The Responsibility of the Security Council in the Maintenance of International Peace and Security: HIV/AIDS and International Peacekeeping Operations

Summary

This Non Paper should be read in conjunction with the 2011 UNAIDS/DPKO Report on United Nations Security Council Resolution 1308, ***On the Front Line: A Review of Programs that address HIV among international peacekeepers and uniformed services****. It serves as a background document for the UN Security Council discussion on UNSC Resolution 1308 and to the Security Council's intention, expressed in S/PRST/2005/33, to contribute, within its competence, to the attainment of the relevant objectives in the declaration adopted at the twenty-sixth special session of the General Assembly and in its follow-up to resolution 1308 (2000) on HIV/AIDS and international peacekeeping operations. The Paper provides an assessment of key factors shaping the risk environment into which peacekeeping operations have been deployed since the Council's first resolution on HIV/AIDS and international peacekeeping operations, 1308 (2000). It further assesses obstacles encountered and identifies new opportunities to strengthen HIV prevention and the response in the context of UN actions to prevent conflict and build peace. Finally, it proposes a new framework for ensuring accountability, leadership and action on HIV in peacekeeping and peacebuilding.*[1]

1 The assessment of obstacles encountered opportunities to strengthen HIV and AIDS prevention and response is based on the Secretary General's report to the High Level Meeting S/XXX, and the 2011 UNAIDS/DPKO Report on United Nations Security Council Resolution 1308, *On the Front Line: A Review of Programs that address HIV among international peacekeepers and uniformed services.* It also takes into account the findings of an initiative referred to in earlier discussions of the Council (S/PV.5220 pg 7), supported by the Netherlands, together with Australia, Canada, Sweden, and UNAIDS: HIVAIDS, *Security and Conflict: New Realities*, New Responses (S/2011/xxxx).

UNAIDS (English original, May 2011)

UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative United Nations partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment, care and support.

CONTENTS

ACRONYMS

AIDS	Acquired immune Deficiency Syndrome
ASCI	AIDS Security and Conflict Initiative
BCC	Behavioral Change Communications
CHAO	Chief HIV/AIDS officers (DPKO)
DDR	Disarmament Demobilization and Reintegration
DFS	United Nations Department of Field Support
DHAPP	United States Department of Defense HIV/AIDS Prevention Programme
DPKO	United Nations Department of Peacekeeping Operations
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
MINURCAT	United Nations Mission in the Central African Republic and Chad
MINUSTAH	United Nations Stabilization Mission in Haiti
MONUC	United Nations Organization Mission in the Democratic Republic of the Congo
NGO	Nongovernmental organization
PEP	Post Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
SEA	Sexual Exploitation and Abuse
S/PRST	United Nations Security Council Presidential Statement
SSR	Security Sector Reform
STI	Sexually Transmitted Infection
T/PCC	Troop/police contributing countries
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAMID	African Union/United Nations Hybrid operation in Darfur
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNMIS	United Nations Mission in the Sudan
UNMIT	United Nations Integrated Mission in Timor-Leste
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counseling and Testing
WFP	World Food Programme
WHO	World Health Organization

BACKGROUND

1. This Non Paper is a contribution to the Security Council's intention, expressed in S/PRST/2005/33, to contribute, within its competence, to the attainment of the relevant objectives in the declaration adopted at the twenty-sixth special session of the General Assembly and in its follow-up to resolution 1308 (2000) on HIV and international peacekeeping operations. The Paper provides an assessment of key factors shaping the risk environment into which peacekeeping operations have been deployed since the Council's first resolution on HIV and international peacekeeping operations, 1308. It further assesses obstacles encountered and identifies new opportunities to strengthen HIV prevention and the response in the context of UN actions to prevent conflict and build peace. Finally, it proposes a new framework for ensuring leadership, action and accountability on HIV in peacekeeping and peacebuilding.

2. Ten years ago, it was with urgency that world leaders declared their commitment to address one of the most formidable challenges to human life and dignity that had already claimed some 22 million lives, three quarters of them in Africa. Security Council Resolution 1308 (2000), adopted on 17 July 2000, is the first to ever address a global public health threat to international peace and security. Bearing in mind the Council's primary responsibility for the maintenance of international peace and security, the resolution recognizes that the AIDS epidemic is exacerbated by conditions of violence and instability and further stresses that the epidemic, if unchecked, may pose a risk to stability and security.

3. Over the following ten years, both the Security Council and the General Assembly continued to address HIV within their respective areas of competence. On 27 June 2001, the Security Council adopted a Presidential Statement (PRST/2001/16) recognizing the need to reduce the negative impact of conflict and disasters on the spread of HIV, and to develop the capacity of peacekeepers to become advocates and actors for awareness and prevention of HIV transmission, including through the deployment of chief HIV officers/advisers and the revision, as required, of relevant codes of conduct.

4. Also on 27 June 2001, the General Assembly adopted an historic Declaration of Commitment on HIV/AIDS (A/RES/S-26/2) that specifies time-bound commitments to, inter alia; intensify national and international efforts to reduce the impact of conflict and disasters on the spread of HIV. Significantly, the Declaration also recognizes the increased risks of exposure among populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and, in particular, women and children. Later, in 2006, the General Assembly adopted the Political Declaration on HIV/AIDS (A/RES/60/262) in which Heads of State and Government and representatives of States and Governments recognized that HIV constitutes a global emergency and poses one of the most formidable challenges to the development, progress and stability of societies and the world at large, and requires an exceptional and comprehensive global response.

5. In 2004, the Report of the High-level Panel on Threats, Challenges and Change (A/59/565) recommended that the Security Council, working closely with UNAIDS, host a second special session on HIV as a threat to international peace and security, to "explore the future effects AIDS on States and societies, generate research on the problem and identify critical steps towards a long-term strategy for diminishing the threat."

6. A second session was convened on 18 July 2005 during which the Security Council adopted a Presidential Statement (S/PRST/2005/33) encouraging member states to prepare their personnel to participate in peacekeeping operations using best practices in HIV and AIDS education, prevention, awareness, countering stigma and discrimination, voluntary and confidential counseling and testing as well as treatment, care and support. Significantly, the Statement recognizes the role of peacekeeping operations in addressing the risks posed by HIV to vulnerable communities in post-conflict environments and welcomes actions taken by the United Nations Secretary-General and United Nations Peacekeeping Operations to integrate HIV awareness into their mandated activities and outreach projects. It also urges that particular attention is paid to the gender dimensions of HIV.

