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Sexual Violence – Spread of HIV/AIDS in Armed Situations

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ABSTRACT

To understand the synergistic relationship between conflict, sexual violence and HIV/AIDS one must, first, examine the relationship between conflict and STIs; conflict and sexual violence; and sexual violence and STIs. This chapter will begin with a review of the literature that has found a correlation between war and increased prevalence of STIs among military personnel and conflict-affected civilian populations. The chapter then presents the research findings concerning the relationship between sexual violence and STIs. The research findings are taken from various academic and non-academic sources and are based on studies that were conducted in different conflicts in the world.

Keywords: *International Humanitarian Law, Sexual Violence, Crime Against Humnity, Armed Conflicts*

I. INTRODUCTION

To understand the synergistic relationship between conflict, sexual violence and HIV/AIDS one must, first, examine the relationship between conflict and STIs; conflict and sexual violence; and sexual violence and STIs. This chapter will begin with a review of the literature that has found a correlation between war and increased prevalence of STIs among military personnel and conflict-affected civilian populations. The chapter then presents the research findings concerning the relationship between sexual violence and STIs. The research findings are taken from various academic and non-academic sources and are based on studies that were conducted in different conflicts in the world.

II. THE RELATIONSHIP BETWEEN CONFLICT AND SEXUALLY TRANSMITTED INFECTIONS

Historically, conflict has played an instrumental role in the transmission of STIs. For example, during WWI there was an elevated prevalence of syphilis and gonorrhea among the soldiers and nearby civilian population; from 1914-1917, there were over a million syphilis and

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gonorrhoea cases recorded among civilians in France; in 1917, 23,000 British soldiers were hospitalized with STIs (Hankins et al., 2002); and in WWII an estimated 750, 000 American military personnel contracted syphilis. Several decades later, a study conducted in a Rwandan refugee camp in Tanzania showed that over half of the women receiving prenatal care were infected with an STI, three percent testing positive for gonorrhoea and four percent with syphilis. The report also revealed that more generally, women and men within this community frequently reported experiencing a STI (Rehn & Sirleaf, 2002).

The rising rate of STIs needs to be considered in relation to the increasing number of conflicts that have multiplied in the last decade. In the last 20 years, no region in the world has been more affected by violent conflict than sub-Saharan Africa (SSA); armed conflicts have doubled from 11 in 1989 to 22 in 2000 (Save the Children, 2002). A 'conflict belt' has been said to stretch across Angola to the Horn of Africa (Mock et al., 2004). Nearly all of the countries in this region have been directly (in country conflict), or indirectly (bordered a county in conflict), affected by the ravages of war. Conflict produces conditions of political and economic insecurity, ruptures the social fabric of a society, and all but halts the functioning of essential infrastructures such as the local economy and healthcare system; conditions, that have long been identified as risk factors for HIV/AIDS.

An additional factor that needs to be considered in an analysis of sexual violence in conflict, especially in SSA is the HIV/AIDS pandemic. In SSA, AIDS has become the single leading cause of death, killing 1.6 million people in 2007, with an estimated 1.7 million newly infected people (UNAIDS, 2007). The spread of the disease has been profound, indiscriminately affecting women, men and children from all segments of society and regional boundaries. In SSA the scope and impact of the disease is marked; HIV/AIDS has struck the most productive members of society, between the ages of 15 and 45 years old, creating labour shortages in key areas that are fundamental to development such as education, healthcare and agriculture. The burden of the disease has strained already fragile healthcare systems, reduced economic output, and eroded familial networks and social capital. In the coming years, HIV/AIDS is projected to kill ten times more people than conflict (Save the Children, 2002). Researchers have concluded that the destabilizing effect of HIV/AIDS on human capital, economic productivity, and social political institutions will set the stage for increased conflict on the continent (Smallman- Raymor, 1991; Mock et al., 2004).

