for both the state and non-state organisation to reach the population with healthcare services. Medical personnel and clients are regularly subjected to threats by the illegal armed groups and the confidentiality of medical records has become a serious problem. In addition physical damage to the healthcare infrastructure, such as that caused by bombing campaigns, has put further strain on the delivery of healthcare services to the conflict affected population.

Infiltration by the illegal armed groups into local government and the healthcare infrastructure

The issue of infiltration into the healthcare infrastructure by the illegal armed groups is a major preoccupation in the conflict affected areas. The municipal mayor and the local ministry of health are the institutions which have been particularly infiltrated in ways such as asking for quotas and influencing contracting procedures. One way the infiltration has manifested itself is that many of the administrative bodies of the subsidised healthcare regime are now owned by the paramilitary, or at least controlled by them. With the decentralisation of healthcare provision the local townships obtained considerable say over budgetary allocations and thus priority setting, which in many regions in Colombia has therefore become determined or influenced by the illegal armed groups. The paramilitary and the guerrilla have also been found to use the healthcare infrastructure to serve as their own networks. Healthcare service providers are co-opted through threats or bribes to provide healthcare to the guerrillas or paramilitaries, which has resulted in the displacement of supplies from the civilian population. In the Atlántico department alone $100 million was taken from health system by the paramilitaries[51]. Apart from the financial benefits, controlling the healthcare system is also highly useful for maintaining the fighting force.

Controlling the healthcare infrastructure has resulted in a lack of confidentiality as the illegal armed groups possess access to confidential information on clients. HIV positive individuals have been identified in this way and been subject to threats, displacements or disappearance. As such, while the general population can theoretically access testing services under the government insurance scheme the main issue with

VCT services is the inability to ensure confidentiality, security and protection of all those accessing the services. In a research conducted by UNHCR it was reported that in nearly every field visit conducted PLWHA had been discovered, through informants or by other means, and assassinated. Forced testing and forced disclosure of the results was also frequently cited.

Barriers to access

In many parts of the country the state is unable to deliver healthcare services which leave many people without access. The armed groups controlling these areas decide who can access what kind of services. The UN and other international organisations have encountered serious difficulties in accessing areas targeted for healthcare provision including HIV/AIDS prevention and treatment initiatives or to mobilise people around project activities. Access to IDP communities is often denied or limited due to the high risk of violence or death for both healthcare personnel and clients. FARC has let it be known that international organisations are not welcome in the territories they control in north-eastern Colombia and few agencies have been prepared to insist on access due to safety fears[52]. Projects implemented by national and international organisations are frequently subject to threats from illegal armed groups throughout the country. One such example is Proyecto Colombia, one of the largest HIV/AIDS projects in Colombia implemented by the International Organisation for Migration (IOM). The majority of these threats related to providing information on HIV tests results in the communities and have resulted in the displacement and exile of project staff and beneficiaries. This has had the adverse effect of transforming initiatives to promote VCT, and thus improving public health, into risk factors.

As a result access to HIV/AIDS care and support services in Colombia is very limited. For example, there is an acute lack of test kits, adherence to ARV has become a serious problem, with people not following the regime strictly and thus threatening resistance to ARVs. In addition, as many people fear the discovery of their status they may not access the care and support services even when available. One response to the problem would be to target the illegal armed groups with information and education on HIV. However, the Uribe government has prohibited the UN or any other organisation apart from the ICRC accessing the paramilitary or the guerrilla[53]. Although working with these groups on HIV/AIDS education and prevention as well as other human rights issues could be an effective way to counteract the aforementioned problems, it could also risk providing certain legitimacy to these groups.

Dysfunction of monitoring and surveillance systems

In many parts of the country there is a complete lack of surveillance of public health, including monitoring of HIV/AIDS. Reporting is serious problem in conflict affected zones, complicated further by the lack of confidentiality. HIV/AIDS surveillance and monitoring is of utmost important for targeted prevention and treatment strategies to combat HIV/AIDS and measuring the success of strategies and programmes. The above mentioned barriers to access to healthcare services may be a significant factor in the underreporting of HIV, as people are unable or unwilling to access VCT services. As such, the statistics that indicate that HIV/AIDS is mainly a problem in urban areas may be skewed as the conflict is taking place mainly in rural areas. As most existing VCT and treatment services are found in the larger cities, which also have better reporting mechanisms, the reported HIV/AIDS situation in Colombia might be distorted. There is also the risk that AIDS deaths are recorded by the opportunistic infection rather than the presence of the virus.

