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Multi-Country Demobilization and Reintegration Program

Guidelines for Incorporating HIV AIDS

Activities in Demobilization, Reinsertion and Reintegration Programs for Ex-Combatants

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GUIDELINES FOR INCORPORATING HIV/AIDS ACTIVITIES IN DEMOBILIZATION, REINSERTION AND REINTEGRATION PROGRAMS FOR EX-COMBATANTS

Prepared by the Multi-country Demobilization
and Reintegration Program (MDRP)
with support from the AIDS Campaign Team for Africa (ACT africa)

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[1] These institutions are: in Angola, the Instituto de Reintegração Sócio-profissional dos Ex-militares (IRSEM) ; in Burundi, the Secrétariat Exécutif de la Commission Nationale de Désarmement, Démobilisation et Réinsertion (ES/CNDDR) ; in RoC, the Programme National de Désarmement, Démobilisation et Réinsertion (PNDDR); and in Rwanda the Rwanda Demobilization and Reintegration Commission (RDRC).

Acronyms and Abbreviations

ACT africa	AIDS Campaign Team for Africa
AG	Armed Groups
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti Retro Viral
CSW	Commercial Sex Worker
DDR	Disarmament, Demobilization and Reintegration
FAB	Forces Armées du Burundi (Burundi Armed Forces)
HIV	Human Immunodeficiency Virus
IDDRS	Integrated Disarmament, Demobilization and Reintegration Standards
IDDRWG	Inter-Agency Disarmament, Demobilization and Reintegration Working Group
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MDRP	Multi-country Demobilization and Reintegration Program
NGO	Non Governmental Organization
ODA	Official Development Assistance
PLWHA	People living with HIV and AIDS
PMPA	Partis et Mouvements Politiques Armés (Armed Political Parties and Movements)
RoC	Republic of Congo
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
TB	Tuberculosis

Executive Summary

HIV/AIDS can have a concrete impact—positive or negative—on the success of DDR programs. Demobilization can spread the epidemic as sero-positive ex-combatants relocate to areas of the country where HIV is not prevalent. HIV/AIDS can also prevent successful reintegration into home communities by keeping ex-combatants from establishing productive lives that allow them to raise families and live in peace with their neighbors. Experience suggests that by addressing HIV/AIDS, Disarmament, Demobilization and Reintegration (DDR) programs can lessen these negative impacts and even create positive outcomes. Ex-combatant involvement in the fight against AIDS can actually facilitate reintegration and ex-combatants can become key agents in helping turn back the epidemic within their communities. HIV/AIDS activities should therefore be integrated into DDR programming from the beginning.

The circumstances of combatants' lives—separation from spouse and family, frequent opportunities for casual sex, a tendency to assume greater risk during conflict—increase the likelihood of contracting HIV/AIDS. Actual exposure to HIV/AIDS during conflict, however, varies depending on where combatants serve, the situations encountered during conflict, and differing individual reactions to the realities of war. The same violence and uncertainty that make some more prone to risk make others avoid it and concentrate on survival. As one former fighter explained in a discussion group in Burundi: "…there was no time for sex; there was only the war."

Certain factors may also reduce the risk of HIV/AIDS among combatants. In formal military structures, HIV prevention and education programs about sexually-transmitted infections (STIs) are common and soldiers generally have access to reliable information prior to, and often during, conflict. In some armies, the rules and discipline of military life extend to sexual behaviors, with soldiers officially restricted to one partner.

The situation is usually quite different for those who serve with irregular forces. For many in these groups, demobilization is the first opportunity to hear accurate, in-depth information about STIs and HIV/AIDS. Prior to that time, what such members of irregular armed groups know about HIV/AIDS comes from the radio in some cases, but most often by word-of-mouth. The information they have is generally very sketchy, often a mix of correct and incorrect facts, and in many cases simply wrong.

Input from ex-combatants suggests that some risk behaviors, such as unprotected sex, are consistent across groups. Other behaviors, such as sex with commercial sex workers during conflict, vary from none to very frequent depending on the group in question. Risky behaviors also vary by age, marital status and area of resettlement. Young ex-combatants are reported to engage in higher-risk sex than their older counterparts for instance, as are ex-combatants resettling to urban areas as compared to their rural counterparts.

For most ex-combatants, it is during the reinsertion phase when ex-combatants first re-enter civilian life that they are most at risk of contracting or transmitting the HIV virus. It is at this time that ex-combatants are ready to celebrate their end of service, often have money in their pockets, and frequently find themselves in situations that facilitate HIV transmission. Discussion group participants indicated that during this time, sex was frequent, often with multiple partners, at times with commercial sex workers, and generally without condoms. The choices ex-combatants make during this time can lead to a lifetime of illness, reduced productivity and even stigma, which can reduce their chances of ef-

fective reintegration into their communities of return.

Experience in demobilization programs suggests that ex-combatant involvement in HIV/AIDS education and outreach activities can facilitate their reintegration and that ex-combatants returning to their communities can be a very important asset in the fight against AIDS.

All DDR programs should therefore include an HIV/AIDS component that follows these guidelines:

- *Act within the framework of the national AIDS strategy.* Consistent with the UNAIDS "Three Ones" Initiative—one coordinating agency, one strategy, one monitoring and evaluation system—all DDR HIV/AIDS activities should be in accordance with the country's national AIDS strategy. DDR leaders should work closely with national AIDS leaders in determining DDR HIV/AIDS project strategies, designing program activities and selecting monitoring and evaluation indicators. In addition, all DDR-AIDS programs should draw upon the network of national organizations and service providers that support HIV/AIDS in a given country.

  HIV/AIDS lasts a lifetime; DDR programs only a few years at most. As such, DDR programs must link with and insert ex-combatants into the existing HIV/AIDS and health systems, structures and support within a country. To do this, DDR programs should ensure that ex-combatants have the same rights and access to national HIV/AIDS programs as any other citizen, that they know what resources are available and where to access them, and that they have the practical information necessary to access information, prevention, testing and treatment as needed.

- *Ensure ex-combatants are included in national AIDS policies and programs.* DDR should encourage those involved in the fight against HIV/AIDS to take ex-combatants into account when developing strategies, preparing funding proposals, and identifying priority target groups. DDR should share best practices for HIV/AIDS interventions with ex-combatants and convey how ex-combatants themselves can play an important role in the fight against AIDS.

- *Develop a policy for sero-positive ex-combatants*. Prior to demobilization, DDR programs need to work closely with national HIV/AIDS leaders, health officials and the military to determine how best to ensure that sero-positive ex-combatants have access to prevention measures, testing and treatment.

  Should national HIV/AIDS programs not yet be established in an ex-combatant area of return, DDR planners may consider facilitating an early start-up to coincide with the reintegration of ex-combatants. This is only an option, however, if the proposed activities are consistent with the overall national AIDS strategy. Maintaining—not establishing—services is the primary challenge to financing an AIDS program. Any actions undertaken by a DDR program for sero-positive ex-combatants must correspond to the decisions that health officials have made concerning where and when to establish new services, balancing overall need with available resources.

- *Meet five basic requirements at demobilization* (or as soon thereafter as possible):

  - Ex-combatants acquire the skills and knowledge they need to protect themselves and those around them from AIDS.
  - Voluntary counseling and testing is available at the demobilization site.
  - Detection and treatment of sexually transmitted diseases is included in medical screening.
  - Male condoms are distributed in all take-home kits. All ex-combatants receive information on the female condom and the female condom is available to all upon request.
  - Ex-combatants leave demobilization centers with precise information on how and where to access condoms, testing and treatment in their areas of return.

- *Partner with NGOs and/or Government departments to continue prevention activities beyond demobilization.* Even when DDR programs have taken all the essential steps to sensitize ex-combatants about HIV and given them appropriate support, many ex-combatants do not put into practice what they know, especially during the crucial first weeks following demobilization when ex-combatants are most at risk. DDR institutions should work with AIDS leaders and partners involved in the fight against AIDS to ensure targeted prevention initiatives during the high-risk, immediate post-demobilization phase.

- *Fight AIDS by supporting economic reintegration.* Research suggests that there is a connection between poverty and AIDS. The links are complex and operate in both directions—poverty affects behavior and can lead to contracting AIDS; AIDS in turn can lead to poverty. Currently there are funds available in most sub-Saharan countries (as well as many other parts of the world) for HIV/AIDS work. The same can not be said of financing for livelihoods support and income-generating activities that are, as a rule, part of reintegration efforts under DDR operations. Given these facts, DDR managers should seek to prioritize the use of DDR funds for those activities that address poverty, such as reintegration assistance and economic programs for areas where ex-combatants settle, and seek specific outside financing for the HIV/AIDS components of their programs. However, if other funding is not available, then DDR leaders must allocate available DDR funds to the core set of essential HIV/AIDS activities outlined in these guidelines.

Furthermore, DDR programs should consider going beyond the basic HIV/AIDS elements suggested above to include the following additional steps:

- Adapt the program according to the evolution of the epidemic and variations in risk behavior among demobilizing groups.
- Address the factors that put women at greater risk of contracting HIV/AIDS.
- Give priority to urban areas where the risk is often the highest.
- Consider work migration patterns when assessing exposure and risk.
- Add malaria prevention and information on family planning to the demobilization program.
- Prepare disabled ex-combatants for high-risk situations.
- Promote ex-combatant involvement in the fight against AIDS.

AIDS cannot be ignored; DDR programs have no alternative but to join the government and civil society organizations in actively addressing HIV/AIDS. Implementing the range of actions discussed will help prevent the disease from disrupting the process of ex-combatant reintegration. In addition, national HIV/AIDS leaders need to learn about the interactions between ex-combatants and the disease, and learn how to incorporate this key population into national efforts to combat it.

A STEP-BY-STEP CHECKLIST FOR IMPLEMENTING A DDR HIV/AIDS COMPONENT

Essential steps during demobilization planning

STEP 1. APPOINT AN HIV/AIDS FOCAL PERSON WITHIN THE DDR COMMISSION. As prevention initiatives will be a priority, in most cases this person should be someone who works with information, education and communication (IEC) activities. If it is likely that significant numbers of sero-positive persons will be demobilizing, the DDR commission should consider forming an HIV focal team that includes an IEC person and a medical professional from a relevant partner institution such as the Ministry of Health, or an NGO working in HIV/AIDS service delivery.