The relationship between conflict and HIV/AIDS is complex; literature on conflict affected countries in SSA has pointed to a bi-directional causal influence on one another. For instance, in conflict increased HIV risk is associated with sexual bartering, sexual violence, increased

rates of partner change, low awareness about HIV, the erosion of health and education services and the breakdown of social support networks (Hankins et al., 2002; Mock et al., 2004). This scenario has been described by Save the Children (2002) as a 'double emergency' because food and economic insecurity lead to increased HIV transmission through the increased engagement of survival sex (commercial sex trade and material needs based sexual relationships) and HIV transmission further leads to food and economic insecurity as the health of the population declines causing the collapse of key development sectors.

In 2000 the UN Security Council, recognizing the increased risk of exposure to HIV infection in settings of conflict, humanitarian emergencies and natural disasters, adopted Resolution 1308 which acknowledges that "HIV/AIDS is exacerbated by conditions of violence and instability; and...the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security" (UN Security Council Resolution 1308, 2000). Echoing the same concern, UNAIDS noted in a 2003 report that:

‘ Conflict and displacement is associated with increased risk of HIV transmission among affected populations because of behavioural change due to interruption of social networks and economic vulnerability (particularly among women and adolescents), as well as sexual violence and the disruption of preventive and curative health services. [Further] in circumstances of war and conflict, the vulnerability of women and young girls particularly rises as economic and social structures are weakened and violence, including sexual abuse increases’.

There are few and conflicting epidemiological studies on the relationship between conflict and HIV/AIDS (Smallman-Raynor et al., 1991; Cossa, et al., 1994; Maman, et al., 2000; Amowitz, et al., 2002; Hankins et al., 2002; Mock, et al., 2004; Mulanga, et al., 2004; Fabiani, et al., 2006; Jansen, 2006; Aniekwu, et al., 2007; Westerhaus et al., 2007). Anecdotal reports and the intuitive appraisal of the vulnerabilities in the war zone have led many researchers, activists and international institutions alike, to conclude that conflict acts as a vector for HIV/AIDS. Issues of security, the mortality and mobility of a conflict-affected population and the diversion of government resources to military spending make the accurate assessment of HIV surveillance extremely difficult. Complicating matters further, many countries in SSA possess already strained and overwhelmed healthcare infrastructures raising questions on the reliability of pre-conflict HIV prevalence estimates.

III. EVIDENCE OF THE RELATIONSHIP

Within the available research, conflict has been linked to the spread of HIV in a number of

countries. For example, it is hypothesized that the armed conflict in Uganda (1978-79) seeded the dissemination of HIV infection throughout the country (Fabiani et al., 2001; Chagalucha et al, 2002; Mock et al., 2004; Aniekwu & Atsenuwa, 2007; Westerhaus et al., 2007). The spread of HIV infection in the 1980s and the geographical distribution of AIDS during the 1990s showed to be significantly and positively correlated with the ethnic patterns of recruitment into the Ugandan National Liberation Army (UNLA) after the overthrow of Idi Amin (Smallman-Raynor & Cliff, 1991). Other examples can be found in the 1987 conflict in Angola where HIV is believed to have spread from the northern areas of Angola to the central and south-eastern regions through war-induced population displacement (Santos-Ferreira et al., 1990, p. 786). In

East Timor a spiked increase in the HIV prevalence has been associated with the high incidences of sexual violence during the war, and the new patterns of commercial sex relationships between East Timorese women and foreigners, peacekeepers, business people, and aid workers (Rehn & Sirleaf, 2002, p.52). A high HIV prevalence rate among soldiers was also linked to the risky sexual behaviour and prostitution centers surrounding military posts in the 12 year conflict in El Salvador (Wollants, 1995, p. 1292). HIV prevalence rates in rural areas of Rwanda increased from 1 percent before the start of the 1994 conflict to 11 percent in 1997. A survey, conducted by the *Rwandan Association for Genocide Widows* (AVEGA) revealed that close to 70 percent of the women raped contracted HIV (WHO, 2004). In Sierra Leone, Save the Children (2002) found that girls were infected with HIV after being raped by rebels terrorising civilians. In 2003, health clinics in Monrovia, Liberia reported that most of the female patients who said they had been raped by former government soldiers or armed opposition fighters tested positive for at least one STI (Amnesty International, 2004).