Changed behaviour of conflict affected people

Coping strategies

Loyalty towards a paramilitary or guerrilla leader is often demanded in the areas they control and the community is obliged to fulfil certain rules. This includes paying taxes, informing on rivalling armed groups, renouncing any kind of collaboration with such groups and respecting the formal and informal norms and regulations imposed by the leaders. In return citizens will receive protection from extortion, crime and physical violence from other armed groups, provision of justice and access to public services such as healthcare[54]. Access to healthcare services thus becomes conditional on cooperation with the illegal armed groups, which through this system are also supplied with informants on PLWHA. These conditions have generated a level of tolerance within the community towards crimes committed against PLWHA and other minorities. Another coping strategy reported by UNAIDS to be of increasing concern is the rise in sex in exchange for money or food or for access to social benefits. UNCHR has reported that young girls, in order to ensure their survival and wellbeing and that of their family, purposely become pregnant by paramilitary leaders. Relationships between young girls and older and powerful paramilitaries are common and is a factors making young women particularly vulnerable to HIV.

High-risk behaviour

Promiscuity and prostitution is widespread in Colombia and is particularly rampant in rural areas. While this can partly be explained by the social structure of the Colombian society it is also a result of the lack of opportunities and the short-term life perspective felt by many as a result of the conflict. There is a high level of uncertainty towards the future amongst the Colombian population as they harbour a real fear of armed groups entering their villages and either massacre, displace or forcefully recruit them. This is believed to lead to increases in sexual activity, often with prostitutes, and an rise in women turning to transactional sex for survival. There exists a strong

machismo culture, in particular in the countryside, which has resulted in the common practice that men will have children with a number of women and the children of one woman are likely to all have different fathers. UNHCR has reported high rates of trafficking of young women for the sex industry, including trafficking to Panama, Europe and the USA. The Health Secretariat reported that many return HIV positive and continue to sell sex on their return. It was also reported that families highly value the money their daughters can earn abroad and many saw this as an only option for the young women out of poverty. This was a problem particularly found in Valle de Cauca.

According to the Demographic Health Survey knowledge of HIV/AIDS is high in Colombia, including in rural areas. What is less known is the right to VCT services as part of the national health insurance. However condom use continues to be insufficient and is particularly low amongst sex workers and their customers. In a study carried out in Bogotá in 2001 reported by the UNHCR amongst sex workers and their customers, 41% of the women reported that they rarely used condoms, the main reason being the offer of more money (72%). 61% of the customers reported that they never used condoms; 75% responded that they sometimes paid to have sexual relationships without condom; and 69% did not use condoms when under the influence of psychoactive substances.

Sexual violence

According to the UN World Organisation Against Torture sexual violence is common in Colombia. Rapes are rarely reported, confirmed both by human rights organisations and the police. The crime is perpetrated by the illegal armed groups and the FFAA alike. UNHCR reported that rape and gender based violence were common occurrences in all areas researched, with many women and girls not reporting the rape or being killed after being raped. While post-exposure prophylaxis is available in certain areas and within some programmes, women often do not attend clinics post-rape due to stigma and shame and do therefore not access prophylaxis services. It was found that in some areas many young women after being raped preferred to access emergency contraceptives at a pharmacy as this was seen as more confidential than reporting the rape and receiving counselling at a government hospital.

Refugees and IDPs

Government estimates there are between 2 and 3 million IDPs in Colombia though only 1.6 million are registered. In surrounding countries more than half a million Colombians live in refugee-like situations. NGO figures suggest the presence of more than 3.4 million IDPs. This means that up to 1.8 million IDPs are without any access to healthcare services. In an investigation made by WHO in 2002 -2003[55] in 6 of the largest municipalities targeting IDPs it was found that only 24% of IDPs and 34% of the host population living in the poorer areas were affiliated to one of the state health insurance schemes. This is well below national average for both groups. Approximately 20% of IDPs and 30% of host populations did not possess any kind of document to access healthcare services and only 23% of those with symptoms or illness sought medical assistance. 10% of IDPs who sought medical assistance were denied, in comparison to 2% amongst the host populations. It was found that HIV amongst IDP populations is not a priority issue and there exist very limited data on HIV/AIDS for this group.