7. Since 2005, some 186 reports of the Secretary General to the Security Council have included information about actions taken on HIV in the context of international peacekeeping operations spanning 20 countries of concern on the Council's agenda, and in relation to thematic priorities on the Protection of Civilians, Children and Armed Conflict, Sexual Exploitation and Abuse, Conflict-Related Sexual Violence, Durable Peace in Africa, Women and Peace and Security, Regional and Sub-Regional issues, and Post-Conflict Peacebuilding. These reports provide a basis for the assessment provided in this Paper, of obstacles encountered and new opportunities to strengthen HIV prevention and response in peacekeeping and peacebuilding. It is also informed by the 2006 Political Declaration on HIV/AIDS by UN Member States that recognized the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention, treatment, care and support by 2010, and by the Secretary General's report to the High Level Meeting S/XXX, and the 2011 UNAIDS/DPKO Report on United Nations Security Council Resolution 1308, On the Front Line: A Review of Programs that address HIV among international peacekeepers and uniformed services. It also takes into account the findings of an initiative referred to in earlier discussions of the Council (S/PV.5220 pg 7), supported by the Netherlands, together with Australia, Canada, Sweden, and UNAIDS: HIV/AIDS, Security and Conflict: New Realities, New Responses (S/2011/XXX).

8. Zero new HIV infections, zero discrimination and zero AIDS-related deaths represents UNAIDS long-term vision in informing strategic actions targeting security and peace keeping operations.

I. Introduction

Resolution 1308 (2000) should be... well known….and it should be fully implemented. It should not be the end of the process, but only a cornerstone for future.

I have elsewhere called it the most important and biggest problem in the world today… if we do not address AIDS, it will go on and on. Because of the long incubation period of the disease, because of the stigma attached to it and because of the its spread, it will kill more people and undermine more societies than even the worst conflicts that we deal with here.

Richard Holbrooke
Statement to the Security Council
on the Impact of AIDS on Peace and Security in Africa
10 January 2000

9. Since the beginning of the AIDS epidemic, more than 60 million people have been infected with HIV. In 2010, HIV prevalence remains high among those countries and regions affected by conflict. Sub-Saharan Africa continues to shoulder the disproportionate burden with 68% of the 33.3 million adults and children living HIV. Africa represents the region with the highest number of new infections and the least access to HIV prevention, treatment, care and support. At the end of 2009, a mere 37% of people eligible for treatment in low and middle-income countries have access to life saving medicines. No conflict on the agenda of the Security Council has resulted in such widespread devastation as has HIV.

10. Over the past ten years, the rapidly changing landscape of demographic crises and conflicts throughout the world have reshaped these challenges and elevated the need for a new response to AIDS in the context of United Nations actions to prevent conflict, promote security and build peace. Each of the concerns expressed in the Security Council's Resolution 1308 (2000) on HIV/AIDS and international peacekeeping persist today: the severity of the crisis in Africa in particular (SC/6781); the potential damaging impact on international peacekeeping personnel; the implications for vulnerable populations in emergencies and post-conflict environments; and its gender dimensions. These challenges are compounded by threats to governance and stability as demands for rights and access to services for people living with HIV and people most vulnerable increase in the face of social and legal exclusion and limited resources.

11. As understanding of the epidemic, its variation within and across geographic and cultural settings has deepened, new obstacles and new opportunities to strengthen HIV prevention, care, treatment and support have been identified. Biomedical advances in the development of antiretroviral treatment and the changing financial and institutional arrangements for AIDS have created the possibility of achieving the United Nations' goal of universal access to HIV prevention, treatment, care and support. Section III of this paper identifies key factors, over the past five years, that have reshaped the impact of AIDS on international peace and security and the environment of prevention: (1) gender relations, human rights and inequalities; (2) conflict-related sexual violence; (3) the protection environment and post-conflict transitions; (4) regional and trans-border dynamics; and (5) the growing role of private military contractors.

12. The diverse threats posed by AIDS to human security and to national and international security, can be ameliorated. But this will require a frank assessment of the challenges encountered in meeting the needs of peacekeeping personnel and conflict-affected communities. Section IV

assesses progress made and obstacles encountered in implementing Security Council actions on AIDS in relation to national uniformed services, peacekeeping personnel, and international peacekeeping and peacebuilding operations.

13. The framework by which the Security Council can strengthen its response to AIDS must now be updated to reflect the new challenges and opportunities arising within the context of its commitments to improve responses to the potential damaging impact of HIV on the health of international peacekeeping personnel, including support personnel, and reduce risks to civilians in conflict. Section V of this Paper proposes a new framework for assessing and responding to the threats posed by HIV for international peace and security, in armed conflicts and their aftermath. It builds on previous commitments made and takes into account the mutually reinforcing nature of other relevant actions/commitments by the General Assembly and the Security Council including the 2001 Declaration of Commitment, the 2006 Political Declaration and the conclusions of the 2011 High Level Meeting (Political Declaration A/RES/60/262 paras 373, 30, 31, 37).

14. The Paper outlines six principal commitments that will be required to meet these challenges and ensure accountability across a broad spectrum of leadership, including by member states and troop contributing countries, militaries, police and other uniformed services, peacekeeping and peacebuilding operations, regional organizations, the UN system, NGOs and civil society: (1) to scale up prevention, treatment, care and support programs among peacekeeping personnel and other uniformed services; (2) to strengthen prevention, treatment, care and support programs among troop contributing countries and in the context of post-conflict transitions; (3) to address the specific risks and opportunities for HIV prevention, treatment, care and support in armed conflicts and post-conflict transitions; (4) to address sexual violence and HIV prevention in armed conflict and its aftermath; (5) to address the regional dimensions of risk and response; and (6) to improve information collection, monitoring and reporting.

II. HIV, Security and Conflict: Assessing the Risk Environment

15. In Resolution 1308 (2000), the Security Council identified conditions in which violence and instability increase HIV exposure risks, including through large movements of people, widespread uncertainty over conditions, and reduced access to HIV prevention, treatment, care and support. Although these factors are still relevant today, much more has been learned about the deadly nexus linking HIV, conflict and insecurity, and its implications for the risk environment into which UN peacekeeping operations are deployed. This paper draws attention to four important dimensions of risk that have yet to be adequately factored into HIV prevention and response in peacekeeping environments: (1) transborder and regional dynamics; (2) the protection environment and post-conflict transitions; (3) gender relations and human rights concerns; and (4) conflict-related sexual violence.