STEP 2. MEET WITH NATIONAL HIV/AIDS LEADERS. Explain the DDR process and timeframe, and describe the profiles of ex-combatants to be demobilized. Exchange information about the AIDS situation in the country including the areas and groups most affected, how the epidemic is evolving, and the status of, and future plans for, prevention and treatment. Ask about NGOs and other organizations working in AIDS and inquire about funds available for AIDS initiatives and how to access them.

STEP 3. LEARN ABOUT SERVICES IN COMMUNITIES OF RETURN. Obtain information about prevention and treatment services available in ex-combatant communities of return so that links can be established for ex-combatants to receive support after demobilization.

STEP 4. ESTABLISH OBJECTIVES AND EVALUATION INDICATORS OF THE DDR HIV/AIDS COMPONENT. DDR objectives should be consistent with the national AIDS strategy, if in existence. Monitoring and evaluation (M&E) questions should be the same as those used in the national plan, in order to facilitate comparisons over time and among groups.

STEP 5. ANTICIPATE NEEDS AND CHARACTERISTICS OF GROUPS TO DEMOBILIZE AND PLAN ACCORDINGLY. Within the commission, meet to discuss types of ex-combatants to be demobilized, likely levels of knowledge and information about HIV/AIDS, likely HIV/AIDS status, services available in likely areas for reintegration. Make plans accordingly. If national soldiers are to demobilize, meet with military officials to better understand their profiles.

STEP 6. ESTABLISH POLICIES AND PROCEDURES FOR DEMOBILIZING SERO-POSITIVE EX-COMBATANTS.

STEP 7. EXPLORE FUNDING OPTIONS. Identify non-DDR funding for HIV/AIDS initiatives from available AIDS funding sources. If funding is not available, ensure essential activities with DDR funds.

STEP 8. IDENTIFY PARTNER ORGANIZATIONS IN HIV/AIDS AND DECIDE ON IMPLEMENTATION MECHANISMS.

STEP 9. UPDATE DDR FIELD OFFICE STAFF ON HIV/AIDS ISSUES. Ensure that field staff is up to date on causes and prevention of HIV/AIDS. Brief staff on DDR role and activities in HIV/AIDS. Introduce field staff role in linking returning ex-combatants to AIDS organizations, to available testing and treatment, and to sources where condoms are available.

Other important considerations when planning for demobilization:

IF POSSIBLE. MEET WITH ORGANIZATIONS WORKING ON AIDS. Explain DDR process, timeframe and profiles of ex-combatants to be demobilized. Share lessons learned in DDR HIV/AIDS initiatives, including the positive role that ex-combatants can play. Discuss AIDS activities at demobilization, need for new strategies at reinsertion, ways to integrate ex-combatants into ongoing programs of organizations. Map current interventions of organizations in AIDS.

Essential steps during demobilization

STEP 10. CONDUCT HIV/AIDS EDUCATION SESSION. The session should provide knowledge and skills ex-combatants will need to protect themselves and their families from HIV/AIDS including how to discuss condom use with partner, how to refuse to engage in unsafe sex, where to obtain condoms, how to use a condom correctly, and how to recognize the need for STI treatment.

STEP 11. DETECT AND TREAT TB and SEXUALLY-TRANSMITTED INFECTIONS. Include syndromic management of STIs (a way to detect and treat the infection that does not require a laboratory test) in the medical screening of ex-combatants.

STEP 12. OFFER VOLUNTARY COUNSELING AND TESTING (VCT) AT THE DEMOBILIZATION SITE. Include VCT best practices and lessons learned in demobilization, including pre-counseling, time for reflection prior to voluntary testing and post-test counseling with detailed information and specific referrals for any next steps.

STEP 13. WITH HIV-POSITIVE EX-COMBATANTS, DISCUSS WAYS TO ACCESS SERVICES AND TREATMENT IN THEIR HOME COMMUNITIES.

STEP 14. DISTRIBUTE MALE CONDOMS IN RESETTLEMENT KITS. PROVIDE INFORMATION ON, AND OFFER FEMALE CONDOMS ON DEMAND.

STEP 15. FACILITATE LINKS TO SERVICE PROVIDERS IN COMMUNITIES OF RETURN. Provide information on how and where to access condoms, testing and treatment in ex-combatants' home communities as they leave demobilization.

Other important considerations during demobilization:

IF POSSIBLE. INVITE HIV/AIDS ORGANIZATIONS WORKING IN COMMUNITIES OF RETURN TO DEMOBILIZATION. Ask AIDS organizations to share information with ex-combatants about programs being implemented in their respective communities of return.

IF POSSIBLE. ORGANIZE PROBLEM-SOLVING DISCUSSIONS ABOUT WOMEN'S PARTICULAR VULNERABILITY TO HIV/AIDS WITH EX-COMBATANTS. Pose the issue of women's vulnerability as a participatory discussion topic. Discuss the factors involved and have groups identify ways to address issues that put women at increased risk of contracting HIV/AIDS.

IF POSSIBLE. PROVIDE INFORMATION ON MALARIA, FAMILY PLANNING. Include information on the link between malaria and HIV/AIDS, on malaria prevention and treatment, and on family planning during HIV/AIDS education session.

IF POSSIBLE. MEET WITH DISABLED EX-COMBATANTS. Organize meeting with disabled to prepare for reinsertion by discussing what to expect upon returning home, including possible reactions of others, and to review how to protect themselves from HIV/AIDS.

IF POSSIBLE. MAKE AVAILABLE INSECTICIDE-TREATED BED NETS. Have insecticide-treated bed nets available for purchase at demobilization site along with information where bed nets can be obtained in the ex-combatant's community of return.

Essential steps during reinsertion

STEP 16. WITH PARTNER ORGANIZATIONS, ENSURE CONTINUATION OF PREVENTION ACTIVITIES DURING THE REINSERTION PHASE. To increase chances that ex-combatants practice safe sex, DDR should encourage partner

organizations to try new prevention strategies at reinsertion, such as ensuring condoms be available in bars and other sites frequented by ex-combatants, or encouraging ex-combatants to watch out for each other.

STEP 17. FACILITATE LINKAGES BETWEEN EX-COMBATANTS AND ORGANIZATIONS WORKING IN AIDS. Encourage involvement of sero-positive ex-combatants in organizations of persons living with HIV/AIDS (PLWHA). Communicate to organizations working in HIV/AIDS the potential of the ex-combatant network in HIV/AIDS education and outreach. Link interested ex-combatants to organizations in their communities involved in AIDS activities.

Other considerations during reinsertion:

IF POSSIBLE. EXPLORE WHY MANY EX-COMBATANTS DO NOT USE CONDOMS OR FOLLOW PREVENTION ADVICE. By using simple qualitative tools, DDR commissions or their partner NGOs should determine what factors keep ex-combatants from adopting preventive behaviors and gather and consider ex-combatants' ideas on what to do to promote safer sexual practices.

Essential steps during reintegration

STEP 18. VERIFY THAT EX-COMBATANTS ARE ABLE TO ACCESS HIV/AIDS SERVICES AND PARTICIPATE IN HIV/AIDS PROGRAMS. DDR programs should ensure that ex-combatants do not have difficulty accessing prevention, testing or treatment services or participating in AIDS education and outreach programs due to discrimination related to their previous role in conflict or for any other reason. If problems are being encountered, DDR personnel should work with local health authorities and NGOs to find ways to make sure programs reach ex-combatants.

Other considerations during reintegration:

IF POSSIBLE. FACILITATE FOLLOW-UP WITH DISABLED EX-COMBATANTS ON HIV/AIDS ISSUES. Provide follow-up to disabled ex-combatants via their contact with the medical unit, during reintegration activities, or by way of local AIDS organizations. Help them find ways to overcome any problems in accessing HIV/AIDS prevention, testing or treatment.

IF POSSIBLE. GIVE PRIORITY TO GROUPS AND AREAS AT HIGHER RISK OF HIV/AIDS. Prioritize those areas and groups most at risk of contracting and passing on the AIDS virus—peri-urban areas, rural areas with significant in-out migration for work, areas bordering countries with high HIV/AIDS prevalence, and younger ex-combatants—for continuing AIDS education. The level of risk of contracting HIV/AIDS should also be considered as a possible selection criteria for DDR reintegration activities.

IF POSSIBLE. CONSIDER WAYS TO SUPPORT FAMILIES OF EX-COMBATANTS LIVING WITH AIDS. For example, education and training opportunities could be transferred to another family member in situations where an ex-combatant with AIDS is unable to work.

IF POSSIBLE. KEEP THE FOCUS ON CONDOMS. Have condoms available—without having to ask—in district commission offices as a way to remind ex-combatants of the need to use condoms and increase, in even a small way, the chances that an ex-combatant has a condom when he or she needs one. At district commission offices and during reintegration activities, have a list of sites where condoms are available in the community.

IF POSSIBLE. DISCUSS WITH LOCAL HIV/AIDS LEADERS HOW NETWORKS OF EX-COMBATANTS COULD ASSIST IN THE FIGHT AGAINST AIDS.

