

# OG 5.60: HIV/AIDS and DDR

## Objectives

This module will:

- ✓ highlight the importance of including HIV/AIDS interventions in DDR programmes;
- ✓ provide guidance on planning and implementing HIV/AIDS interventions during DDR; and
- ✓ emphasize that HIV/AIDS initiatives in DDR programmes should be linked with national HIV/AIDS control programmes and strategies, and broader recovery frameworks.

## 1. Introduction

The impact of HIV/AIDS at every level of society undermines development. AIDS threatens to deplete the supply of skilled labour, reverses economic progress, overwhelms health systems and changes the demographic profile of nations.

A number of converging factors make conflict and post-conflict settings high-risk environments for the spread of HIV. The age range, mobility and risk-taking attitudes of members of armed forces and groups place them at high risk of contracting HIV. Female combatants, women associated with armed forces and groups, dependants and abductees are frequently at high risk, as sexual violence and abuse are often widespread in these settings.

Integrating HIV/AIDS initiatives into DDR programmes is necessary to meet the immediate health and social needs of participants and beneficiaries. DDR pro-

### **Box 5.60.1: UN mandate and responsibilities on HIV/AIDS**

*Security Council Resolution 1308 (2000)* stressed that, “the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security”.

*The 2001 Declaration of Commitment on HIV/AIDS*, endorsed by the UN General Assembly resolution A/RES/S-26/2, recognized that “populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular women and children, are at increased risk of exposure to HIV infection”.

In addition, the Declaration called on Member States “by 2003 to have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence forces”.

grammes offer a unique opportunity to reduce new infections and to avoid negative community responses to returning ex-combatants and their dependants because of their actual or perceived HIV status.

## 2. Planning factors affecting HIV/AIDS programmes in DDR

DDR programmes should include HIV/AIDS interventions and link them with national HIV/AIDS control programmes and strategies. During the planning process, a risk-mapping exercise and assessment of local capacities at the national and community levels need to be carried out as part of the overall situation analysis in order to profile the country's epidemic. This should include:

- qualitative and quantitative data, including attitudes of the community towards those being demobilized, and presumed or real HIV infection rates among different groups;
- the identification of risk factors, such as levels of rape, gender-based violence and 'survival sex', and cultural attitudes to condom use; and
- an inventory of both actors on the ground and existing facilities and programmes, in particular HIV voluntary counselling and testing (VCT) facilities and treatment providers.

National HIV/AIDS control programmes, where they exist, should be the first point of reference for, and key actors in, designing and running DDR HIV/AIDS programmes. The UN theme group is the main mechanism to coordinate HIV/AIDS initiatives among UN agencies. HIV advisers deployed with peacekeeping missions can help with the initial training of peer educators, provide guidance on setting up VCT facilities, and assist with the design of information, education and communication materials. They should be involved in the planning of DDR from the start.

### **Box 5.60.2: Implementing partners in HIV/AIDS initiatives**

Key HIV/AIDS implementing partners may already be working in the country, but not necessarily in all the areas where demobilization and reinsertion/reintegration will take place. To start programmes, DDR officers should consider providing seed money to kick-start projects, for example, covering the initial costs of establishing a basic VCT centre, and training counsellors in a particular area, on the understanding that the implementing partner would be responsible for the costs of running the facility for an agreed period of time.

### **2.1. Basic requirements**

The basic requirements for HIV/AIDS initiatives in DDR are:

- the identification and training of HIV/AIDS focal points in DDR regional offices;
- the development of awareness material and training;
- the provision of confidential VCT, with the routine offer of an HIV test in countries with an HIV prevalence of 5 percent or higher;
- screening and treatment for sexually transmitted infections (STIs);
- the provision of condoms and HIV post-exposure prevention (PEP) kits;
- treatment for opportunistic infections and referrals to the national health care system or appropriate non-governmental organizations (NGOs); and
- HIV/AIDS public information and awareness campaigns in receiving communities as part of general preparations for reintegration.