TRANSBORDER, REGIONAL DYNAMICS AND GOVERNANCE

16. Since the Security Council's first engagement on AIDS in Africa, the sub-Saharan region continues to account for the highest percentage of people living with HIV. Would the international response have been so slow if AIDS had reduced life expectancy by 30 years in non-African countries?

Although this question, posed in 2004 by the High-level Panel on Threats, Challenges and Change (A/59/565) is still relevant today, its conclusions are not: "The experience of some countries shows that properly funded and institutionalized efforts can yield remarkable successes in the fight against AIDS. By contrast, where Governments have refused to acknowledge the gravity of the threat and failed to address the problem, countries have experienced a dramatic turn for the worse and international efforts to address the problem have been hampered. Leaders of affected countries need to mobilize resources, commit funds and engage civil society and the private sector in disease-control efforts." (OP65-66).

17. While it is true that well funded institutionalized efforts can and do make a significant difference, political will is not the only determinant of success or failure. Other demographic factors, poverty, crises and HIV itself will also impinge on state capacities to respond to AIDS related losses among skilled human resources and the additional demands on already over-burdened health systems. In 2010, 90% of new HIV infections among children and about 70% of the world's AIDS-related deaths took place in sub-Saharan Africa, a region that hosts most of the world conflicts and has only 0.1 doctors, 0.6 nurses and midwives per 1000 population.

18. AIDS is fundamentally transforming family survival and cohesion and increasing demands for governments to deliver social protection and basic services. In situations of armed conflict and natural disasters, where governments may be unable or unwilling to provide appropriate HIV prevention, treatment, care and support, these impacts may be felt even more profoundly. For the most part, people living with and most affected by HIV, particularly in conflict and post-conflict situations, are not receiving access to life saving treatment, HIV prevention, care and support. New HIV infections and AIDS-related mortality and morbidity continue to be most prevalent among children and people at peak productive and reproductive ages. The radical implications for life expectancy at birth will continue to intensify human resource constraints across all sectors – public, private, non-governmental and military - where skills and labor are not easily replaced.

19. The impacts between effective governance and HIV are both reciprocal and mutually reinforcing: AIDS-related morbidity and mortality have an impact on, and are influenced by state capacity to deliver basic services (including HIV prevention, treatment, care and support); as well as the effectiveness of security institutions, the accountability of local governance, the operational capacity and effectiveness of security institutions and the engagement of civil society. Absent indicators that reflect these direct and indirect impacts, the dynamics linking HIV with state capacity will continue to be underestimated, if not rendered completely invisible.

20. Some aspects of state functioning are remarkably resilient in the face of crises, and especially epidemic diseases which are long wave events that evolve over time and which disproportionately impact people with the least access to resources. Data from the 2009 AIDS Epidemic Update draw attention to the persistent failure to match national AIDS strategies with the substantial diversity of epidemics within and across countries.

21. Although it is also true that national and international responses to AIDS can strengthen aspects of government capacity, feedback loops make it extremely difficult to discern any causal links. Although the need to address HIV and AIDS in humanitarian assistance and post-conflict transitions is increasingly recognized, the processes and mechanisms are often poorly defined. In practice, funding gaps are typically pronounced during the most critical moments of need.

22. State responsiveness to demand for effective HIV prevention, treatment, care, and support, especially in countries most affected by the epidemic, and their ability to respond to claims of participation from people affected or vulnerable to HIV is instrumental to securing stability and addressing potential social and community unrest. As the language of rights and entitlements is increasingly invoked by people living with HIV, health experts and activists in the context of health and HIV, governments must ensure that their responses to the epidemic are based on a framework of participation and inclusiveness and address exclusion and marginalization.

23. Although the central message of HIV prevention is to tailor prevention strategies to local needs and decentralize responses, it is precisely at the local level where the greatest weaknesses are seen, especially in conflict affected countries, namely on local government's ability to both represent its constituencies and deliver services to meet growing demands. Even with additional resources, decentralization processes promoted by international financial and development institutions may further exacerbate these limitations. In the absence of accountable and functional governance structures, international institutions and networks, non-governmental organizations, the private sector, individuals and armed groups may take on some of these 'domestic' state functions, creating forms of governance that transcend borders and official regulatory mechanisms. Where there are significant leadership vacuums and capacity constraints this may, in some cases, lead to corrupt practices.

24. The globalization of markets, trade, investment and labor have created ample conduits for transnational organized crime, maritime piracy, and the trafficking in weapons, drugs and human beings, including children and women. These issues are of mounting concern for the Security Council. In his report on peacebuilding in the immediate aftermath of conflict (S/2010/386), the Secretary General draws attention to the increased risks posed by organized crime and trafficking networks to the stability of State institutions and to the entire justice and security architecture in countries recovering from conflict or other crises. In some cases, criminal groups work against the state and profit from instability. Symbiotic relationships between antigovernment forces and criminal groups are, or have been, evident in many conflict or post conflict situations, including the Andean region, Afghanistan, the Balkans, the Caribbean, the Caucasus, Central America, Central Asia, the Horn of Africa, Southeast Asia and parts of West Africa.

25. New trafficking routes that result from the spread of these networks and conflict may also fuel injecting drug use, which is illegal in most countries and often follows the drug trade. This is a major driver of HIV transmission, especially in Eastern Europe and parts of Asia. In South East Asia, analyses of distinct strains of HIV have been associated with different heroin trafficking routes, that are also commonly associated with sex trafficking. The risks of HIV transmission, especially in epidemics concentrated among people who inject drugs and sex workers, are influenced by law enforcement practices and by the people who control sex work, including pimps, "protectors", traffickers and long-term clients. The previously underestimated role of some groups of law enforcement personnel as core group transmitters or maintaining populations has been recently highlighted (ASCI, 2009).

26. Although HIV prevention efforts have neglected police and other law enforcement and uniformed services, including customs, immigration, corrections and maritime, some peacekeeping missions have begun to address these phenomena. This year, the United Nations Mission in Timor Leste initiated capacity-building programs in the areas of gender awareness, domestic violence and human trafficking, providing training for 340 UNMIT police and civilian staff (S/2011/32). And MINUSTAH is addressing its specific monitoring and reporting responsibilities with respect to child trafficking, HIV and gender equality (S/2010/200). In Abkhazia, Georgia, the Norwegian Refugee Council carried out six training courses on gender/trafficking and HIV awareness in five district schools (S/2007/15).