Repatriation of IDPs has been prevented by the continued violence. It is also limited due to the long time that many of the victims have been displaced, often between 10-15 years. Many have formed new lives in the towns where they forcedly migrated to and do no longer consider themselves as displaced. This would potentially reduce the likelihood of the spread of HIV caused by population movements. On the other hand, being non-camp based (Colombia does not have any organised IDP camps, which are often established in other IDP affected countries) is a potential factor increasing vulnerability. IDP camps reduce privacy and thus sexual activity, and facilitate access by humanitarian organisations.

Wartime policies and priorities

Healthcare policy

There has been a rather stable financial investment in the national health system, although more resources are needed to implement the National Health Plan and state health insurance scheme. Regarding HIV/AIDS the government is focusing on improving information and quality and there has been some important investments made. Nevertheless, insufficient allocation of human and financial resources continues to be the main barriers to implementations of HIV/AIDS policies and strategies, rooted in the low prioritisation of HIV. Corruption and the infiltration by the illegal armed groups in local government and the healthcare infrastructure have led to the distortion of the funds allocated.

Classifying the conflict as terrorism

Classifying the conflict as terrorism and criminality is seen by many as a smokescreen to divert public attention from the real issues underlying the social turmoil. This include widespread poverty and lack of economic opportunities, the disenfranchisement of those living in impoverished and rural areas, and the failure of the state to deliver social programs and act as a force for order and accountability[56]. It causes further obstacles to the displaced population as in many areas in Colombia they are unable to register as IDPs because the government does not officially recognise displacement when caused by the narco-conflict. The displacement and assassination of PLWHA by the illegal armed groups has not

been considered a main issue by the government or by many of the international organisations working with the government to resolve the conflict.

The post-conflict environment

There have been several attempts to resolve the conflict and peace negotiations have been held with a number of the actors to the conflict. There is an ongoing DDR process with the AUC, negotiations on a humanitarian agreement with FARC and peace talks are being conducted between the government and the ELN guerrilla group. In the last decade peace agreements have been made with five different guerrilla groups.

International presence

Although international presence relating to the peace negotiations in Colombia is fairly recent, it is significant. In the peace negations held with FARC and the Pastrana government in 1998 some 20 countries were present in addition to the UN. In the current demobilisation process the OAS-MAPP holds an important position and has enabled the involvement of further international actors. Foreign governments such as Sweden and Holland play a crucial role. The peace negotiations with ELN currently being held in Cuba includes the 'group of friendly countries' consisting of 7 different countries. More difficult and less formalised are the negotiations being conducted with FARC on a humanitarian agreement, which is led by France, Spain and Switzerland, and more recently includes the participation of Venezuela. The UN has significant presence in Colombia, with 21 of its agencies working in many of the country's regions. Whilst the agencies employ many local staff there is a considerable number of international staff contracted. The research conducted found no indications that this is threatening an increase in HIV.

The demobilisation process

There are several components within the peace negotiations and demobilisation process which could impact on the HIV/AIDS epidemic.