Introduction

1. Background and Rationale

While sub-Saharan Africa has just over ten percent of the world's population, according to UNAIDS it is home to more than two thirds of all people living with HIV—some 22.5 million in 2007. The countries most affected by HIV/AIDS are the neighboring southern African countries of Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe, where HIV prevalence rates in 2005 were in excess of fifteen percent.[2]

Moreover, sub-Saharan Africa is, or has been until the recent past, home to many of the world's armed conflicts. The relationship between conflict and the spread of HIV is complex, unpredictable and poorly understood, but several factors during conflict—population movement, the level of sexual interaction, and the breakdown of community, civil society and government structures—put populations at increased risk of contracting HIV/AIDS. This heightened vulnerability to HIV infection continues through the post-conflict period of reconstruction and UNAIDS recommends that AIDS prevention be an integral part of programs to assist populations affected by conflict.[3]

In 2006, the Secretariat of the Multi-Country Demobilization and Reintegration Program (MDRP) and the World Bank's ACT Africa program collaborated to review the interaction between HIV/AIDS and one specific post-conflict population—that of ex-combatants in disarmament, demobilization and reintegration programs.[4] The goals of the review were to (i) better understand vulnerabilities and risks for former soldiers and armed group members, and (ii) identify specific actions that can be taken to reduce the risk of HIV transmission during and after DDR exercises. To that end, a team visited four MDRP countries: Rwanda, Burundi, Angola and the Republic of Congo. The goal was to learn what HIV/AIDS activities were being implemented through their respective DDR programs and, through discussion with organizations involved in implementing DDR AIDS activities and with ex-combatants, to identify best HIV/AIDS practices in DDR. The insights and information gained during this mission led to the identification of key interventions in HIV/AIDS during demobilization and reintegration of ex-combatants and was the starting point for the development of these guidelines.

2. Possible Uses

These guidelines are designed to help directors, managers and operational staff of DDR programs, as well as partner organizations, to incorporate essential HIV/AIDS prevention, care, testing, treatment, and support activities into DDR programs. They are designed for the layperson without professional training in medicine, HIV/AIDS or public health.

The guidelines can also be a tool for HIV/AIDS activists and leaders, military leaders charged with demobilizing soldiers, and for government leaders committed to the implementation of peace accords. For those working

[2] UNAIDS 2007 AIDS epidemic update: key facts by region. http://data.unaids.org/pub/EPISlides/2007/071118_epi_regional%20factsheet_en.pdf .
[3] HIV/AIDS and conflict. http://www.unaids.org/en/Issues/Impact_HIV/HIV_and_conflict.asp
[4] The MDRP is a regional program administered by the World Bank that supports initiatives in seven great lakes countries aimed at peace, security and DDR. The program is financed by a multi-donor trust fund supported by 13 donors. ACT Africa is the World Bank AIDS Campaign Team for Africa. The team reviewed demobilization programs supported by the MDRP/World Bank and the international community through a multi-donor trust fund.

in national HIV/AIDS programs, they can serve as an introduction to demobilization programs, a reminder of the importance of taking ex-combatants into account in national HIV/AIDS programs, and a primer on lessons learned about HIV/AIDS initiatives in that context. Military leaders can use the guidelines as a planning tool in preparing for DDR operations and as a tool to monitor the implementation of the same programs. For government leaders concerned with a sustainable peace, the guidelines can also serve as a reminder of the importance of addressing HIV/AIDS within DDR programs in order to ensure the successful reintegration of ex-combatants.

The guidelines provide answers to the following questions:

- ✓ how ex-combatants affect and are affected by the AIDS epidemic;
- ✓ why those involved in DDR programs should be concerned about HIV/AIDS;
- ✓ what all DDR programs must do about HIV/AIDS; and
- ✓ what additional actions DDR programs can take to fight HIV/AIDS.

The guidelines draw on both lessons learned in HIV/AIDS programs in general and on experiences to date in DDR HIV/AIDS initiatives, in particular from the MDRP.

A simple step-by-step checklist for implementing HIV/AIDS activities in DDR programs is included at the beginning of this document. Basic information about HIV/AIDS is included in the annexes, as are additional tools and links to other useful resources on HIV/AIDS. Lastly, information on relevant HIV/AIDS topics (such as HIV/AIDS in Africa, feminization of AIDS, HIV/AIDS among displaced, etc.) is presented in information boxes in each chapter.

3. Sources and Methodology

The main source of information for these guidelines was a review of MDRP demobilization programs in Angola, Burundi, the Republic of Congo, and Rwanda between October and November 2006. An MDRP team met with demobilization staff, partner NGOs involved in HIV/AIDS initiatives with ex-combatants, country HIV/AIDS leaders, and with ex-combatants who had participated in the DDR processes in their respective countries. In total, the team met with and conducted discussion group analyses with twenty-one groups of ex-combatants.[5] These ex-combatants were asked to serve as experts on HIV/AIDS and the demobilization process, describing not their own personal experiences, but rather the experiences of ex-combatants like themselves (in terms of age, gender, ex-combatant group, etc.), and describe not their own personal experiences, but rather the experiences of the ex-combatants serving with them. Using a simple participatory learning and action tool, the groups ranked ex-combatant knowledge of HIV/AIDS, risk levels, behaviors, and access to prevention and treatment services during conflict and at each phase of the DDR process. The review team learned both from the outcomes of the consensus rankings and from the rich conversations leading up to these group decisions. Similarities across groups and countries soon became apparent, as did occasional differences. To check for accuracy and validity, the information gathered was compared with available reports, statistical data and input from those involved in HIV/AIDS and the DDR programs in the four countries. In the last two countries that were reviewed—Angola and the Republic of Congo—ex-combatants were also asked to rank potential intervention strategies that grew out of ex-combatant discussions in the first two countries.[6]

The U.N. Integrated Disarmament, Demobilization and Reintegration Standards (IDDRS) module on HIV/AIDS and DDR, developed by the Inter-agency DDR Working Group (IDDRWG) was a key resource in the conduct of this review, as were lessons learned in military HIV/AIDS programs and recent research on AIDS and refugee populations.[7] The guidelines also draw on best practices in the fight against AIDS documented in several excellent print and internet resources. The references and links for these resources are provided in this document whenever possible so that readers may further explore specific issues or contact an existing network of experts and organizations working

[5] For the most part, the groups were homogenous with the same category of ex-combatant making up a group, e.g. all soldiers, all from the same armed group, all men, all women, all handicapped etc. The team met with ex-combatants representing as many of the various types of demobilizing groups in each country as was possible, given logistical constraints and remaining security issues.

[6] The discussion tools used can be found in annexes F and G.

[7] For a broader discussion of many of the issues concerning HIV/AIDS and DDR, the reader should refer to the IDDRS module, which is available on the UN DDR Resource Centre web site: http://www.unddr.org.

on HIV/AIDS. A list of these resources is also provided in the annexes to the report.

Drawing on these diverse inputs, these guidelines recommend a set of core elements for DDR HIV/AIDS components (see Chapter 3) and identify complementary activities to enhance the core DDR-HIV/AIDS interventions (see Chapter 4). The checklist found at the beginning of the guidelines integrates the recommendations presented in these two chapters and serves as a simple tool to DDR program managers to plan and implement an HIV/AIDS component.

Note for DDR Managers
HIV/AIDS IN SUB-SAHARAN AFRICA IN 2007

As of December 2007, UNAIDS reports:

Sub-Saharan Africa remains the most affected region in the global AIDS epidemic. More than two thirds (68%) of all HIV-positive people live in this region where more than three quarters (76%) of all AIDS deaths occurred in 2007. It is estimated that 1.7 million people were newly infected with HIV in 2007, bringing to 22.5 million the total number of people living with the virus. Unlike other regions, the majority of people living with HIV in sub-Saharan Africa (61%) are women.

In most countries in sub-Saharan Africa, adult HIV prevalence—the number of adults living with AIDS—is either stable or has started to decline. Southern Africa remains the most seriously affected region in Africa, with AIDS the leading cause of death. HIV prevalence exceeded 15% in eight countries in Southern Africa in 2005 (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe)[8].

Experts are not sure why southern Africa is most affected. It is likely due to the coming together of several factors, including the ease with which the AIDS viral type common to southern Africa spreads, the fact that southern African men are less likely to be circumcised, the types of sexually-transmitted diseases most common in the region, and the newly-discovered synergy between malaria and AIDS. Also, while the dynamics are not yet completely understood, research indicates that men's migrating for work has had a significant impact. Research also shows that sexual behavior patterns do not account for the extensive spread of AIDS in southern Africa; people in western society are as sexually active outside the couple as people in southern Africa. In fact, reported rates of having had two or more sexual partners in the past year are higher in industrialized than in non-industrialized countries[9].

The good news is that stopping the spread of AIDS is possible. Declining HIV prevalence is evident in Kenya and Zimbabwe, and signs of this trend are being seen in the Ivory Coast, Mali and urban Burkina Faso. In these countries there is also evidence of a shift toward safer behavior. Zimbabwe's success is in part due to increased condom use, delayed sexual debut among youth, and faithfulness among partners. While these successes are hopeful, experience shows that efforts must be maintained. Uganda experienced a decline in prevalence and an increase in safer behavior in the 1990s. Since that time complacency has grown and political commitment and funding for intervention waned. Recent studies show that Uganda is now seeing decreasing condom use in casual encounters and an increasing incidence of multiple casual partners[10].

[8] UNAIDS 2007, http://data.unaids.org/pub/EPISlides/2007/ 071118_epi_regional%20fact sheet_en.pdf

[9] J. Crush, Migration Policy Series No.24; M, Lurie in HIV/AIDS in South Africa, 2005; K. Wellings et al, Lancet 2006; T. Goliber, July 2002, www.prb.org/Articles/2002/TheStatusoftheHIVAIDSEpidemicinSubSaharanAfrica.aspx

[10] UNAIDS 2007; National Public Radio, 2006

Note for HIV/AIDS Managers
THE PHASES OF DDR

The overall goal of DDR programs is to help ensure peace and contribute to recovery in countries affected by conflict. The objective of a DDR program is to support the social and economic reintegration of ex-combatants into communities in order to attain a similar standard of living and social acceptance as others in their area of return.

DISARMAMENT – Ammunition, weapons, and explosives are collected, controlled and disposed of during disarmament. Fairness and sound execution are essential. As mutual trust and confidence gradually build among the warring parties as disarmament proceeds, the quality and caliber of the weapons collected tends to improve over time. Until concluded, members of armed groups are generally considered "combatants" and ODA funding can not be used in support of the process. To avoid giving the impression that DDR is a weapons buy-back program that rewards combatants, it is recommended to avoid providing benefits at this point.