THE PROTECTION ENVIRONMENT IN EMERGENCIES AND POST-CONFLICT TRANSITIONS

27. Resolution 1308 (2000) and PRST/2005/33 recognize the important role of peacekeeping operations in integrating HIV awareness into their mandated activities and outreach projects for vulnerable communities in post-conflict environments. Indeed, enhancing the protection of civilians in armed conflict is at the core of the work of the United Nations Security Council in maintaining international peace and security. Ensuring access to life saving HIV prevention, treatment, care and support services for people living with HIV and people vulnerable to HIV forms part of this protection mandate. But much more than outreach is required to meet the HIV related protection needs of civilians affected by conflict and in post-conflict transitions.

28. As far back as 2005, the Secretary-General's report on the protection of civilians (S/2005/740) associates increased incidence of HIV and the spread of epidemic diseases with the "breakdown of basic services and infrastructure as well as in the disruption or loss of livelihoods." HIV risk is also shaped by uneven access to essential commodities, including male and female condoms, post-exposure prophylaxis (PEP), sterile injecting equipment, harm-reduction efforts related to drug use, expanded access to voluntary and confidential counseling and testing, safe blood supplies, and early and effective treatment of sexually transmitted infections (A/RES/60/262: 22). Similarly, conflicts and disasters may disrupt access to sufficient, safe and nutritious food, access to antenatal care, effective treatment for women living with HIV including counseling and testing, access to treatment and, where appropriate, access to antiretroviral medicines for the prevention mother-to-child transmission of HIV, and a continuum of care; (A/RES/60/262: 27-28).

29. Despite the obligation of all parties to conflict to "respect and protect, the wounded and sick…and to provide, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition without distinction" (PRST/2009/1), essential HIV related health services and commodities are not systematically made available in the context of humanitarian action and peacekeeping. Nor is the social and legal environment typically supportive of and safe for voluntary disclosure of HIV status (A/RES/60/262: 25) and in overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and other services (A/RES/60/262: 24). As a result, local communities in peacekeeping environments often rely on the good will of contingents with medical support facilities.

30. In the absence of core government functionality during or in the aftermath of conflict, sustained attention and resources are needed to ensure basic safety and security and access to essential services. These must be responsive to the complexities of context, increased population mobility, the demobilization of combatants, disruptions in humanitarian provision to displaced persons and refugees in camp settings, and the overload of health and social services in areas of population return. In some camp settings, refugees may have received greater levels of protection, humanitarian support and HIV prevention, treatment, care and support. During return and resettlement, however, lapses in provisioning of health services and antiretroviral treatment may result in new forms of drug-resistance and viral strains.

31. Post-conflict transitions are both a period of heightened vulnerability to HIV transmission and a neglected element in AIDS policy and programming (Progress report UNDPKO and UNAIDS, 2011). Similarly, HIV is a neglected element of post-conflict peacebuilding and has yet to be reflected

in the Security Council's recent actions on post-conflict peacebuilding or as an aspect of policies relevant to the reconstruction of conflict-affected communities and empowerment of affected people, in particular, vulnerable civilians, such as children, the elderly, refugees and internally displaced persons.

32. Although the Security Council recognizes the importance of socio-economic development for the consolidation of peace, and the provision of basic services as among the early peace dividend that can be delivered, the Review on Civilian Capacity in the aftermath of conflict (S/2011/85) consistently overlooks capacity gaps in the delivery of basic social services, both within international support and as a core government function. While the Review does look at capacity needs in relation to the rapid economic changes associated with post-conflict peacebuilding, including urbanization, investments in mining, infrastructure and transportation, the associated risk of HIV transmission remains unaddressed in proposed strategies for strengthening national and international capacities in these areas.

33. Post-conflict peacebuilding, disarmament, demobilization and reintegration programmes are an important and highly underutilized opportunity for HIV prevention, treatment, care and support, especially among military and extended families and women and children associated with armed forces. The time, capacity and resources to tailor HIV interventions to different circumstances and different needs among armed forces and groups are often inadequate. Children associated with armed forces and groups are often sexually active at a much earlier age and face increased risks of exposure to sexual violence and HIV. Female combatants, abductees and dependants are also high risk given widespread sexual violence and abuse, children born of rape and the challenges of reintegrating into their communities. The consequence is that demobilized men and women are not given the basic tools for HIV prevention, much less used as peer educators or messengers for HIV policies and programmes.

GENDER RELATIONS AND INEQUALITIES IN CONFLICT AFFECTED SITUATIONS

34. The overall expansion of the AIDS epidemic and its disproportionate impacts continue to accelerate, particularly in sub-Saharan Africa, where 76% of all women living with HIV are found and 13 women become infected for every 10 men (UNAIDS, 2010). According to the 2010 UNAIDS Report on the Global AIDS Epidemic, this imbalance reflects "not only the heightened physiological vulnerability of girls and young women, but also a high prevalence of intergenerational sexual partnerships, the lack of woman-initiated prevention methods and broader social and legal inequality that impedes the ability of young women to reduce their sexual risk." According to UNAIDS, the disparities are even more extreme in many conflict-affected regions where "gender inequalities and all forms of violence against women and girls increase their vulnerability to HIV" (Figure 1). HIV prevalence among young women 15-24 is typically much higher than among young boys in the same age group in conflict affected countries (figure 1).

35. Yet not enough progress has been made in addressing the gender dimensions of the epidemic– in situations of peace or conflict - or in fulfilling commitments made in the 2001 Political Declaration on HIV/AIDS to, inter alia, "eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and the provision of full access to comprehensive information and education; ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence…" (A/RES/60/262).

Figure 1 HIV prevalence among young women and men in conflict affected countries (2009)

	Prevalence Young Male (15-24) (%)		Prevalence Young Female (15-24) (%)	
Country	Estimate	[low-high estimate]	Estimate	[low-high estimate]
Haiti	0.6	[0.4 - 0.8]	1.3	[1.0 - 1.8]
Somalia	0.4	[0.3 - 0.7]	0.6	[0.4 - 1.1]
Sudan	0.5	[0.4 - 0.7]	1.3	[0.9 - 1.8]
Papua New Guinea	0.3	[0.2 - 0.5]	0.8	[0.6 - 1.2]
Angola	0.6	[0.4 - 0.9]	1.6	[1.1 - 2.2]
Burundi	1.0	[0.8 - 1.2]	2.1	[1.6 - 2.7]
Central African Republic	1.0	[0.6 - 1.4]	2.2	[1.4 - 3.1]
Chad	1.0	[0.7 - 2.0]	2.5	[1.7 - 5.2]
Congo	1.2	[0.9 - 1.6]	2.6	[2.1 - 3.6]
Côte d'Ivoire	0.7	[0.5 - 1.1]	1.5	[1.1 - 2.3]
Democratic Republic of the Congo	...	[0.4 - 0.6]	...	[0.9 - 1.5]
Eritrea	0.2	[0.1 - 0.3]	0.4	[0.2 - 0.7]
Liberia	0.3	[0.1 - 0.5]	0.7	[0.2 - 1.2]
Mozambique	3.1	[2.4 - 4.4]	8.6	[7.0 - 12.1]
Namibia	2.3	[1.3 - 3.6]	5.8	[3.7 - 8.6]
Rwanda	1.3	[0.9 - 1.6]	1.9	[1.3 - 2.3]
Sierra Leone	0.6	[0.3 - 1.0]	1.5	[0.9 - 2.5]
South Africa	4.5	[4.1 - 5.0]	13.6	[12.3 - 15.0]
Uganda	2.3	[1.8 - 2.8]	4.8	[4.0 - 6.4]
Zimbabwe	3.3	[2.5 - 4.4]	6.9	[5.3 - 9.3]