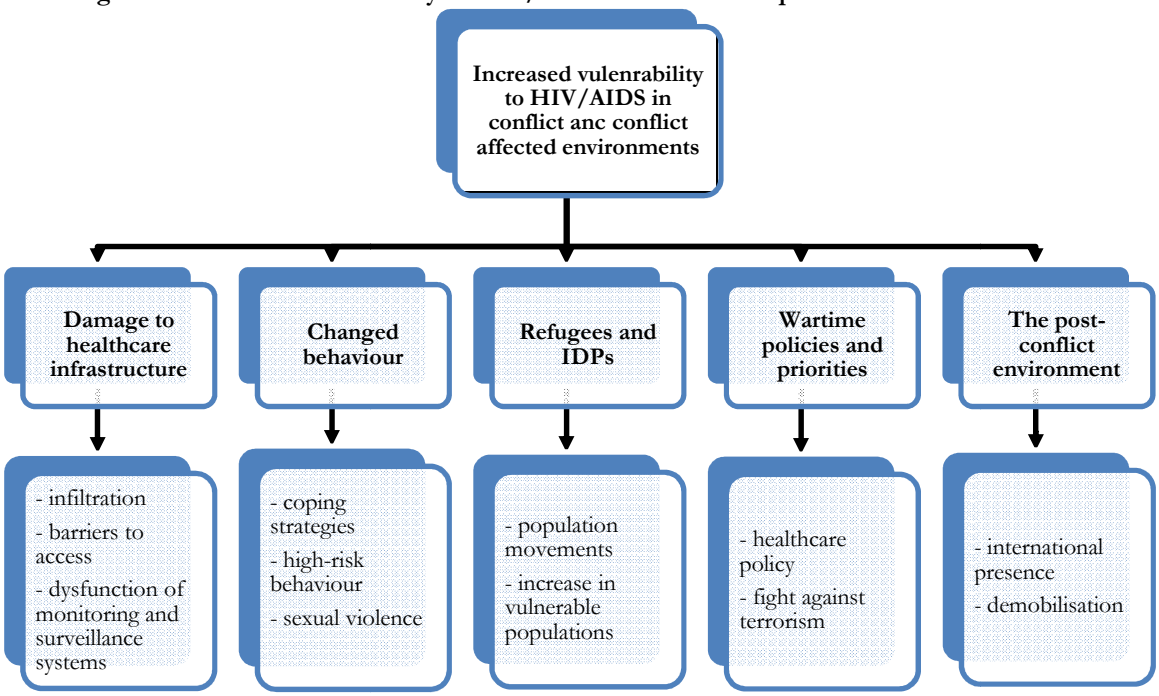
The Santa Fe Ralito Accords

During the talks leading up to the peace agreement with the AUC in Santa Fe Ralito there was a concentration of military personnel, AUC combatants, government officials and other influential people, and significantly an influx of money. As a result both demand and supply of prostitutes increased, with sex workers arriving from many different parts of the country. The sex workers were mainly poor youth with low levels of education. As part of the conditions for the peace talks the paramilitaries were enclosed in large ranches protected by the police in order to negotiate with the government without being attacked by the guerrilla. However, police protection was rather porous in the sense that it permitted young girls and professional prostitutes being buss-loaded into the premises and brothels were established surrounding the ranches. There was also a demand by the paramilitaries for virgin girls to be supplied. The WHO has reported an increase in STI and HIV rates in the region following the Santa Fe Ralito Accords.

Reintegration

The demobilisation programme includes components pertaining to ethics and morale and how to live and interact with civil society. This is deemed important due to the crimes that many of the former combatants committed against the civilian population. There is also a healthcare component, which includes psychosocial treatment and VCT. Nevertheless shortcomings in the programme include insufficient resources (e.g. only 1 healthcare professional per 5,000 demobilised combatants, and 1 psychologist per 120. The WHO recommends a minimum of 2.5 healthcare workers per 1000 people under normal circumstances). It was also found that sexual violence increased during this period. In addition there have been no efforts to sensitise civil society on what is meant by the DDR process, which has resulted in high levels of discrimination against returning ex-combatants. Many ex-combatants were therefore transferred to the larger cities, mainly Bogotá, to better guarantee their security. In the beginning of the demobilisation programme many former combatants did return to their home communities. Though as the programme proceeded this number decreased as a result of the discrimination they faced in their home communities. A large part of the ex-combatants who did not return to their home communities have turned to co-operations or associations of former paramilitaries in order to be with their peers. Some have returned to the paramilitary groups and their successors. The failure to properly reintegrate the demobilised combatants into society, in addition to the shortcomings in sustainable behaviour change activities, could risk that they continue to harbour the attitudes and behaviours found to increase the risk of HIV infection and transmission. However, the argument that DDR processes lead to large-scale population movements has not been the case in Colombia, neither with the AUC demobilisation nor with the previous demobilisation initiatives with the guerrilla groups.

Figure 2: Increased vulnerability to HIV/AIDS in conflict and post-conflict environments



8.5 Obstacles to peace building

There appears to be little evidence pointing towards HIV/AIDS being an obstacle to peace building, in the sense that it becomes a disincentive to end conflict or an obstacle to the reconstruction of national security. However, the increasing HIV prevalence rate merits a discussion on the issue. Prevalence is increasing most rapidly amongst vulnerable groups, to which the uniformed personnel and the illegal armed groups pertain. The risk exist that HIV rates increases dramatically within these groups and could as such become a potential obstacle to peace building, which has been found to have happened in other high-prevalence conflict affected countries. The same could be argued for the theory HIV/AIDS as an obstacle to the reconstruction of national security. The state institutions important to maintaining national security do not appear to be threatened by the impact of HIV/AIDS, though as shown in section 8.3 factors accelerating the HIV/AIDS epidemic are present. In addition, the Santa Fe Ralito process has demonstrated how peace negotiations and initiatives can increase HIV transmission. This points to the importance of early preventing to avoid creating additional obstacles to achieving peace in Colombia.