DEMOBILIZATION – Demobilization is a process whereby armed personnel and dependents are separated from a military structure and identity, and begin to assume a civilian one. In broad terms, the process involves the dissolution of military command and control structures, provision of basic civilian supplies and services, and dissemination of information to assist ex-combatants to begin their new non-military lives. The process also seeks to ensure special support for particularly vulnerable groups including children, disabled and women; and also provides a good opportunity for health counseling, HIV/AIDS education and voluntary testing. In general, the following types of activities are carried out under a demobilization process: encampment; verification of combatant status; provision of food, shelter, and medical attention; registration, socio-economic profiling and provision of identification document; provision of general and programmatic information; and formal discharge.

REINSERTION – During the period immediately following demobilization, ex-combatants will generally receive support to return to their communities and sustain themselves and their families for a limited time period until reintegration assistance can be organized. Reinsertion support can take the form of in-kind assistance or cash payments, depending on the program. Many programs only make payments to ex-combatants once they are back in their area of return, rather than at the demobilization site.

REINTEGRATION - Most DDR programs provide additional support to ex-combatants to help them with their social and economic reintegration into their communities. Information, counseling and referral services, agricultural inputs, jobs training, apprenticeships, and micro-business support may be offered for a limited time to help returning ex-combatants attain the same general standard of living as others in their community. Ex-combatants are encouraged to settle in areas where they have family, and informal networks of ex-combatants – discussion groups, ex-combatant and civilian associations, joint economic ventures – are often facilitated to encourage social reintegration. Where possible, reintegration assistance is structured so that benefits also accrue to other members of the community, especially those made more vulnerable as a result of the conflict, or to the community as a whole. Information campaigns and support for reconciliation activities are also central to the process of social reintegration.

Source: Adapted from "The Greater Great Lakes Regional Strategy for Demobilization and Reintegration", World Bank, March 2002.

CHAPTER 1: Ex-combatants and HIV/AIDS
HOW THEY ARE AFFECTED

Soldiers are often thought to have high levels of HIV/AIDS.[11] Conventional wisdom among those working in AIDS has been that HIV prevalence was typically two to five times higher among soldiers than their civilian population counterparts. More recently however, data suggest that military sero-prevalence rates in some African militaries are only slightly higher than those of the general population.[12] An issues paper presented at a conference on conflict and security in 2005 questions several assumptions related to conflict and AIDS, including the view that HIV is invariably higher among soldiers and armed groups.[13] Similarly, a systematic review by UNHCR of data from seven countries affected by conflict concludes that there is insufficient evidence that HIV transmission increases in populations affected by conflict.[14] Authors of both documents conclude that good data are lacking and more study is needed, and that, since each situation is unique, a better understanding of the array of factors involved is called for.[15]

It is clear that, because of the realities of many soldiers' lives—separation from spouse and family, possible deployment in areas where HIV is widespread, frequent opportunities for casual sex, access to resources, a tendency to assume greater risk during conflict—soldiers may be more at risk of contracting HIV.[16]

It is also clear that there are factors that mitigate or lessen the risk of HIV/AIDS among soldiers. Many militaries have had education programs about sexually-transmitted infections (STIs) in place for decades. The prevention behaviors that protect one from STIs are the same behaviors that lessen the chances of contracting HIV/AIDS through sexual contact. Some militaries also started specific HIV/AIDS education programs early on, and thus many ex-soldiers had reliable information about STIs, HIV/AIDS, risk behaviors and prevention methods prior to involvement in conflict. In discussion groups conducted by MDRP, soldiers from both sides of the given conflicts reported significant knowledge of HIV/AIDS prior to and during the war.

Furthermore, in some regular armies, the rules and discipline that characterize army life extend to sexual behavior,

[11] A 1998 UNAIDS publication reported that studies in the USA, the UK and France had shown that soldiers had a much higher risk of HIV infection than their equivalent age/sex groups in civilian populations. Figures from Zimbabwe and Cameroon at about the same time indicated that military HIV infection rates were three to four times higher than the civilian population. From: Aids and the Military: UNAIDS Point of View. The Best Practice Series. May 1998. http://data.unaids.org/Publications/IRC-pub05/militarypv_en.pdf

[12] Conversations with national HIV/AIDS leaders during the MDRP study.

[13] Alex de Waal. HIV/AIDS and the Military Issue Paper. Presented at AIDS, Security and Democracy: Expert Seminar and Policy Conference, Clingendael Institute, The Hague, 2-4 May 2005. Note that the paper states "we can say with confidence that [a rate of infection between two to five times greater among soldiers] is not the case in sub-Saharan Africa." http://asci.ssrc.org/doclibrary/issue_paper1.pdf

[14] Paul B. Spiegel et al., Lancet, 2007.

[15] Many militaries do mandatory testing of soldiers and thus have reliable statistics on the percentage of HIV. Most are testing even though they do not have a policy as such. In one manner or another, HIV antibody testing is conducted in 94% of militaries responding to the UNAIDS/CMA survey, although only 55% have developed declared testing policies. The most frequent compulsory tests are at recruitment and prior to deployment. From AIDS Brief For Sectoral Planners and Managers: Military Sector. www.ukzn.ac.za/heard/publications/AidsBriefs/sec/Military.pdf

[16] Much attention has been given in the literature to these at-risk factors in both military and public health literature and estimates of military HIV sero-prevalence presented are often alarmingly high. However, these estimates are frequently given without providing a source probably because many militaries consider HIV/AIDS infection levels an indication of military readiness and therefore do not share these statistics publicly. This presents a problem, however, for the researcher, since without being able to validate the source behind the statistic, one cannot be sure of the information. This often leads to either exaggerating the situation or ignoring the issue entirely. Both responses are undesirable as neither result in appropriate responses to what is or could become a serious problem.

Soldiers' Risk of HIV/AIDS

Throughout the world, military personnel are among the most susceptible populations to HIV infection and AIDS. They are mostly young and sexually active, are often away from home and family, are governed more by peer pressure than established social convention, are specifically trained in risk-taking and self-perceptions of invincibility, and are usually exposed to opportunities for casual sex.

Source: From *AIDS Brief For Sectoral Planners and Managers: Military Sector*. This brief has information and checklists that could be of use to DDR managers and their partners. www.ukzn.ac.za/heard/publications/AidsBriefs/sec/Military.pdf

offering further protection from HIV/AIDS during conflict. Ex-soldiers in one of the MDRP groups stated clearly that during their military service, soldiers were to have one partner and that was all. According to these ex-combatants, the rule was taken seriously, enforced and followed.[17]

The situation among irregular forces is usually quite different. In general, these groups are characterized by less structure, less training, and less access to information than formal militaries. In most cases, irregular force personnel do not have access to programs providing information and services about STIs and HIV/AIDS. MDRP discussion group participants reported that their main sources of information are radio, and more often, word of mouth. In almost all cases, this information is very sketchy, often a mix of correct and incorrect information, or in some cases just wrong. Participants in MDRP discussion groups consistently reported low levels of knowledge about HIV/AIDS before and during conflict among members of irregular forces.

We had heard of AIDS but we
could not talk about it. It was a hidden subject.
For many, AIDS meant witchcraft. (RWANDA)

For most irregular forces, the demobilization phase was their first opportunity to hear accurate, in-depth information about HIV/AIDS.

We had heard of AIDS but we were not clear
what it was and we had no information about
how to keep from getting it.
People from Congo said it came from monkeys.
Others said that when you sleep, you get it. (ANGOLA)

Risk behaviors also vary over time and among ex-combatant groups. While involvement in conflict may mean combatants engage in more high-risk sexual behavior, this is not always the case. Survival—making it to the next day—is often the only concern for some soldiers on the front line. As one ex-combatant said in an MDRP discussion group:

There was no time for sex;
there was only the war. (BURUNDI)

Table 1 shows ex-combatant responses (by country and discussion group) to questions about the degree of high-risk behavior, or exposure to a high-risk situation, among their ex-combatant group during the period of conflict. Discussion groups were asked to rank the risk of being exposed to HIV/AIDS (from "none" to "high") in regards to the extent ex-combatants with whom they had served had engaged in specific risk behaviors, or had been exposed to circumstances in which the AIDS virus could be transmitted (i.e. unsterilized medical equipment, for example). Table 1 reveals strong consistency in rankings among most groups for certain behaviors (e.g., sex without condom) and variations in rankings among groups in other areas (e.g., frequency of sex and sex with commercial workers). Ex-combatant rankings of a range of high-risk behaviors and high risk situations by each phase of DDR—war, demobilization, reinsertion, reintegration—are presented in Annex B.

Discussions also revealed that, with very few exceptions, it is during the reinsertion phase– the weeks immediately following demobilization, when ex-combatants first re-enter civilian life– that the risk of contracting or transmitting the HIV virus is highest. They are ready to celebrate the end of the war and their end of service, have money in their pockets, and often end up in situations that facilitate HIV transmission. Discussion group participants indicated that during this time, sex was frequent, often with multiple partners, at times with commercial sex workers, and that condoms were rarely used. This is the case even when the HIV/AIDS component during demobilization was reported to be quite good. In most cases ex-combatants reported having learned during demobilization about risk factors, prevention measures and the importance of condom use; many reported having received free condoms; some reported be-

[17] Both the DeWaal paper and the UNHCR report discuss other factors that can reduce the prevalence of HIV/AIDS among those involved in conflict.

TABLE 1 Risk Factors for HIV/AIDS During Conflict According to Ex-combatants in Angola, Burundi, and the Republic of Congo

In focus groups ex-combatants ranked the extent to which members of their combatant group had engaged in a certain high-risk behavior, or been exposed to a high-risk situation, for HIV/AIDS according to the phase of demobilization. Their insight revealed similarities across groups and countries as well as occasional differences. For example, ex-combatants in each of the three countries indicated that having sex without using a condom was widespread during the period of conflict. However, the number of ex-combatants having sex with multiple partners, while reported to be consistently high in Burundi and the Republic of Congo, varied by group in Angola as did frequency of sex. (A strict military rule to have only one sexual partner was the reason for the differences according to Angolan ex-combatants.) In contrast, the extent to which ex-combatants engaged in sex with commercial sex workers (CSWs) varied considerably by group in each country, with some reporting ex-combatants in their group never or rarely engaging in sex with CSWs and others reporting frequent sexual contact with CSWs by members of their group.