Source: Data from UNAIDS 2010 report

36. The Security Council has drawn attention to many of the same factors in its own work to increase the protection of women and girls in conflict-affected situations and to strengthen their role in peacebuilding. In its Resolution 1889 (2009) op.10, the Council "encourages Member States in post-conflict situations, in consultation with civil society, including women's organizations, to specify in detail women and girls' needs and priorities and design concrete strategies, in accordance with their legal systems, to address those needs and priorities, which cover inter alia support for greater physical security and better socio-economic conditions, through education, income generating activities, access to basic services, in particular health services, including sexual and reproductive health and reproductive rights and mental health, gender-responsive law enforcement and access to justice, as well as enhancing capacity to engage in public decision-making at all levels." Further, in his Report to the Security Council on Women's Participation in Peacebuilding (S/2010/466), the Secretary-General addresses the trauma, discrimination and marginalization of survivors of sexual and gender-based violence, and women and girls living with HIV.

37. Despite these commitments, one of the yet unrecognized obstacles to women's participation in peacebuilding is the disproportionate burden of care they assume for people infected and affected by HIV, conflict related disability and children orphaned by conflict and AIDS. AIDS has irreversibly increased care burdens among women and their families, well beyond manageable levels. An estimated 90 percent of care is provided in the home typically without pay, training or external support. The principal front-line providers are family members, mainly female spouses and daughters. The implications for humanitarian assistance, inclusive broad-based peace processes and post-conflict reconstruction priorities have yet to be addressed.

38. Indeed gender is only one of a number of factors – including location, age, disability, marital status, and family structure – in determining access to HIV prevention, treatment, care and support, It is also among the most important factors explaining the complex interplay between biological and social determinants of HIV transmission risk. The absence of gender analysis within epidemiological and behavioral approaches to HIV prevention have "further limited progress in addressing AIDS, both within and outside conflict situation, and the relevance of interventions that fail to consider the gendered social dynamics that shape individual behavior." (ASCI, 2009).

39. As in other settings, the concept of 'gender' is often understood to mean 'women' or is used to define risk groups according to a single variable or identity, for example. 'truck drivers,' the 'military' or 'sex workers and clients'. These simplistic approaches fail to address the power dynamics within relationships between and among the sexes that are most significant in shaping HIV risk behaviors. They may also inadvertently obscure sub-populations within these social categories who may be most at risk, e.g. men who have sex with men and women, women in the military, or the pimps, handlers and partners of sex workers or people who inject drugs. These approaches also underestimate the extent to which individual behavior is influenced by deep-seated patriarchal norms, socio-cultural practices, gender, age and family relations.

CONFLICT RELATED SEXUAL VIOLENCE

40. Recent Security Council resolutions on conflict-related sexual violence, namely 1820 (2008), 1888 (2009) and 1960 (2010), affirm that effective strategies for preventing and responding to sexual violence can significantly contribute to the maintenance of international peace and security. In his reports to the Security Council on Women and Peace and Security (S/2009/465) and on the Protection of Civilians (S/2007/643), the Secretary-General drew attention to HIV, as among the individual and societal costs and potential consequences of sexual violence.

41. In conflict and post-conflict situations, sexual and gender-based violence and exploitation increase both the physiological and social risks of HIV transmission. Forced and coerced sex increases physiological susceptibility, due to genital injury, bleeding and tearing, which can facilitate transmission of HIV and other infections. An individual's susceptibility to HIV will also vary according to exposure opportunities, the availability of and access to services, including condoms, emergency and reproductive health care, treatment for sexually transmitted infections (STIs)), safe blood and uninterrupted access to anti-retroviral treatment.

42. Transmission probabilities will vary according to the level of force and coercion, and therefore the type and pattern of violence, and the motives and modus operandi of perpetrators, e.g. trafficking, incest, child rape, sexual slavery, the purposeful transmission of HIV through rape and other manifestations of sexual violence as a tactic and consequence of war. Widespread sex work, sex trafficking and sexual exploitation, including concubinage, near military bases and 'rest and relaxation' in surrounding countries are also likely to contribute to HIV risk. Despite the significant variations of risk associated with different scenarios of forced and coerced sex, epidemiological models of transmission risk have yet to identify sexual violence as a 'mode of exposure' or estimate HIV transmission probabilities among survey populations. Until the role of force or coercion is made explicit in the data linking HIV with social and behavioral factors, any potentially decisive impact on transmission risk will continue to be obscured.

43. All of these factors are context specific and highly varied even within one conflict and may extend over borders and involve regular and non-state actors. Availability and access to services and protection will reflect gender and economic inequalities as well as pre-conflict levels of health infrastructure and care. 2009 data from UNAIDS indicates that divorced and widowed women tend to have significantly higher HIV prevalence than people who are single, married or cohabitating. Absent adequate humanitarian protection, displaced and refugee women who are unmarried, widowed or separated often experience sexual violence in camp settings or may be forced to exchange sex for survival, safe passage or protection. Similarly, without policies that provide support for military families, the probability of HIV transmission is likely to increase for women who are 'left behind' without protection, resources or livelihoods and may be forced into violent and coercive situations.