Reduced willingness by states to provide or receive peacekeepers

Research did not indicate the deployment of peacekeepers in the near future, although Uribe has expressed the possibility of the arrival of blue helmets to maintain peace[57]. The seriousness of this statement can be questioned given the denial by the government of an armed conflict in Colombia. However, with the various negotiations currently taking place between the government and the illegal armed groups, a peace agreement could be reached which would include UN or regional peacekeepers or peace observers. One example is the peace talks presently being conducted with ELN in Cuba, where demands by the ELN include a stronger verification mandate and increased international presence. This would involve more international observers. It is not clear yet who will fill this mandate, whether the UN, OAS, EU, or the Group of Friendly Countries, etc. If this becomes a reality the issue of HIV/AIDS should not be ignored given the fact that Latin America and the Caribbean is the second most affected region by HIV/AIDS.

The various peace negotiations have involved significant international presence and there appears to be a general belief that international presence will increase in the next five years. This was viewed as a positive development by many organisations and not seen as threatening an increase in HIV infection.

8.6 Effects on the Provision of Humanitarian Assistance

Humanitarian organisations play an important role in working with the conflict affected population in Colombia and are significant providers of HIV/AIDS prevention and

treatment programmes. 21 UN agencies are present in Colombia. IOM, UNAIDS, UNFPA, WHO, UNICEF, UNHCR, WFP, ICRC and MSF are the main agencies working with HIV/AIDS related issues. However, the conflict and government policies are causing major obstacles to the effective provision of humanitarian assistance, including the provision of HIV/AIDS prevention and treatment services to some of the most vulnerable populations in Colombia.

Working environment

Colombia presents a particularly difficult working environment for the provision of humanitarian assistance, ranging from the views held by the government to the threats by the illegal armed groups. President Uribe has expressed on a number of occasions that human rights groups are FARC sympathisers. These statements were widely seen by humanitarian organisations as providing a license for right-wing armed actors to harass and kill activists. In particular Uribe spoke of human rights groups as "serving terrorism" and referred to donor governments as sponsors or defenders of terrorists[58]. Nevertheless there is an increasing recognition by the state of the important role these groups play in providing life saving services to the conflict affected population, with a resultant increase in collaboration and coordination. The illegal armed groups have also on many occasions expressed their intolerance towards aid personnel. FARC accuses aid personnel active in paramilitary-controlled areas of promoting their adversary's cause, and the reverse was true for the paramilitaries. In one incident several human rights workers kidnapped by FARC for activities on behalf of people in areas controlled by paramilitaries were, following their release, detained by the paramilitaries on suspicion of being FARC sympathies.[59]

The impacts on humanitarian organisations has included a reduced profile and outreach and in some areas suspension of programs altogether. As of March 2006, eight of the 32 provinces had been closed to humanitarian operations for security reasons[60]. Promotion of human rights, such as the rights of PLWHA, continues to be high-risk activities with human rights activists regularly targeted by the illegal armed groups and assassinated. An additional problem faced by humanitarian agencies is the fluidity of the Colombian conflict. With the geographical focus areas constantly moving, implementing HIV/AIDS prevention and treatment programmes becomes difficult.

Implications of HIV/AIDS projects

Whilst the projects implemented by humanitarian agencies in conflict affected areas offer important access to lifesaving services, several agencies have reported adverse effects of particular concern. Due to the discrimination and human rights abuses suffered by PLWHA, promoting VCT has placed both clients and service providers at an increased risk to violence and death by the illegal armed groups. The same holds true for PLWHA accessing treatment services. Project staff are repeatedly threatened and asked to provide information on the people accessing the services provided by the projects. Another problem encountered by amongst others IOM, results from the organisation of youth into projects. The illegal armed groups have been found to approach youth groups organised by the projects and forced to join their group.