Risk of exposure to HIV/AIDS as a result of inadequate medical services also varied considerably. All Angolan groups except one estimated that there was little or no risk of contracting AIDS via this route since army personnel had access to good health services throughout the war (but not after). Having a better understanding of ex-combatant risk behavior is important in order to target groups most at risk of contracting HIV/AIDS and to develop effective prevention and treatment strategies.

This table presents ex-combatants' rankings of certain risk behaviors and risk situations during the period of conflict (see also Annex B).

	Ex-combatant groups	Frequency of sex	Multiple partners	Sex without condom	Sex with CSWs*	Rape	Inadequate medical care	Sex with refugees or IDPs	Sex with peace-keepers
ANGOLA	Luanda-Viana women I	XX	XXX	XX	men XX	Rural X Urban XXX	O	XX	O
	Luanda-Viana women II	X	X	XXX	men XXX	XXX	XX	O	X
	Benguela disabled men	X	X	XXX	O	O	O	X	O
	Benguela disabled women	XXX	O	XXX	O	X	O	O	O
	Cubal women	XX	XX	O	O	O	O	O	O
	Cubal men young & old	X	X	XXX	XXX	XXX	O	O	O
	Cubal only older men	X	XXX	XXX	XXX	XXX	O	O	O
	Bocoio men	X	O	XXX	O	O	O	O	men 0 women XXX
BURUNDI	Rumonge men	XXX	XXX	XXX	O	XX or XXX	X	O	O
	Bureri men	XXX	XXX	XX	XXX	X	O	XX	O
	Gitega men	X	XXX	XXX	X	X	X	X	O
	Gitega young men	XXX	XXX	XXX	O	XX	X	X or XX	O
	Gitega disabled men	XX	XXX	XXX	O	O	XXX	O	O
	Gitega women	XX	XX	XXX	O	XXX	O	O	O
	Bujumbura women	XXX	XXX	XXX	O	XXX	XX	O	O
REPUBLIC OF CONGO	1st grp Brazzaville men	XX	XXX	XXX	XXX	XXX	XX	XX	O
	2nd grp Brazzaville men	XXXX	XXX	XXX	XX	XXX	XXX	O	O

* CSW = commercial sex worker

O = no risk, X = some risk, XX = medium risk, XXX = high risk

ing shown how to put on a condom, and a few reported learning about negotiating condom use with their partners. Nonetheless, with only a few exceptions as shown in Table 2 the risk of unprotected "at-risk" sex in the weeks after demobilization was assessed by the ex-combatants as "medium" or "high".

TABLE 2 Risk Factors for HIV/AIDS at Reinsertion According to Ex-Combatants in Angola, Burundi, and the Republic of Congo

In focus groups ex-combatants ranked the extent to which members of their combatant group had engaged in a certain high-risk behavior, or been exposed to a high-risk situation, for HIV/AIDS according to the phase of demobilization. This table presents ex-combatants' rankings of certain risk behaviors and risk situations at reinsertion (See also Annex B for ex-combatant rankings of a range of high-risk behaviors and high risk situations by each phase of DDR—war, demobilization, reinsertion, reintegration.)

	Ex-combatant groups	Frequency of sex	Multiple Partners	Without condom	Sex with CSWs*	Rape	Inadequate medical care	Sex with refugees or IDPs	Sex with peace-keepers
ANGOLA	Luanda-Viana women I	XX	XX	XXX	Men XX	XX	O	O	XX
	Luanda-Viana women II	XX	XX	XXX	XXX	XXX	XXX	X	O
	Benguela disabled men	X	O	XXX	O	O	XXX	O	O
	Benguela disabled women	X	O	XXX	O	O	O	O	O
	Cubal women	X	O	XX	O	O	O	O	O
	Cubal young men	XXX	XXX	XXX	XXX	XXX	O	O	O
	Cubal older men	XXX	O	XXX	XXX	O	O	O	O
	Bocoio young men	XXX	XXX	XX	XX	O	XXX	O	O
	Bocoio older men	XX	XXX	XX	XXX	O	XX	O	Women XXX
BURUNDI	Rumonge men	XXX	XXX	XXX	XXX	O	O	O	O
	Bureri men	XX	X	X	XX	O	O	X	O
	Gitega older men	XXX	XXX	XX	XX	O	O	X	O
	Gitega young men	XXX	X	XXX	X	O	O	X	O
	Gitega disabled men	X or XX	X	XX	X	O	O	XX	O
	Gitega women	X	X	XXX	Men XXX	O	O	O	O
	Bujumbura women	XXX	XXX	XXX	O	O	O	O	O
REPUBLIC OF CONGO	Brazzaville men under 30	XXX	XX	XX	XXX	XX	XXX	XX	O
	Brazzaville men over 30	X	XX	X	X	O	XX	O	O
	2nd grp Brazzaville men	XXX	XXX	XXX	XX	XX	XXX	O	O

* CSW = commercial sex worker

O = no risk, X = some risk, XX = medium risk, XXX = high risk

Overall, discussion group findings suggest that things tend to calm as the ex-combatant returns to life within his or her community. Ex-combatants in Burundi, the Republic of Congo and Rwanda indicated that high-risk sexual behavior decreases once ex-combatants settled into their communities. In Angola however, input from ex-combatants suggests that risk levels either remained constant from demobilization to reintegration or in some cases increased.[18] Further study is needed, but comparing trends across age groups and by geography suggests that high-risk behavior remains high among young male ex-combatants and among those living in urban areas.[19]

You can get HIV by...:

- Having unprotected sex - sex without a condom - with someone who has HIV. The virus can be in an infected person's blood, semen, or vaginal secretions and can enter your body through tiny cuts or sores in your skin, or in the lining of your vagina, penis, rectum, or mouth.
- Sharing transfusion or blood clotting factor from a source that is infected by HIV.
- Sharing needles and syringes used to inject drugs, steroids, vitamins, or for tattooing or body piercing, or by sharing equipment used to prepare drugs to be injected.
- Sharing razors or toothbrushes (because of the possibility of contact with blood).

Babies born to women with HIV also can become infected during pregnancy, birth, or breast-feeding, although there are some drugs that can reduce the chances of this.

You cannot get HIV...:

- By working with or being around someone who has HIV.
- From sweat, spit, tears, clothes, drinking fountains, phones, toilet seats, or through everyday things like sharing a meal.
- From insect bites or stings.
- From donating blood.
- From a closed-mouth kiss (but there is a very small chance of getting it from open-mouthed kissing with an infected person because of possible blood contact).

Source: Center for Disease Control (CDC) Pamphlet. HIV and AIDS: Are you at risk? www.cdc.gov/hiv/resources/brochures/index.htm

[18] Except in rural Bocoio where there was some decrease in risk behavior reported among men over 35, and in urban Viana where the group reported a slight increase in condom use, from no one using condoms to a few using them. The Angolan demobilization process differed from that of the other countries in this review. It may be that the different phases were less precise and thus not easily distinguishable for ex-combatants

[19] Of particular note are the reported use of intravenous drugs in the low-income neighborhood of Viana located in the outskirts of Luanda, Angola, and high levels of rape in Viana (reported by female ex-combatants), Cubal, a rural village in central Angola (reported by male ex-combatants), and in Brazzaville, the capital city of Congo (reported by male ex-combatants).

Note for DDR Managers
BASIC FACTS ABOUT HIV/AIDS, OTHER SEXUALLY TRANSMITTED INFECTIONS, AND OPPORTUNISTIC INFECTIONS

HIV/AIDS is a disease of the immune system, the system within the body that fights off disease and infection. HIV—human immunodeficiency virus—kills CD-4 cells in the blood that are part of our immune system. CD-4 cells attack other cells that enter the blood and cause disease or infections. When a person no longer has enough CD-4 cells to fight off disease-causing cells, he or she becomes ill. (One of the ways doctors determine when a person with AIDS needs to start taking medicine is by counting the number of CD-4 cells in the blood. This is called a CD-4 count.) The stage of the disease when a person starts having symptoms of HIV or becomes ill is called AIDS. Go to the Engender Health website at http://engenderhealth.org/wh/inf/index.html for more information on HIV/AIDS.

People with AIDS die of the infections or diseases they get because their body can no longer defend itself. The infections that take advantage of the body's weakened defenses are called "opportunistic infections". Common opportunistic diseases are: tuberculosis, certain cancers, and specific viruses and bacteria that cause diarrhea, fever, weight loss, stomach problems or pneumonia. In sub-Saharan Africa, tuberculosis, or TB, is the most commonly diagnosed opportunistic infection resulting from HIV, and it is also the most frequent cause of death among those infected with HIV.

The primary way that HIV is transmitted is through unprotected sex—sex without a condom with someone who has HIV. It can also be contracted by sharing a needle and syringe to inject drugs or using other drug equipment, from contaminated needles or other sharp objects used in health care, or from a blood transfusion with infected blood. In many countries, however, contracting HIV through blood transfusions is no longer a risk, since blood for transfusions is tested and only used if it is found to be free of the virus.

A person does not get sick right away when he or she contracts the HIV virus. Someone can have HIV and still feel and look perfectly healthy. Often it takes years from when a person gets the virus to when he or she starts to become ill. The only way to know for sure if you are infected or not is to be tested. One of the problems in containing the spread of AIDS is that many people don't know they have it: the vast majority of those infected worldwide have not been tested and remain unaware of their status.

There is currently no cure for HIV/AIDS, but new anti-retroviral drugs that slow down the progression of the virus and drugs to treat opportunistic infections have extended and improved the quality of life of those with HIV/AIDS. Living with AIDS is like living with any other chronic disease. Sometimes a person with AIDS suffers from infections and feels sick. At other times, he or she may feel fine and participate in normal activities. Treatment is also not simple and usually involves a combination of drugs with the person taking many pills on a set schedule throughout the day. Some drugs have side effects that may require a person to stop taking treatment or to switch to another drug. Over time, it has also been found that the AIDS virus can develop resistance to certain drugs. While many of these drugs are very expensive and are only available in industrialized countries, international AIDS leaders are working to make more drugs available in developing countries and most countries are rapidly scaling up treatment to persons living with AIDS.

While scientists are working on developing a vaccine that will prevent a person from getting HIV, a successful HIV vaccine is believed to be at least a decade away.