**Box 5.60.3: The way in which armed forces and groups are deployed affects HIV/AIDS programmes**

It may be possible to start awareness training after the peace agreement is signed but before demobilization begins if combatants are in barracks or camps. In such cases, DDR planners should design joint projects with other actors working on HIV/AIDS issues in the country.

## 2.2. Organizational structure

The organizational structure of DDR programmes should take into account the need to oversee HIV/AIDS initiatives in DDR. Options include a central dedicated (but mobile) unit to coordinate HIV/AIDS issues; the establishment of focal points in each region; and the secondment of experts from partner agencies, NGOs or the national HIV/AIDS control programme. All DDR practitioners working at regional and/or local offices should be trained in HIV/AIDS awareness.

Specific expertise is needed in HIV/AIDS training, counselling and communication strategies, in addition to medical personnel to implement programmes. Teams should include both men and women, because the HIV/AIDS epidemic has specific gender dimensions, and it is important that prevention and care are carried out in close coordination with gender officers.



### OG and IDDRS 5.10 on Women, Gender and DDR



*When the time allotted for a specific DDR phase is very limited or has been reduced, the planned HIV/AIDS programme should not be dropped, but should be included in the next DDR phase. DDR planners must work with national HIV/AIDS control programmes and strategies, and must be transparent about the limitations of any DDR-specific HIV/AIDS initiatives. Programmes should seek to strengthen – not duplicate – existing capacity.*



**Do you need more detailed guidance on how to plan HIV/AIDS interventions in emergency settings? See Annex B of IDDRS 5.60 on HIV/AIDS and DDR.**

### 3. HIV/AIDS initiatives during demobilization

Demobilization is often a very short process, in some cases involving only reception and documentation. During cantonments of five days or more, awareness sessions, voluntary counselling and testing should be provided during demobilization. While cantonment offers an ideal environment to train and raise the awareness of a ‘captive audience’, there is a general trend to shorten the cantonment period and instead carry out community-based demobilization. Usually, most HIV/AIDS initiatives will take place during the reinsertion phase and the longer process of reintegration.



*Men and women, and boys and girls should be included in all HIV/AIDS initiatives. Standard definitions of the ‘sexually active age’ often do not apply in conflict settings. Child soldiers, for example, may take on adult behaviours, which can extend to their sexual behaviour, and children of both sexes can also be subject to sexual abuse. Programmes should be designed and implemented in close coordination with child protection officers.*



#### OG 5.30 on Children and DDR

Table 5.60.1 shows HIV/AIDS initiatives that should be undertaken during demobilization:

**Table 5.60.1: HIV/AIDS initiatives during demobilization**

<p><b>Planning of cantonment sites</b></p>	<ul style="list-style-type: none"> <li>■ Ensure that the safety and protection of women, girls and boys is taken into account in the planning of cantonment sites and interim care centres (ICCs), to reduce the possibility of sexual exploitation and abuse.</li> <li>■ Plan medical screening facilities to ensure privacy.</li> <li>■ Provide an enclosed space for HIV testing and counselling (laboratory facilities are not required).</li> </ul>
<p><b>HIV/AIDS awareness training</b></p>	<ul style="list-style-type: none"> <li>■ Provide HIV/AIDS awareness training, covering the basic facts of HIV transmission and prevention methods and debunking common myths.</li> <li>■ Develop education and communication materials that are sensitive to the local culture, customs and levels of literacy (using local languages and pictures).</li> <li>■ Make available separate training for men and women, and special training in ICCs for children, in consultation with child protection officers.</li> <li>■ Initiate peer education programmes during extended cantonment periods of four weeks or more, to be continued during reinsertion. This involves training and supporting a small group with the same background, experience and values to share knowledge and influence individual and group behaviour patterns.</li> </ul>