44. The monetary and non-monetary costs and consequences of conflict-related sexual violence will be significant for countries emerging from conflict. Despite the many factors linking conflict-related sexual violence and HIV, including practices of sexual slavery, violently enforced long term sexual relations, forced marriage and trafficking, and sexual violence used or commissioned as a tactic of war, HIV has yet to be reflected in any of the Security Council's recent resolutions on conflict-related sexual violence, namely S/RES/1820 (2008), S/RES/1888 (2009), and S/RES/1960 (2010), nor is it mentioned in the resolution on sexual violence against children affected by armed conflict, S/RES/1882 (2009). There is now an unprecedented opportunity to align and strengthen Security Council actions on conflict-related sexual violence, on women and peace and security, women's participation in peacebuilding, the protection of civilians, children and armed conflict and on HIV. This would complement similar commitments made by the General Assembly to reduce vulnerability to HIV infection, including through the elimination of all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls (A/RES/60/262 op 31).

45. In addition, much more needs to be known about how HIV, as one of the dynamics and

consequences of conflict related sexual violence, can impede the restoration of international peace and security, a theme explored in the 2010 Report of the Secretary- General on the implementation of Security Council resolutions 1820 (2008) and 1888 (2009) A/65/592-S/2010/604. Moreover, the implications of HIV have yet to be given adequate consideration in the context of transitional justice mechanisms, truth commission mandates, judicial opinions, reparations programmes and policy reform proposals. Nor have they become central to transitional recovery, SSR and DDR efforts.

III. HIV and AIDS, Uniformed Services and Peacekeeping Personnel

HIV POLICY AND PLANNING IN UNIFORMED SERVICES

46. At the level of security institutions, the impact of HIV on operational capability and effectiveness will be shaped by the distribution of prevalence among the ranks and recruitment pool, and associated implications for unit cohesion, morale, discipline and human resource quality. At the individual level, HIV prevalence is related to a constellation of factors, including age, rank and time in service, and maturity of the epidemic. Individual risks will be determined largely on the basis of access to HIV prevention, testing, treatment, care and support among uniformed services and their families, as well as access to safe blood, PEP, and emergency reproductive health care.

47. Transmission risks, among uniformed services and in relation to the populations with whom they engage, can be mitigated or exacerbated by effectiveness of command structures, including disciplinary enforcement mechanisms, as well as policies and norms regarding drug and alcohol use, sexual exploitation and abuse, military sexual trauma, and 'Rest and Recreation' policies. The risk of transmission will also be shaped by deployment related exposure opportunities among high prevalence groups in deployment locales.

48. For all of these reasons, the impact of AIDS on operational capability and effectiveness varies across different security sectors – from military, police and international peacekeeping personnel, to corrections, private military contractors and non-state armed groups. Over the past ten years, relatively more focus has been given to HIV among militaries and peacekeeping personnel, and far less to other uniformed services, including police and law enforcement, corrections, customs, marine, immigration. Very little is known is about irregular forces and private military contractors.

49. Stigma and denial around homosexuality contributes to HIV risks in most uniformed services. In many armed forces, sexual relations between men are forbidden or illegal. Men may engage sexually with men during periods of isolation from women and/or transactional sex. These men (and their families and sexual partners) may therefore face additional risks that are not likely to be considered within military HIV programmes.

50. Although standard HIV prevention in the military emphasizes information and education campaigns among the lower ranks, behavior-change communication (BCC) approaches are not universally considered effective or suitable to uniformed services.[2] BCC approaches often rely on participatory processes

2 Bratt, Duane. "Blue Condoms: The Use of International Peacekeepers in the Fight Against AIDS." *International Peacekeeping*, 9, 3, 2002: 67-86.

and peer communication strategies, which work only if there is buy-in from ranking officers so that the process and message are endorsed by the hierarchy. They also underestimate the influence of deeply entrenched social factors that shape individual behavior, including age and gender relations, household and family dynamics, cultural and religious practices, economic independence and political liberties.

51. Current approaches to HIV counseling and testing have not sufficiently incorporated HIV prevention, counseling, testing, treatment and care policies that reflect both operational requirements and the needs of soldiers, their families and dependants and other women and children with whom they may have been associated during deployment. The provision of HIV counseling and testing (HCT) without care and HIV treatment raises ethical dilemmas that should be solved by dialogue at country level. Without their access to HCT and treatment it is highly unlikely that a soldier's family members and associated dependants and partners will do the same without risking stigmatization, blame, ostracism and a reduction in family status and access to resources, including property, inheritance and custody.

52. At the national level, despite some coordination and/or the harmonization of military and civilian AIDS policies there tends to be little harmonization of policies in relation to HIV testing, discrimination in employment or advancement, and treatment. This is important, especially when both civilian and military personnel are deployed within the same contingent, but may have different terms of service (including medical benefits) and tours of duty and who are subject to different AIDS policies and programmes. Further dialogue is still needed on pre- and post- deployment HIV testing and the establishment of health criteria for deployment and, if HIV positive personnel are deployed, the requisite HIV prevention and HIV treatment.

POLICING HIV AND LAW ENFORCEMENT

53. Among all security sectors, police and other law enforcement institutions face substantial risks of exposure to HIV. DPKO evidence points to underdeveloped policies for HIV prevention, treatment, care and support. The way in which police and law enforcement practices shape the risk environment for HIV and, in turn influence trajectory of the epidemic is similarly underexplored. Civilian police forces that participate in international peacekeeping operations face the same problems and constraints as their military counterparts in such missions; indeed they may even be less prepared and more exposed to risk by virtue of their direct—and sometimes abusive—engagement with local populations.

54. Police and other law enforcement are typically first to engage with populations at higher risk of HIV, including in the context of drug and sex trafficking within and across borders, as well as criminal syndicates. The previously underestimated role of law enforcement in HIV prevention is a growing concern among people with sustained contact with populations at higher risk of HIV, including people who inject drugs, sex workers, street children, trafficked women, illegal migrants, survivors of sexual abuse and rape, and others, such as detainees and prisoners. Where HIV prevalence is higher among such subpopulations, policing practices and behavior can play a determining role in either preventing or accelerating HIV risks.

55. In conflict affected situations, police may be responsible for providing protection from conflict-related sexual violence and in developing appropriate norms of conduct and protection priorities. Their responses can either elevate or minimize HIV risk transmission. As former combatants demobilize and reintegrate into national police forces, their public engagement with people at risk, including the protection of sex workers and the promotion of harm reduction in the context of injecting drug use, will influence the atmosphere of stigma and discrimination.

HIV AND AIDS AND INTERNATIONAL PEACEKEEPING PERSONNEL

56. In 2000, the Security Council's first actions on AIDS sought to minimize its potential damaging impacts on international peacekeeping personnel and to prevent peacekeepers from transmitting or contracting HIV. At the time, militaries were estimated to have prevalence 2-3 times higher than of civilian populations. Since then, the varied trajectories and maturation of HIV epidemics and scaled up national responses with increased access to prevention, treatment and care, have lowered the exposure of peacekeeping personnel and the risks they may pose to the communities they are deployed to serve. Although HIV prevalence varies greatly across troop contributing countries and those locations where peacekeepers are deployed, the overall geographic contour of proximity suggests exposure potential.