9. CONCLUSION

The paper has studied whether in the light of the increasing international recognition of HIV/AIDS as a threat to national security, *Should HIV/AIDS be securitized? If so, what would be the consequences to humanitarian assistance?* The purpose of securitizing HIV/AIDS would be two-fold. It would contribute to peace and security by preventing HIV/AIDS becoming a reason for conflict, and secondly it would contribute to the global efforts to halt and reverse the HIV/AIDS epidemic by preventing that conflict situations exacerbate the spread of the epidemic. Based on the evidence found in Colombia and on previous research by other authors, HIV/AIDS should be considered as a security issue. The four theories linking HIV/AIDS, conflict and national security appear to hold true even in countries with comparably low prevalence rates, though their significance will vary from case to case. This point to the importance of targeted responses on a case to case basis, founded on empirical evidence. A targeted response based on case specific evidence becomes difficult however, due to the problems with functioning and reliable surveillance mechanisms and the lack of monitoring and evaluations of HIV/AIDS initiatives in conflict contexts.

The thesis reaches two conclusions:

With the adoption of Security Council Resolution 1308, and the subsequent international declarations on HIV/AIDS, HIV/AIDS has already been securitized at international level. Based on the scale of the HIV/AIDS pandemic, its cross-sectoral impact and impact on issues which falls under both the wider and narrow security definition, the declaration of HIV/AIDS as a threat to national and international security is arguably justified. Declaring HIV/AIDS as a threat to national and international security should increase the attention and focus on HIV/AIDS, and strengthen a multisector approach, which is of crucial importance for halting and reversing the epidemic. The recognition that HIV/AIDS is a threat to national and international security through the demonstrated linkages between HIV/AIDS, conflict and national security, should force governments into action and at the same time give power to the international community to ensure governments are providing necessary care and treatment services. It should help mobilise resources, increase the availability and affordability of ARVs by overriding patient laws and thus permitting the production of cheaper generic ARVs, as part of

the extraordinary measures available when fighting a declared threat to national and/or international security.

Considered as a factor that can exacerbate conflict and provide an obstacle to peace building HIV/AIDS should be included as a security concept in conflict resolution. Resultantly it should be applied as a variable in conflict analysis and integrated into DDR programmes. This would put pressure on national governments in conflict affected countries to seriously consider the issue of HIV/AIDS, which has been found to often be ignored or de-prioritised in such settings. HIV/AIDS is already high on the agenda amongst humanitarian organisations, including the UN, but securitization would further broaden the multi-sector approach and the themes which HIV/AIDS crosscut. It should lead to an increase in resources committed as donor governments and agencies move HIV/AIDS further up the priority agenda. In addition, further attention would be given to other closely related issues, such as sexual and reproductive health, which is of utmost importance for the prevention of HIV/AIDS though often given very little attention and subsequently largely under-funded, in particular in conflict environments. Care need to be taken however, to ensure that any increased resources for HIV/AIDS is a result of an increase in governments and donor agencies' funding commitments and not a diversion of funds from other important development themes.

The answer becomes more complex when looking at whether national governments should securitize HIV/AIDS. What is clear is that there is a need for case specific responses, as the strength of the theories will vary depending on the specific context. Whereas in some countries the validity of securitizing HIV/AIDS may be more obvious, presumably in countries with a high HIV/AIDS prevalence rate experiencing prolonged conflict, in other cases, politicising HIV/AIDS may be more appropriate than securitizing the issue.

In Colombia evidence was found to support all four theories, though their strength varied. The theories *uniformed personnel as a vector of HIV*, and *increased vulnerability to HIV/AIDS in conflict environments* demonstrated the strongest linkages between HIV/AIDS, national security and conflict. The relatively low HIV prevalence rate made the theories *national security threatened by HIV/AIDS affected state institutions*, and *HIV/AIDS as an obstacle to peace building*, less of an issue. However both theories were demonstrated in reverse, i.e. that a weakened state and peace building initiatives could contribute the spread of HIV/AIDS, thus the link is definitely present. What was clear in the Colombian case was the role played by the illegal armed groups in the spread of the HIV/AIDS epidemic, and that the conflict environment is contributing to the increased spread of HIV. This triggers the question of where the response should lie and the more difficult issue of how to deal with these groups. If HIV/AIDS was securitized by the Uribe government, the response would risk being shifted to state institutions which have proven to be highly undemocratic and non-transparent, as well as repeatedly condemned for human rights violations. It would bring the issue of HIV/AIDS into the framework of the democratic and security policy, under which Uribe has already claimed that human and civil rights are obstacles to defeating the illegal armed groups. It would risk the mis-use of resources earmarked for HIV/AIDS, or the diversion of the resources to the security and state elite echelons, on the expense of services provided to the civil population. Also with the war policies of the government, it would be highly unlikely that the illegal armed groups would be included in the response. There is discrimination between how the government treats the illegal armed groups. Doubts are reported on the effectiveness of the FFAA in regaining control over the territories previously controlled by the AUC, as well as their commitment to fighting the new armed groups emerging after the demobilisation of the AUC. FARC is the main object of the military strategy and frequently the FFAA has been reported to turn a blind eye towards the AUC successors. Securitizing HIV/AIDS, i.e. presenting HIV/AIDS as a security issue would in the Colombian context most likely lead to further stigmatisation of HIV positive people, if an all-inclusive sector-wide approach is not taken.