<b>Syndromic management of STIs</b>	<ul style="list-style-type: none"> <li>■ Include screening and treatment for STIs as a standard component of health screening for participants.</li> <li>■ Encourage individuals with an STI to bring their partners so that both can receive treatment in order to prevent re-infection.</li> </ul>
<b>HIV counselling and testing</b>	<ul style="list-style-type: none"> <li>■ Ensure that any HIV test is confidential and based on informed consent, and that providers are transparent about benefits and options. (Even if treatment is not available, HIV-positive individuals can be provided with nutritional and other health advice to reduce the risk of opportunistic infections.)</li> <li>■ Encourage pregnant women to find out their HIV status, as this may affect the health of their baby. During counselling, information on mother-to-child transmission, including short-course anti-retroviral (ARV) therapy and guidance on breastfeeding, can be provided.</li> </ul>
<b>Provision of condoms</b>	<ul style="list-style-type: none"> <li>■ Provide male and female condoms, and information regarding their correct use, during cantonment/demobilization and as part of transitional assistance. Link the introduction of female condoms with national/local initiatives.</li> <li>■ Provide a range of contraception options.</li> </ul>
<b>Provision of post-exposure prophylaxis (PEP) kits</b>	<p>PEP is treatment to reduce the chances of sero-conversion (when a person becomes HIV-positive) after occupational exposure to infected body fluids, such as a needle-stick injury, or because of rape.</p> <ul style="list-style-type: none"> <li>■ Ensure that the treatment is administered by a qualified health care practitioner, as it involves taking high doses of anti-retrovirals (ARVs) for 28 days.</li> <li>■ Ensure treatment is started within 2 to 72 hours of the possible exposure.</li> </ul>



*Undergoing an HIV test cannot be a condition for participation in the DDR process or eligibility for any programme. The confidentiality of test results shall be assured. Planners, however, should be aware of any national legislation, such as policies on testing at recruitment into the armed forces and the types of HIV tests that are approved by the national health sector.*

#### **Box 5.60.4: Counselling and testing**

*Counselling:* Counselling is generally offered before and after an HIV test in order to help individuals make an informed decision about whether they want a test, understand their risk behaviour and cope with a possible positive result.

- *Pre-test counselling* is ideally provided on an individual basis, but can be provided in group settings with individual follow-up (providers must ensure that individuals understand the implications of an HIV test before undergoing the test).

- *Post-test counselling* should be given on an individual basis. HIV-positive individuals should be encouraged to bring their partners in for testing.

*Testing:* In countries with an estimated HIV prevalence of 5 percent or more, testing, with counselling and informed consent, should be systematically offered as part of the standard health checks for ex-combatants.

- Rapid tests can give a result in approximately 30 minutes.
- HIV-positive results need to be confirmed to rule out 'false positives'. If local laboratory facilities do not exist, a combination of two further different rapid tests should be used to confirm an HIV-positive result.
- HIV-positive individuals should be referred to treatment options in the national health care system or provided by NGOs.



**For more detailed information on HIV initiatives during demobilization, see section 8 of IDDRS 5.60 on HIV/AIDS and DDR; and on HIV counselling and testing, see section 8.4 of IDDRS 5.60 on HIV/AIDS and DDR.**

## 4. Reinsertion and reintegration

Reinsertion and reintegration are key phases in which to address HIV/AIDS, particularly to train peer educators and to counter stigma and discrimination in communities. Table 5.60.2 shows HIV/AIDS initiatives that should be undertaken during reinsertion and reintegration:

**Table 5.60.2: HIV/AIDS initiatives during reinsertion and reintegration**

### Planning and preparation in receiving communities

- Start HIV/AIDS initiatives in receiving communities in advance of reinsertion and reintegration.
- Ensure a balance in services so that communities do not think that ex-combatants are receiving preferential treatment.
- The DDR programme should plan and budget for the following community initiatives:
  - *Community capacity enhancement:* This involves HIV/AIDS training and support for community forums to talk openly about HIV/AIDS and related issues of stigma, discrimination, gender and power relations. This enables communities to better define their needs and address concerns;
  - *Public information programmes:* Public information campaigns should raise awareness among communities, but avoid stigmatizing any groups;
  - *Training and funding of HIV/AIDS counsellors:* Based on an assessment of existing capacity, this could include local medical personnel, religious leaders, NGOs and community-based organizations (CBOs).