57. Significant attention and resources to control HIV were mobilized within the UN system, through bilateral and military-to-military cooperation and among troop-contributing countries nationally. To date, the UN has established ten HIV Units and a further twelve HIV Focal Points in peace operations. Their functions are providing awareness and prevention training, VCT, male and female condoms, and post-exposure prophylaxis; training counselors and maintaining peer educators; and where mandated working on DDR programmes; mentoring and training national military and police services, running HIV awareness in IDPs camps and local prisons; and in outreach working with local non-governmental organizations of women to build national capacity; and data collection for analysis of impact and effectiveness.

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59. Although the UN and member states have formally adopted universal access to HIV prevention, treatment, care and support as a goal, the UN is not at present providing treatment to peacekeepers actually engaged by the UN itself. Treatment is a matter for national militaries and police according to their national protocols, noting limited treatment monitoring facilities in field missions; and personnel deployed on UN missions come from those national uniformed services and will return to them after their peacekeeping duties conclude. The United Nations requires that all uniformed peacekeepers be offered voluntary confidential counseling and testing prior to deployment but notes that this should not be interpreted as a requirement for mandatory testing. The DPKO also recognizes that many TCCs have a mandatory HIV testing policy and do not deploy HIV-positive personnel and respects this national requirement. Troop and police contributing countries should provide pre-deployment HIV testing as part of comprehensive health and medical assessments to ensure fitness for peacekeeping duties during deployment.

60. Given the onerous demands on current peace-support operations, the requisite human and financial resources will need to be secured for testing, especially for TCCs that face high-prevalence HIV epidemics at home.

61. A coherent approach to HIV prevention in a peace mission would require that each TCC should have an HIV policy that takes into account the specific needs of the contingent that it deploys.

62. Command responsibilities should be established, across military and civilian medical services. Force commanders and other senior staff also need to be sensitized to HIV and the range of related issues, including stigma and discrimination. They should also incorporate the UN policy of zero tolerance for sexual exploitation and abuse (SEA) in UN peacekeeping operations, which urges troop- and police-contributing countries to ensure that their personnel are trained and that disciplinary action is taken upon incidents of SEA, as outlined in the UN General Assembly Report of the Special Committee on Peacekeeping Operations and its Working Group (2007).

63. The challenges of developing coherent HIV strategies across national militaries are also being dealt with, in part, through the establishment of regional HIV networks of military and uniformed services. One result of these networks will be the harmonization of HIV policies among the different national contingents contributing to a peacekeeping mission. Since national military policies and strategies concerning HIV are derived from national circumstances rather than international principles or the requirements of peacekeeping operations, regional cooperation is a logical step towards adopting common policies among troop and police contributors at a regional level.

64. Military-to-military assistance and bilateral and multilateral cooperation provide important resources – financial and technical – for strengthening HIV prevention nationally and regionally. The United States Department of Defense HIV Prevention Program, for example, supports activities in a total of 70 countries. Programs are based on host nation needs and encourage comprehensive strategy development and training in prevention and care among uniformed services. UNFPA is the largest provider of reproductive health commodities (HIV test kits, post-exposure prophylaxis kits, and condoms) for uniformed services programmes and supports national programmes in several countries. The UNAIDS Secretariat also contributes to the overall UN efforts in HIV responses among all cadres of uniformed services and coordinates a global Uniformed Services Task Force on HIV, with the aim of strengthening and expanding effective and comprehensive HIV prevention, treatment, care and support for uniformed services personnel and their families and communities, in both developed and developing countries.

IV. IV. A New Framework for Ensuring accountability, leadership and action on HIV in peacekeeping and peacebuilding

Over the past ten years, the rapidly changing landscape of natural disasters, demographic crises, and conflicts throughout the world have reshaped these challenges and elevated the need for a new response to HIV in the context of United Nations actions to prevent conflict, promote security and build peace. A coordinated international response is needed through a new framework to reduce the spread of HIV and its devastating impact on social instability, emergency and conflict affected situations. The proposed framework of activities, outlined below takes into account the conclusions of the 2011 High Level Meeting on AIDS, and relevant actions taken by the Security Council, on women and peace and security, sexual violence in conflict, children and armed conflict, the protection of civilians and post-conflict peacebuilding. It also recognizes that sexual violence in conflict situations may increase HIV risk and that effective steps to prevent and respond to acts of sexual violence can be an effective way to reduce HIV risk and contribute to the maintenance of international peace and security. It further recognizes the critical importance and limited availability of field level data and analysis in assessing threats to civilian populations, types and patterns of violence and motives and modus operandi of perpetrators as well as the relevance of this information – especially on conflict-related sexual violence (including rape in situations of armed conflict and post-conflict and other relevant situations) for developing mission-specific strategies and plans of action, and identifying training and technical capacity gaps, relevant equipment and personnel.

The following recommendations are offered as proposals to be considered by all relevant partners

HIV AND PEACEKEEPING OPERATIONS

65. Institute command-centered approaches to HIV prevention that emphasize civilian-military command responsibility for HIV policy development and implementation and that complement education and training based on individual behavioral, medical, or human rights approaches. HIV policies should be based on the troop contributors, the nature of the local epidemic and the health infrastructure available;

66. The UN should continue to provide necessary technical support for TCCs to provide appropriate prevention, treatment, care and support, backed by donor commitments to provide the requisite resources;

67. DPKO should continue to scale up HIV interventions and in doing so ensure adoption of best practices. Medical services and force medical officers should streamline collection and reporting of HIV repatriation, evacuation and mortality data; HIV units should enhance partnerships and develop and strengthen monitoring and evaluation capacities across the missions;

68. Ensure that resolutions to establish or renew peacekeeping and peacebuilding mandates contain provisions, as appropriate, for HIV prevention, treatment, care and support in the mandate of UN peacekeeping operations (S/RES/1889:7); and including, as appropriate, the appointment of HIV advisers and adequate resources pre- deployment and in-mission training, testing, condoms, treatment, care and support services for all peacekeeping personnel and capacity strengthening programmes that involve national staff wherever possible;