As for the issue of how to deal with illegal armed groups, both FARC and the paramilitaries have been declared terrorist groups by the national government and part of the international community (e.g. the European Union and the USA). The Uribe government has prohibited any organisation, including the UN, from dealing with these groups. However, to prevent that HIV/AIDS further negatively affects the Colombian conflict as well as preventing that the conflict further exacerbates the HIV/AIDS epidemic, any response must target the illegal armed groups. What is needed is an attitude and behaviour change around HIV/AIDS, access to prevention and treatment services, the guaranteeing of the rights pertaining to PLWHA and functioning and reliable monitoring and surveillance mechanisms. If the conflict is not resolved, and thus local state institutions continue to be infiltrated by the illegal armed groups and the central state is unable to regain full territorial control, securitizing HIV/AIDS could permit the UN and humanitarian organisations to provide these essential life saving services to the conflict affected populations. It would also give the government an opportunity to seek the assistance of the international community without declaring a civil war or changing its war policies. However, conferring the response to the non-state sector and international agencies and organisations would relieve the government from its responsibility to provide basic services to its populations, and makes the response to HIV/AIDS subject to the goodwill of such agencies. What is tremendously clear in the fight against HIV/AIDS is the need for a multisectoral approach.

As such, politicisation might be more appropriate in the Colombian context. There is a strong need to view HIV/AIDS as a wider security issue and not just a public health issue in Colombia. HIV/AIDS impacts negatively on the conflict, and the conflict has a negative impact on the HIV epidemic and prevention is urgently required to avoid that this situation is exacerbated. Nevertheless, it cannot be argued that HIV/AIDS on its own poses a threat to national security in Colombia. By politicising HIV/AIDS the government would acknowledge the two-way cause and effect relationship between HIV/AIDS, national security and conflict, thus prevention would become an

issue not only for public health purposes, but also for resolving the conflict. This however raises the question of what would trigger Uribe to politicise HIV/AIDS? This particularly so in the light of a dysfunctional monitoring and surveillance system and with the government's stance on civil and human rights. HIV prevalence rate is estimated to reach 1.5% in 2015, more than doubling within 9 years. Moreover the official HIV prevalence rate 0.7%, could potentially be underestimated as in the rural conflict affected areas accessing VCT is seriously hindered, and reporting a problematic issue. Not only healthcare providers and human rights activists face serious difficulties in reporting, journalists also suffer serious threats and attacks from both the illegal armed groups and the state. Due to such intimidation many journalist refrain from travelling to certain areas, preferring to report only official figures. Intimidation of humanitarian groups and journalists deprives the public of an understanding of what is taking place. Underestimating both the actual and future scale of the HIV/AIDS epidemic could be a further cause for the government to de-prioritise the issue and continue to view HIV/AIDS as a public health issue only and the resulting apathy by the public towards the issue. If securitized at international level and adopted in conflict resolution mechanisms, the pressure to give a higher priority to HIV/AIDS in conflict settings would come from the outside when such pressure proves difficult to provide from within the country.

HIV/AIDS does not on its own cause wars, neither does armed conflict directly generate HIV/AIDS. However, the structural damage HIV/AIDS is able to inflict can have a profound effect on national security and the presence of armed conflict can exacerbate in vulnerable societies those factors that could lead to greater incidence of HIV transmission. There is an uncertainty whether HIV rates have yet reached their peak, with some taking the view that rates peaked in the 1990s while others believe that it is possible that the epidemic is still at an early state[61]. In both cases, deaths from AIDS have yet to reach their peak. As such, the 21st century may offer a test to the correlation between high HIV/AIDS prevalence rate and destabilisation and civil conflict.

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[42] Universal precautions are infection control measures that reduce the risk of transmission of blood borne pathogens through exposure to blood or body fluids among patients and healthcare workers.
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