<b>Peer education programme</b>	<ul style="list-style-type: none"> <li>■ Initiate peer education programmes during the reinsertion phase (or continue programmes from the demobilization phase), and maintain capacity through refresher courses.</li> <li>■ Include both DDR participants and communities in peer education sessions.</li> </ul>
<b>VCT</b>	<ul style="list-style-type: none"> <li>■ VCT should be available in communities during the reinsertion and reintegration phases. Mechanisms include free-standing sites, VCT services integrated with other health services, VCT services provided within already established non-health care locations and facilities, and mobile/outreach VCT services.</li> </ul>
<b>Condoms and PEP kits</b>	<ul style="list-style-type: none"> <li>■ Male and female condoms should continue to be provided to the target groups during the reinsertion and reintegration phases, but this process should link with, and ultimately hand over to, national/local initiatives to provide condoms.</li> <li>■ DDR planners should work together with local initiatives to provide PEP kits, especially in cases of rape.</li> </ul>
<b>Vocational training</b>	<ul style="list-style-type: none"> <li>■ Poverty reduction initiatives, including income generation and vocational training programmes, are vital parts of overall community reconstruction, and also contribute to reducing the social risk factors for HIV transmission.</li> </ul>
<b>Caring for people living with AIDS</b>	<ul style="list-style-type: none"> <li>■ Provide support to existing medical and hospice facilities, linking up with national and local programmes, with referrals for families caring for ex-combatants with AIDS. Overall, the burden of care in communities tends to fall on women, who will already be facing an increased burden of care with the return of ex-combatants. This will make the overall support and absorption of ex-combatants into civilian life more complicated.</li> </ul>



*Selection of peer educators: It is important to identify whether ex-combatants and those associated with armed forces and groups may be stigmatized or feared within the communities. They should not be selected as peer educators if involving them in HIV/AIDS training will increase stigmatization and therefore undermine reintegration efforts. The selection of peer educators should be based on an assessment of an individual's skills and personal profile, and should also consider the different phases of a programme. Furthermore, it cannot be assumed that all those trained will be sufficiently equipped to become peer educators. Trainees should be individually evaluated and supported with refresher courses in order to maintain levels of knowledge and tackle problems that may arise.*



**For more detailed information on dealing with HIV/AIDS during reinsertion and reintegration, see section 9 of IDDRS 5.60 on HIV/AIDS and DDR.**

## 5. Monitoring and evaluation

To monitor the progress and impact of HIV/AIDS initiatives, it is recommended that planners include process indicators, such as the provision of condoms and the number of peer educators trained and maintained, and outcome indicators, like STI incidence by syndrome and the number of people seeking VCT. The indicators used should be harmonized with national indicators.



**For more general information on monitoring and evaluation, see OG 3.50 on Monitoring and Evaluation of DDR Programmes.**

### **Box 5.60.5: HIV/AIDS and UN personnel**

*Universal precautions and training for UN personnel:* Universal precautions shall be followed by UN personnel at all times. There is a standard set of procedures to be used in the care of all patients or at accident sites in order to minimize the risk of transmission of blood-borne pathogens, including, but not exclusively, HIV. All UN personnel shall be trained in basic HIV/AIDS awareness and prevention.



**Do you know how to design and carry out HIV/AIDS initiatives? See the Inter-Agency Standing Committee Guidelines for HIV/AIDS Interventions in Emergency Settings (<http://www.unfpa.org>).**

## 6. Summary of key guidance on HIV/AIDS and DDR

- ✓ It is essential to link DDR HIV/AIDS initiatives to national control HIV/AIDS programmes and strategies and local initiatives at the community level.
- ✓ It is essential to be transparent about the limitations of what can be offered specifically as part of the DDR programme, and initiatives should build on existing capacity.
- ✓ Targeted awareness strategies and the provision of HIV voluntary confidential counselling and testing are essential throughout the demobilization, reinsertion and reintegration phases.
- ✓ Communities should be informed and sensitized about HIV/AIDS before the DDR programme begins, and communication strategies should be designed not to increase stigma or discrimination.