Sources: UNAIDS 2006 Report on the Global AIDS Epidemic.

HIV/AIDS in Southern Africa: Background, Projections, Impacts and Interventions. Prepared by The Policy Project for Bureau for Africa, Office of Sustainable Development, US Agency for International Development, Oct 2001.

Engender Health, "HIV Infection and AIDS", Online Resources, www.engenderhealth.org

Note for DDR Managers
MALE CIRCUMCISION AND HIV/AIDS

Recent research indicates that circumcision can reduce the risk of HIV/AIDS. Experts say the reduced risk may be because cells on the inside of the foreskin, the part of the penis cut off in circumcision, are particularly susceptible to HIV infection. Circumcision is not a guarantee however; at most, it reduces the chance of getting AIDS by just over half. A man who is circumcised can still contract AIDS. Existing programs to encourage condom use and reduction in numbers of sexual partners must continue.

Source: The Lancet, Volume 369, Issue 9562, Pages 708 - 713, 24 February 2007

CHAPTER 2: Reasons to address HIV/AIDS in DDR
WHY BE CONCERNED

HIV/AIDS can have a concrete impact—positive or negative—on the success of disarmament, demobilization and reintegration programs. HIV/AIDS activities should therefore be integrated into programming and the disease addressed from the start.

1. HIV/AIDS can disrupt successful reintegration

For reintegration to succeed, ex-combatants need to move back into communities and establish livelihoods, raise families and live in peace with their neighbors. AIDS can prevent this from happening. On an individual level, without information and links to services, chances for a sero-positive ex-combatant to reintegrate successfully are not high.[20] Rather than earning a living and supporting a family, the sero-positive returnee will eventually need support and care for him or herself. On a broader level, AIDS destroys the fabric of society, and as losses due to AIDS mount within a community, opportunities for growth and change for the better diminish. Moreover, as possibilities for a better individual and collective future decrease, odds for a return to conflict increase.[21]

2. Ex-combatants can carry HIV back home

While ex-combatants may or may not have higher levels of HIV than the general population, in all likelihood some ex-combatants in a group demobilizing will be sero-positive. When these ex-combatants go back home, they risk extending the epidemic, spreading the virus to new areas and new groups of people in their home communities. Adding to this risk, and making reinsertion a potential driving factor in the spread of HIV/AIDS, are the high rates of unprotected sex with multiple partners during the reinsertion phase of DDR, which were consistently reported in MDRP discussion groups in each of the four countries studied.

3. Ex-combatants can be at risk if returning to a high prevalence area

Sero-negative ex-combatants moving back into areas of high prevalence risk contracting HIV/AIDS. The ex-combatant tendency to have unprotected high-risk sex during the post-demobilization period places them at risk of becoming infected with HIV and adds to the interaction that spreads the virus.

4. The stigma of AIDS can make reintegration more difficult

HIV/AIDS makes gaining community acceptance more difficult for the ex-combatant. To settle in successfully, ex-combatants need to overcome community perceptions that link them to conflict and violence. The common perception that soldiers and armed groups are more affected by AIDS adds to this mistrust and makes it all the more difficult to counter. In this context, it is important to equip ex-combatants with information and knowledge of their own HIV status.

[20] A 1998 review of a DDR program in Uganda found when trying to access a random sample of participants discharged between 1992 and 1996, that one out of four were reported deceased. The evaluation team attributed this to the policy of the Ugandan forces at the time to discharge those with "advanced medical conditions", which in many instances at this time in Uganda, was HIV/AIDS.

[21] http://www.unaids.org/en/PolicyAndPractice/SecurityHumanitarianResponse/default.asp

5. Joining the fight against AIDS facilitates reintegration

Becoming involved in the fight against AIDS can facilitate ex-combatants' reintegration into their home communities. As they work side by side with other community members against AIDS, the lines that separate ex-combatants from former enemies or communities affected by conflict tend to fade, negative attitudes towards ex-combatants become more positive, and ex-combatants help build a stake in a peaceful, prosperous community together with other members of the community. Ex-combatants in Rwanda remarked that in some ways reintegration had been easier for HIV-positive ex-combatants due to their contact and interaction with groups involved in the fight against AIDS.

6. Ex-combatants can be key players in turning back the epidemic

Ex-combatants returning to communities can also be a very important asset in the fight against AIDS. The most effective strategies to combat AIDS have come from within communities. In places as different as California, Uganda, and Thailand, successful strategies have involved simple messages and actions, and relied on interpersonal communication channels and networks—people talking to people they knew.[22] As ex-combatants demobilize, they move back to farms, villages, towns, and cities all over a country. Properly informed and motivated, these individuals reconnecting with local networks can make a world of difference as they talk to people about the disease.[23] Ex-combatants among the discussion groups in all four countries of this study indicated a willingness and potential to play such a positive role in the fight against AIDS.

In sum, addressing HIV/AIDS in DDR programs is vital to successful reintegration of ex-combatants. Moreover, ex-combatants themselves can also play a positive role in the fight against AIDS. DDR programs need to address HIV/AIDS head on, joining in the fight against AIDS with government and civil society organizations. In turn, those leading the fight against AIDS need to be aware and supportive of DDR programs and should seek to engage ex-combatants as active agents in AIDS prevention activities.

[22] David Wilson. Partner Reduction and the Prevention of HIV/AIDS. BMJ 2004;328;848-849

[23] Where ex-combatants are returning to communities that have been isolated as a result of the conflict (e.g., the plan alto region of Angola that UNITA drew its base of support from) they can serve as an entry into local community networks, which may be unavailable to other groups, such as formal Government HIV/AIDS structures and services.

Note for DDR Managers
THE FEMINIZATION OF AIDS

The fastest growing infected group in sub-Saharan Africa is women. Over the past few years, there has been a clear feminization of the epidemic in Africa: three out of four HIV-positive Africans between the ages of fifteen and twenty-five are women. Biologically, women are more susceptible since the HIV virus passes more easily from men to women than the reverse. More importantly though, the position of women in society makes it difficult for a woman to dictate the terms of sexual relations in general and to negotiate condom use in particular. This vulnerability is constant among very different women: a woman who has turned to prostitution to feed her family, a woman who agrees to sex in exchange for a specific benefit, a woman faithful to a husband who is not faithful to her. All three are vulnerable because of their gender.

> *"What's fueling the 'feminization of AIDS'? Gender inequality, say experts. A host of cultural, legal and economic factors limit the control women have over their lives, their sexual relationships and the power to protect themselves from infection. Sadly, the majority of women are being infected by their husbands, making marriage one of the most dangerous places for women today." [From "The Feminization of AIDS" by Marielena Zuniga. See http://www.iwhc.org/resources]*

Many reproductive health experts are concerned that a widespread approach to behavior change used in HIV/AIDS programs in Africa does not take the situation of women into account adequately. It is called the ABC approach: Abstain, Be faithful, or use Condoms. The concern is that where women and girls have little control over their sexual relationships, they do not have the choice to abstain from sex or to use a condom. Plus in practice, many believe that the approach promotes abstinence and faithfulness over condom use and can lead to linking the condom with promiscuous behavior, e.g. condoms are for use with "loose" women, not for use with wives. In fact, ex-combatants in MDRP discussion groups tell stories of women they know being beaten for only suggesting condom use with their husbands. With no right to use a condom—and often no way to get one—the married woman has no way to protect herself from a husband who may very well have not followed the first two rules, to abstain and be faithful, and refuses the third, to use a condom.
Poverty and precarious living situations also push some women to prostitution or transactional sex (when men and women exchange material benefits and sex). The response of a Rwandan female ex-combatant in an MDRP discussion group to a question about prostitution underscores the precarious living situation of women and, as well, the concept of transactional sex. She answered:

> *"What's a prostitute? Are you a prostitute when you have sex with a truck driver for a ride when you have to get into town?" (Rwanda)*

The situation of a South African woman recounted by a reporter in 2005 lays out even more clearly the difficult choices facing some women today.

> *"Sheila turned to prostitution to feed her children after her husband deserted her to look for work in South Africa. She reasoned that AIDS takes ten years to kill you, but hunger would finish off her kids much sooner." [Angus Shaw, Guardian Weekly, 2005]*

Note for DDR Managers
STIGMA

Stigma—shame or disgrace associated with having HIV/AIDS—is a critical problem that blocks efforts to fight the disease. It pushes those with HIV/AIDS to hide their condition because they are ashamed and because they fear being rejected. Because of the fear of being "found out", AIDS stigma keeps people from using condoms, being tested, seeking counseling, and getting treatment. It also affects how persons living with HIV/AIDS (PLWHA) are perceived and treated by their communities, their families and their partners. AIDS stigma must be overcome if the AIDS epidemic is to be stopped.

Stigma is measured by people's responses to questions such as whether they would buy fresh vegetables from a shopkeeper who had HIV/AIDS, whether they believed that a female teacher living with HIV/AIDS should be allowed to continue teaching, or whether they would want to keep secret that a family member had been infected with HIV/AIDS. Tracking responses to questions such as these over time provides information concerning how attitudes towards AIDS can change over time.

Experience has shown that something can be done about stigma and that it can be reduced through a variety of intervention strategies (including information, counseling, developing coping skills of those with AIDS, and contact with persons living with HIV/AIDS). The key is providing clear, factual information in a non-judgmental way. Involving people living with HIV/AIDS (PLWHA) in the fight against AIDS has also been shown to reduce stigma over time. [Interventions to Reduce HIV/AIDS Stigma: What Have We Learned? Lisanne Brown, Lea Trujillo, Kate Macintyre, The Population Council Inc., 2001]

The best way to counter rumor and suspicion is with facts and openness. Providing ex-combatants with information about AIDS during demobilization, how it is and how it is not transmitted, will prepare the ex-combatant to address negative community perceptions about ex-combatants in particular and to work to lessen the stigma associated with HIV/AIDS in general.

For ways to address stigma, see Understanding and challenging HIV stigma: Toolkit for action. It was written for and by African HIV trainers and has tested activities for fighting stigma. It can be found online at www.aidsalliance.org/custom_asp/publications/.