IV. DISAGREEMENT ON THE RELATIONSHIP

It is important to note that there has been a recent study that has challenged the veracity of the HIV and conflict association. Spiegel et al. (2007) analysed various data on the prevalence of HIV infection in conflict and refugee settings. They concluded that there is insufficient data to support the assertion that conflict and forced displacement increase HIV prevalence. In response to this report, Jewkes (2007), a gender and health research officer at the Medical Research Council in South Africa, challenged that the study went against conventional wisdom. The study, she argues, did not capture "the prevalence of HIV infection in people who spend little time in camps, or those who are internally displaced and do not enter a [refugee] camp" (p.2140). In addition, she highlights that the assessments referenced by Spiegel et al., were

"made several years after the conflict and the lower than expected prevalence of HIV infection could have reflected an effect of conflict on disease progression and death" (p. 2140).

The critique offered by Jewkes (2007) reiterates the point made earlier about the extreme methodological challenges of accurately assessing the relationship between conflict and STI transmission. However, for practitioners and researchers in the area of human security this is a relationship that is hard to ignore when we know the social and biological vulnerabilities of women in the war zone. The following section will expand on these vulnerabilities.

V. THE ROLE OF SEXUAL VIOLENCE IN SEXUALLY TRANSMITTED INFECTIONS

Haunting images, from place to place after place, of adolescent victims of rape, which has become as much a weapon of warfare as bullets and machete. Armed conflicts also increasingly serve as vectors for the HIV/AIDS pandemic, which flows closely on the heels of armed troops and in the corridors of conflict.

- Former UN Secretary General, Kofi Annan (2006).

In spite of the limited empirical evidence demonstrating a relationship between sexual violence and HIV, there has been a growing recognition of the link (Garcia & Watts, 2001; Rehn & Sirleaf, 2002; Jansen, 2006). It is understood among researchers, activists and humanitarian workers on the ground that conflict fuels HIV/AIDS; furthermore, sexual violence is one of the methods by which the virus is spread. Recent reports from the United Nations have confirmed that the common occurrence of SGBV carried out in the scope of armed conflict considerably increases women's vulnerability to HIV/AIDS (United Nations Economic & Social Council, 2003). Several studies have found that women who experience intimate partner violence, male control in relationships and adult sexual assault by a non-partner are associated with increased risk of HIV infection (Maman et al., 2002; Gielen & O'Campo, 2002; Dunkle et al., 2004). For example, a report by the World Health Organization (WHO) (2003) found that among the proportion of Nigerian women testing HIV positive, 31 percent were raped compared with 11 percent of women who were not.

One of the challenges of obtaining reliable information is that the scope of sexual violence in the war zone is hard to assess, mainly because of the erosion of the criminal and judicial system and the underreporting of rape. Faced with the threat of retaliation, fear of stigmatization, familial and community rejection, and feelings of shame, survivors in war are far less likely to report. Underreporting is not uncommon; a 2001 study from Timor-Leste found that only seven percent of women who had experienced physical or sexual violence during the 1999 crisis ever reported their victimisation to local authority (Hynes et al., 2004). In Rwanda, a survey

concluded that only six percent of respondents who had been raped during the genocide ever reported it or sought medical treatment (AVEGA, 1999). In Mozambique the rate of reporting was marginally higher at 8.4 percent (Cossa et al., 1994). In Sierra Leone, only eight percent of women reported warrelated sexual assault (Amowitz et al., 2002), and during the Liberian civil war only 15 percent reported either being raped, subject to attempted rape or sexual coercion (Swiss et al., 1998).

What we do know is that there are certain social and biological factors that make women more vulnerable to HIV infection. One of those risks is that women are biologically more susceptible to HIV transmission than men; this issue is explored further in the following section.

VI. THE RISK OF HIV TRANSMISSION DURING RAPE

Women are physiologically more vulnerable than men to HIV infection during unprotected heterosexual vaginal sex; the data estimate that women are twice as likely to become infected as men. Factors that contribute to this increased risk include the larger surface area of the vagina and cervix and the high concentration of **HIV** in the semen of an infected man (UNIFEM, 2005).