STRENGTHENING NATIONAL HIV POLICIES FOR UNIFORMED SERVICES

69. National authorities should consider ways to increase alignment among international, regional and national policies for national uniformed services and their families, including armed forces and civil defense and police forces and other security sectors, including customs, maritime, immigration, corrections and private security sector, that establish pre and post-deployment HIV prevention programmes and voluntary counseling and testing, care and treatment for uniformed services and their families and work place policies that reflect AIDS in pension and retirement schemes, funeral and survival benefits, compassionate leave, disability and medical discharge benefits as well as entitlements for children born out of wedlock and/or as a result of rape. The rights of people living with HIV to serve in armed forces should be recognized;

70. With technical support from the UN and other entities, national authorities should consider carrying out institutional audits to assess the implications of HIV for internal processes including for procurement, personnel profiling and, risks related to deployment patterns and rotation, alcohol and drug use;

INCREASING HIV PREVENTION AND PROTECTION FOR CIVILIANS AFFECTED BY ARMED CONFLICT

71. UN agencies, regional and international organizations and NGOs involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters (A/RES/62 – DC), should strengthen as a matter of urgency, HIV prevention, care and awareness elements into the provision and delivery of international assistance;

72. HIV prevention and response efforts should be incorporated in programmes responding to host communities and communities of concern (S/RES/1889:7), in and around UN managed refugee and internally displaced persons camps as well as in all disarmament, demobilization and reintegration processes and in justice and security sector reform efforts assisted by the United Nations (S/RES/1820:10); that such efforts should take account of and focus on men's use of violence and especially sexual violence, and the specific needs of female combatants, children and women associated with armed forces;

73. Ensure the inclusion of HIV prevention and response among host communities and communities of concern (S/RES/1889:7), in and around UN managed refugee and internally displaced persons camps as well as in all disarmament, demobilization and reintegration processes and in justice and security sector reform efforts assisted by the United Nations (S/RES/1820:10); that focus on men's use of violence and especially sexual violence, and the specific needs of female combatants, children and women associated with armed forces;

REDUCING HIV RISK IN POST CONFLICT TRANSITIONS AND PEACEBUILDING

74. Authorities in consultation with civil society, including women's organizations, in post-conflict situations should be encouraged to specify in detail community needs and priorities in

relation to HIV and ensure that national planning and financing considers the care burdens that women assume for people living with and affected by HIV among the responses to the needs of women and girls in post-conflict situations;

75. HIV programming should be included as one of the basic services and core tasks of government functionality in the aftermath of conflict. Planning should address and specify associated gaps in civilian capacities – internationally and nationally – and propose strategies for meeting these needs;

76. Institutions with complementary peacekeeping and peacebuilding mandates, namely, the UN Security Council, the African Union Peace and Security Council, the UN Peacebuilding Commission, and other regional mechanisms, should increase dialogue to address the heightened risks of HIV during post-conflict peacebuilding and to ensure the continuity of HIV prevention, treatment care and support during post-conflict transitions and peacebuilding, including disarmament, demobilization and reintegration and in the context of conflict-related cross-border activities that can increase HIV risks including child and sex-trafficking and the illicit drug trade (S/RES/1820: 14) and S/RES/1539: 3, 12);

ADDRESSING THE GENDER DIMENSIONS OF HIV IN CONFLICT AND PEACEBUILDING

77. Noting that the disproportionate burden of HIV on women is one of the persistent obstacles and challenges to women's participation and full involvement in the prevention and resolution of conflict and in peacebuilding, the new framework for ensuring accountability leadership and action on HIV and peacekeeping should above all, amplify and complement the Council's existing commitments on preventing and addressing conflict-related sexual violence. It should make existing commitments more comprehensive. To these ends:

- The many factors linking HIV and conflict-related sexual violence should be recognized and member states should be encouraged to comprehensively address the increased risk of HIV transmission for women and girls, as part of their national HIV response, particularly with respect to strengthening monitoring, evaluation and reporting in support of evidence based programming – and aligning this reporting with reporting on conflict related sexual violence resolutions 1880 and 1960.
- The issue of HIV and other sexually transmitted infections should be taken into consideration and raised in the engagement with parties to armed conflict pursuant to resolution 1960 (2010), with a view to preventing and deterring high-risk behavior like acts of sexual violence. In particular, HIV-awareness should routinely be included in dialogue with parties to armed conflict that are credibly suspected of committing patterns of sexual violence or employing sexual violence as a tactic of war.
- Member states should ensure that all uniformed personnel receive training on the prohibition of sexual violence which should include its nexus with HIV and issues related to preventing the spread of HIV. This should include the increased risk of HIV transmission resulting from forced or coerced sex in situations of conflict, where immune status may be compromised by malnutrition and conflict-related stress, combined with collapsed health and social care systems. Communication with local communities should convey messages to help counter the stigma associated with sexual violence and with HIV infection, which are often related. This dual stigmatization can lead to the rejection of sexual violence survivors from their families and communities, which can in turn undermine social and economic stability and cohesion.

- All parties to armed conflict should be encouraged to take measures to debunk the myths that fuel sexual violence, including those that relate to HIV, such as the myth that the rape of minors can "cure" HIV. Parties to conflict should enforce appropriate military disciplinary measures in response to such acts and attitudes.
- All parties concerned, including Member States, United Nations entities and financial institutions, should support the development and strengthening of capacities of national health systems and civil society networks, to provide sustainable assistance to women infected or affected by HIV in armed and post-conflict situations.

IMPROVING RESEARCH, INFORMATION COLLECTION, MONITORING AND REPORTING

78. Troop and police contributing countries should carry out force capability assessments and institutional audits of militaries, police and other uniformed and civilian services to determine the impact of HIV on the tactical level of operations, on combat effectiveness, unit cohesion, morale and discipline, and human resource quality. In this context, DPKO and UNAIDS should provide technical support and strengthen cooperation with interested Member States to further develop their surveillance, monitoring and reporting;

79. Relevant United Nations bodies, in cooperation with Member States and civil society, should collect data on, analyze and systematically assess conflict related needs relating to HIV; conduct studies on the effectiveness of HIV prevention programs and incorporate findings in new HIV prevention programmes; ensure that information from these studies and assessments are included in reports of the Secretary-General on country specific situations, in the context of post-conflict peacebuilding and the monitoring, analysis and reporting arrangements on conflict-related sexual violence.

UNAIDS
20 avenue Appia
CH-1211 Geneva 27
Switzerland
T (+41) 22 791 36 66
F (+41) 22 791 48 35
distribution@unaids.org
www.unaids.org

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA
UNODC ILO UNESCO WHO WORLD BANK