CHAPTER 3: Essential elements for every DDR program

WHAT ALL DDR PROGRAMS SHOULD DO

All DDR programs should include a set of core HIV/AIDS activities so that the disease does not reduce the chances of successful reintegration. DDR programs should seek support for core program activities from organizations working in country on HIV/AIDS issues. Should support not be available, the DDR program should ensure that the basic elements outlined here—ranging from policy issues to program activities—are undertaken using DDR funds, directly contracting for services as necessary. No matter how these core services are ultimately provided, they should be in accordance with the country's national AIDS strategy.

1. Act within the framework of the national HIV/AIDS strategy

DDR HIV/AIDS initiatives must fall within the context of a country's HIV/AIDS program. Consistent with the UNAIDS "Three Ones Initiative"—one coordinating agency, one strategy, one monitoring and evaluation system—DDR commissions should work closely with national AIDS leaders to define objectives of the HIV/AIDS component, defining program activities, and selecting monitoring and evaluation indicators to measure the program success of DDR HIV/AIDS activities.

DDR programs usually work as a country is coming out of war and, thus, are often the first post-emergency type of assistance provided. At this early stage, government services are often not up and running, and most NGOs are focused on emergency assistance. National policy, an institutional AIDS framework, and services for DDR programs to tap into may not be in place when demobilization programs are first getting underway.[24] In these situations, DDR programs should work to establish critical HIV/AIDS education and testing as early as possible with DDR funding, building collaboration with government actors and NGOs as soon as feasible.

HIV/AIDS lasts a lifetime; DDR programs only a few years at most. Therefore DDR programs should aim to insert ex-combatants back into their communities with full access to local prevention and treatment programs available to community residents. DDR needs to ensure that the ex-combatant:

i) has the practical information and links necessary to access information, prevention, testing and treatment as needed,
ii) has the same rights and access to HIV/AIDS program activities as any other citizen, and
iii) knows what is available to him/her and what his/her rights are.

2. Ensure ex-combatants are included in AIDS policies and programs

Not all of those leading the fight against HIV/AIDS are aware of DDR programs, nor have the opportunities and risks presented by demobilizing ex-combatants been taken into account in all national HIV/AIDS strategies. Even when national HIV/AIDS leaders do know about demobilization and its potential significance in the fight against HIV/AIDS, they often are not aware of the specifics of the demobiliza-

[24] While there is a chance that a country undertaking DDR will not as yet have a national AIDS strategy in place, it would be unusual. Even when Angola was emerging from a decades' long civil war, a national AIDS strategy was in place when the bulk of the demobilization was carried out.

tion process nor how and by whom demobilization is managed. Many assume that militaries run DDR processes and that funding for HIV/AIDS activities within militaries will reach those demobilizing. That is usually not the case.

To address these gaps, demobilization commissions should share information about demobilization with national HIV/AIDS leaders, brief government agencies and NGOs involved in the fight against AIDS about the DDR program and strategies for HIV/AIDS interventions, and discuss the importance of including ex-combatants in HIV/AIDS policies and programs. Governments should be encouraged to consider ex-combatant needs when preparing funding proposals and identifying priority target groups for NGO involvement.

3. Develop a policy for sero-positive ex-combatants who are demobilizing

For sero-positive ex-combatants, the task of DDR when prevention and treatment are available nationwide is clear: provide them with the information they need and link them to services in their home community. However, in countries where prevention, testing and treatment services are not established throughout the country, what a DDR program should do is less apparent. For example, what should the policy of a DDR commission be for a sero-positive ex-combatant intending to return home to an area where testing and treatment are not available? Important policy questions also arise in situations where demobilizing ex-combatants already on ARV treatment plan to demobilize to areas without treatment services. Interrupting treatment could result in drug resistance as well as a rapid deterioration of the ex-combatant's health. One option in this situation would be to counsel the ex-combatant to resettle in an area where services are available and support him/her in moving to the new area. Another option—only in cases where a significant number of sero-positive ex-combatants are involved—would be to "kick-start" services by financing the immediate set-up of services in the area of return.[25] Some militaries have chosen a third option, to retain—i.e., not demobilize—sero-positive soldiers and those on ARV so they continue to have access to military health services. These issues should be discussed between DDR program planners and managers and relevant national health officials, both civilian and military. Decisions should be made in accordance with national policies regarding HIV/AIDS and public health.[26]

After transmission there is often a lengthy period from infection with HIV to development of the disease AIDS that may last from two to 12 years, or even longer. Some people may survive longer than 12 years, while others may develop AIDS within two to three years and die soon thereafter. On average, a person does not develop AIDS until 8 years after becoming infected. For most of this period, the person may not have any symptoms and so may not even be aware that he or she is infected. This contributes to the spread of HIV, since the person can transmit the infection to others without knowing it. People with full AIDS, of course, remain infectious. For children, the incubation period is much shorter because their immune systems are not fully developed. Most children who are infected at birth die within five years.

No one is sure why some infected individuals develop AIDS at a slower pace than others. Countries where the overall health of the population is poor may have shorter incubation periods, on average, than countries with better health conditions.

Sources: USAID/AFR/SD, Washington, DC (October 2001) http://pdf.usaid.gov/pdf_docs/PNACN255

HIV/AIDS in Southern Africa: Background, Projections, Impacts and Interventions, The Policy Project.pdf

Ultimately, when developing policy for sero-positive ex-combatants, DDR managers need to be aware that good public health decision-making involves using resources in the best way possible in order to protect the public's health. In an epidemic, health leaders channel resources to areas most affected in order to treat those afflicted and to contain the spread of the disease. This means that not all areas will have—nor should have—the same HIV/AIDS service package, but rather a service package that corresponds to the level of need and the level of risk in the area. The return of ex-combatants is only one of many factors that health officials need to take into account in planning a sound response

[25] Kick-starting services is an option if, and only if, providing testing and treatment services in an area is part of the national AIDS strategy. The cost of maintaining services, not the cost of setting up services, is the primary challenge of financing an AIDS program. Health officials must make service decision balancing need with available resources. See Kombe et al.

[26] If sero-prevalence levels among ex-combatants are significantly higher than that within their home communities, their return may represent a public health risk. Ex-combatants also represent an important opportunity in fighting the epidemic as discussed elsewhere in these guidelines.

to the AIDS epidemic. It should also be borne in mind that the primary challenge to financing AIDS testing and treatment is not the cost of setting up the services, but rather the cost of maintaining services over time.

4. Meet five basic requirements at demobilization

Demobilization presents a unique and strategic opportunity to make what could be a life-or-death difference in the future of ex-combatants. Demobilization is a critical juncture in the lives of combatants when they emerge from one lifestyle and move onto another. It is the point to ensure that an ex-combatant infected with the virus has information about his or her status, how to stay well and access available services, and how to protect those around him or her. It is also the point to ensure that an ex-combatant not infected with the virus remains so by ensuring he or she has the information and access to means of protection in the future. As demobilization usually involves encampment of ex-combatants, it is also the point when DDR programs can most efficiently deliver information and services needed to support ex-combatants in the transition back to their communities and civilian lives.

As such, all DDR programs should ensure that the following five basic requirements are met during the demobilization phase.

1. Ex-combatants acquire the skills and knowledge needed to protect themselves and those around them from HIV/AIDS.
2. Voluntary counseling and testing (VCT) is available at the demobilization site.
3. Detection and treatment of sexually transmitted diseases is included in medical screening.
4. Male condoms are distributed in take-home kits. Information on female condoms is provided and the condom available to all upon request.
5. Ex-combatants leave demobilization centers with precise information on how and where to access condoms, testing and treatment in their area of return.[27]

The first, and most critical, requirement at demobilization is that ex-combatants leave the demobilization center with the knowledge and skills they need to protect themselves, their families and others around them. Ex-combatants should know the key facts about AIDS—how you get it, how you don't, how you give it to others, and how you can protect yourself. Equally important, they should leave the center with the skills necessary to put their knowledge into practice: knowing is not enough. This includes how to discuss condom use with partners, how to refuse to engage in unsafe sex, how to put on a condom, and how to recognize the need for treatment of STIs.[28]

The second basic requirement at demobilization is voluntary counseling and testing (VCT) available at demobilization centers. Demobilizing ex-combatants should know the importance of knowing their HIV status and have the opportunity to find it out. Studies have shown that VCT is a powerful behavior change tool: knowing and discussing one's HIV status with a trained counselor is very effective in bringing about lasting behavior change for both infected and uninfected people. Those who test negative and undergo quality risk reduction counseling are more likely to change their behavior in order to stay free of HIV. Those who test positive and receive counseling are motivated to protect themselves and others and to seek the help they need.[29]

Testing must be voluntary. The World Health Organization (WHO) and UNAIDS have asserted that *"there is no public health justification for mandatory HIV screening as it does not prevent the introduction or spread of HIV. Public health interests are best served by promoting voluntary counseling and testing in an environment where confidentiality and privacy are maintained"*.[30] Making testing mandatory, in fact, risks an opposite effect to that desired. Testing is only the first in a series of behaviors an individual must adopt to stop the transmission of HIV. Forcing the first behavior makes it unlikely that a person will continue willingly with the necessary follow-on behaviors. Making the first step of testing voluntary—positive rather than negative—is likely to pave the way for continuing voluntary preventive behavior.

[27] Female ex-combatants should also receive information on how and where to obtain male condoms.
[28] It is recommended that the percentage of ex-combatants citing correct information about the causes of AIDS and prevention measures should be included in the M&E indicators of the demobilization phase.
[29] The Voluntary HIV-1 Counseling and Testing Efficacy Study Group. Efficacy of voluntary HIV-1 counseling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomized trial. Lancet 2000; 356:103-112.
[30] UNAIDS Policy Brief: HIV and Refugees. This document also stresses the right of freedom from mandatory testing.

VCT Works!

A multi-country—randomized controlled study conducted in Kenya, Tanzania, Trinidad and Tobago by Family Health International, UNAIDS and WHO documented a forty-three percent reduction in the occurrence of unprotected sex among those who received HIV voluntary counseling and testing.