Due to the violent nature of rape, it is associated with a higher risk of **HIV** transmission because of the elevated exposure of non-intact mucosa caused by vaginal and anal wounds through which the virus can enter the blood stream. War rape, generally, encompasses acts of extreme brutality such as insertion of foreign objects such as rifles, genital mutilation, sexual enslavement and gang rape, and with multiple assailants comes increased sources of HIV exposure.

Another key factor in the conflict-HIV nexus is the impact of military and armed combatants; both are considered a high-risk group for both infection and transmission. As discussed earlier, within war there is the frequent disassortive mixing of the military and civilian population, and this relationship has been correlated with increased prevalence of STIs for both populations (Mock et al., 2004). In addition, during wartime, militaries commit higher rates of rape and sexual violence compared to the general population. Examples of military involvement in sexual violence during conflict abounds; for instance, during WWII the U.S. military's rape rate was 260 percent of the U.S. civilian rape rate (Morris, 1996). Consequently, a discussion on the association between conflict and HIV would be remiss without an examination of the impact and role of military and armed combatants. In the following section, I discuss the STI prevalence rate among these groups.

VII. HIV/AIDS PREVALENCE AMONG ARMED COMBATANTS

UNAIDS has stated that, on a whole, military personnel have a higher risk of STIs, including HIV. In times of peace, the STI prevalence rates among military personnel in some countries have been documented to be two to five times greater than the civilian populations, and the difference can be upwards of 50 times higher in times of conflict (UNAIDS, 1998; Radhika, 2003). Findings from comparative sexual health studies conducted in the USA, United Kingdom and France reveal that soldiers from these countries have a much higher risk of HIV infection than those in the civilian population of the same age and sex group (Radhika, 2003). Similarly, African military personnel have higher HIV prevalence rates than the general civilian population (Rehn & Sirleaf, 2002). Figures from Zimbabwe and Cameroon show that the rate of HIV infection among the military is three to four times higher than the civilian population (UNAIDS, 1998). A study among the Ugandan military in the 1990s revealed that soldiers had a HIV prevalence rate of 27 percent compared to the national adult prevalence of 9.5 percent (Save the Children, 2002). In Angola the HIV prevalence among the military was 40-60 percent to the national rate of 5.5 percent, in the Congo the prevalence was 10-20 percent to 7.2 percent, in Nigeria it was 10-20 percent to 5.8 percent, in Tanzania it was 15-30 percent and 7.8 percent, in Eritrea it was 10 percent and 2.8 percent, and in Cote d'Ivoire it was 10-20 to 9.7 percent (Radhika, 2003).

In June 2001, a report from *International Crisis Group* estimated that HIV prevalence in the South African military to be as high as 40 percent. High HIV prevalence trends were also found among other African militaries including Chad with 10.1 percent; Cameroon at 14.7 percent; and, Gabon at 5.8 percent (US Census Bureau Population Division International Program Centre, 2003). In the Democratic Republic of the Congo, where rape by combatants continues to be widespread it has been reported that 60 percent of the combatants are HIV positive (United States Institute for Peace, 2001). As for non-state combatants the risk of HIV infection is estimated to be even higher, in part because they possess little military discipline, engage in high risk behaviour and have no access to health information or services (Rehn & Sirleaf, 2002).

The reasons for the high HIV prevalence rate among the military include the age group of soldiers, the deployment of military personnel far from their homes and families, a high stress environment, and a disposal income. Conditions that facilitate an environment in which soldiers may engage in causal sex with multiple partners and engage in the commercial sex trade (Radhika, 2003). The extended periods away from home also plays a key role, studies examining populations with similar occupational travel, such as truck drivers, have also been

linked to the spread of STIs including **HIV**. This has been documented in several countries including Thailand (Podhisita, et al., 1996); Brazil (Lacerda et al., 1997), South Africa (Ramjee & Gouws, 2002), Bangladesh (Gibney et al., 2002), and China (Chen et al., 2006).

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