Source: From a study by the Voluntary HIV-1 Counseling and Testing Efficacy Study Group

The third basic requirement at demobilization is screening for and treating sexually-transmitted infections (STIs). Relatively simple to do, diagnosing and treating STIs is important for two reasons. First, it identifies those whose behavior puts them at risk of contracting HIV and thus provides an early warning to an ex-combatant to adopt safer sex practices. Second, certain STIs increase the transmission of HIV: if one has an STI, it can make it easier for the AIDS virus to enter the body. In fact, having an untreated STI can increase up to ten times the chance to contract or pass on the HIV virus.[31] Treating the STI will reduce chances of later contracting HIV/AIDS should one be exposed.

The fourth basic requirement at demobilization is providing condoms to ex-combatants as they leave the demobilization site to return home. Ex-combatants report that the period just following demobilization is one of frequent sexual activity. DDR programs should ensure that each ex-combatant leaves demobilization with enough condoms to see them through this high-risk period. Ex-combatants of both sexes should also receive information about the female condom. Female ex-combatants should receive female condoms and learn how to use them. Female condoms should also be made available to those men who wish to try them with their partners.

The fifth basic requirement is that ex-combatants know how to access services and support (information, condoms, testing and treatment) as they travel back and settle in their home areas. Ex-combatants should be provided with specific information about resource persons, places, programs, and procedures of services available in their communities of return. For women ex-combatants, this should include information on where male condoms are available and ways to overcome the social barriers that discourage a woman from seeking male condoms. Experience shows that even the best intentions can wane if something is too difficult to do or a person does not know how to go about doing it. Providing information about community services to ex-combatants is an easy and inexpensive way DDR programs can give the extra push needed to help ex-combatants put knowledge into practice.

Every DDR program should ensure these five basic requirements are met during the demobilization process. While a contained, on-site demobilization program is ideal for HIV/AIDS activities, many DDR programs are moving to shorter non-residential demobilization processes. It may not be feasible then to do all five—AIDS education, VCT, treatment of STIs, distribution of condoms, and information on community services—during demobilization. If that is the case, DDR commissions should ensure that what is not accomplished during demobilization is integrated soon thereafter into later phases of the DDR program—preferably during reintegration.[32]

Five essential actions during demobilization

1. Conduct AIDS education that provides both the skills and knowledge ex-combatants will need to protect themselves and their families from HIV/AIDS.
2. Provide voluntary counseling and testing at the demobilization site.
3. Include detection and treatment of sexually transmitted diseases in medical screening.
4. Distribute male condoms in take-home kits. Also provide information about female condoms and distribute female condoms upon request.
5. Provide precise information to the ex-combatants on how and where to access condoms, testing and treatment in their area of return.

[31] Sexually-transmitted infections—such as gonorrhea, syphilis, herpes, genital warts—are very common. In developing countries, such infections are among the top five reasons for which people seek health care. Many more people have an STI than those who seek treatment as many are without noticeable symptoms. The high number of sexually-transmitted infections is believed to be one of the factors why AIDS has spread so rapidly in Southern Africa. See http://www.who.int/reproductive-health/stis/index.htm

[32] Note that it is not necessary that a DDR program directly provide these services. DDR officials may rather choose to facilitate their provision by an organization(s) routinely involved in HIV/AIDS activities.

Experience in encouraging voluntary counseling and testing (VCT)

Experiences encouraging VCT among significant numbers of demobilizing soldiers have been mixed under World Bank supported DDR programs. In Ethiopia, only around 15% of 130,000 demobilizing volunteered to be tested. Given that the program targeted government soldiers and guidance on VCT could be considered an order, these results are lower than would normally be expected. In Rwanda, to the contrary, almost all ex-combatants agreed to be tested.

Ex-combatants in MDRP discussion groups had quite a bit to say about their VCT experiences. From their perspective a key element in successfully encouraging ex-combatants to be tested is to provide VCT on-site as an integral part of the demobilization program--having VCT available nearby is not the same. Other elements that facilitate VCT acceptance according to ex-combatants are:

- The idea of a "new start". Ex-combatants spoke of the new start that demobilization represents and the importance of knowing their HIV status to make the most of the opportunity to start anew. During demobilization they had been told that they were going from one life to a different life. To succeed in their new life, they would need to be healthy. Knowing their HIV status was an important factor in staying healthy.
- The concept of VCT as the duty of a good soldier. Ex-combatants spoke of knowing one's HIV status and being tested as the duty of a soldier. Having this "good soldier" argument come from a respected commanding officer was especially effective in promoting VCT among demobilizing soldiers.
- A gradual build-up from initial education session to testing and results. Ex-combatants in Rwanda recommend the approach used in their demobilization session: the education session led directly into testing with the results given the following day. Individual counseling was provided for each ex-combatant. Those testing positive received support, information and referral to specific services. Those testing negative were provided individual counseling on prevention and a recommendation for periodic follow-up testing with specific information on where to go. Some spoke of a slightly different and less positive experience, reporting several days between the education session and VCT during their demobilization and many ex-combatants losing their motivation to be tested during the lapse.*
- A sense of being part of something bigger, not being alone. Ex-combatants found going through the VCT experience as part of a group very positive: "We were all in it together." They spoke of a rapport that developed in the lead-up to testing that resulted in feeling less frightened and more ready to be tested because they were one of many and they knew they would not be alone when the results came.

* Contrary to what Rwandan ex-combatants recommend, international best practices suggest allowing some time for reflection after the initial education session and before voluntary testing.

5. Partner with NGOS to continue prevention beyond demobilization

Prevention efforts should go beyond demobilization. Feedback from ex-combatants in MDRP discussion groups indicated that even when the essential had been done, and done well, during demobilization, many ex-combatants did not put into practice what they knew they should, most notably during the first weeks following demobilization. DDR commissions should go one step further with targeted prevention initiatives for the high-risk reinsertion phase in cooperation with capable implementing partners.

DDR programs are not on their own in ensuring basic HIV/AIDS prevention for ex-combatants. Many excellent organizations work in the fight against AIDS and are seeking opportunities to make a difference.[33] DDR programs should seek to partner with organizations active in HIV/AIDS pre-

[33] Reinsertion is an opportunity to make a big difference. MDRP discussion group participants indicated that at this point in the demobilization process sex was frequent, sex was with multiple partners, sex was often with commercial sex workers, and condoms were rarely, if ever, used.

vention to increase the likelihood that ex-combatants will adopt safer sexual practices during the transitional reinsertion period just following demobilization.[34]

Ex-combatants in discussion groups clearly indicated that high-risk sexual behavior is common during the reinsertion phase of DDR. They suggested two specific strategies to be promoted during this phase: (i) make adoption of safe-sex practices more likely through changes to the surroundings ex-combatants find themselves in during reinsertion, and (ii) encourage the reinforcement of safe-sex practices through the ex-combatant's social network. For example, invest in key inputs (condoms and information) along the routes and in the places (guest-houses, bars, etc.) where ex-combatants are most like to pass en route to their areas of return. In addition, promote a "buddy" system among ex-combatants prior to departing demobilization centers so that pairs or groups of ex-combatants can watch out for each other and remind each other of safe-sex practices.

Prevention Strategies Recommended By Ex-Combatants for the Reinsertion Period

Making "The Way Home" Safe. "HIV-AIDS proof" the ex-combatant's route home. If ex-combatants tend to visit certain bars after leaving the demobilization site, work with partner organizations to ensure that condoms are available in bar restrooms or through bar workers, commercial sex workers in the area have condoms and know about HIV/AIDS prevention, and information is posted reminding the ex-combatant to stay safe.

Looking Out For A Friend. Promote a "buddy" system—a mutual protection agreement—among ex-combatants. Ex-combatants would watch out for each other in high-risk situations. For example, ex-combatants together at a bar would pass a condom to a fellow ex-combatant as he leaves with a woman or convince him to skip the encounter altogether.

A third issue to explore is the relationship between alcohol use and high-risk behavior. Alcohol affects judgment and decision-making and people are more likely to engage in behaviors that risk the transmission of HIV and other sexually-transmitted infections when they have been drinking. Recent research with STI clinic patients in South Africa has shown that a single counseling session on alcohol risk reduction can have significant impact on decreasing at-risk behavior.[35] Counseling ex-combatants on alcohol risk during demobilization could also have a positive result in safer sex practices during reinsertion.

6. Fight AIDS by supporting economic reintegration

Recent research suggests that there is a connection between unemployment, poverty and AIDS.[36] These links are complex and operate in both directions. AIDS has an impact on the socio-economic well-being of households and individuals; socio-economic status has an impact on sexual behavior, prevention measures and thus AIDS. MDRP discussion groups echoed this assessment, saying that unemployment and poverty among ex-combatants—especially younger ones—leads to high-risk sexual behavior and, consequently, the spread of AIDS. This dynamic underscores the importance of DDR reintegration efforts in general, and affirms the importance of DDR initiatives to improve the economic situation of ex-combatants in particular.

> ". . . [the] surprising finding is that it is the developed nations that report comparatively high rates of multiple partnerships, not those parts of the world which tend to have higher rates of HIV and AIDS, such as African countries. This has led the authors to suggest that social factors such as poverty, mobility and gender are a stronger factor in sexual ill-health than promiscuity, and they call for public health interventions to take this into account".
>
> Source: The Lancet Study

In general, while funds are readily available for AIDS initiatives in most sub-Saharan African countries, funds for

[34] Funding in most countries in Africa is not an issue as grants are available for HIV/AIDS activities. Each DDR commission can determine where it should be on a continuum from playing a direct role in implementing and funding ex-combatant HIV/AIDS initiatives to facilitating implementation and funding by others.

[35] A 60-minute session combined information on alcohol's effect on self-control, a motivational component based on WHO's alcohol counseling model, and skills-building focusing on self-control and sexual communication. Six months after the counseling session, evaluators documented a 25% increase in condom use and a 65% reduction in unprotected sex. See S.C Kalichman et al, (2007).

[36] While this has not been confirmed statistically, researchers consider this relationship to be credible.

income-generating and other economic support activities also important to fighting AIDS are much harder to come by. DDR managers should thus focus DDR funds on economic reintegration and other traditional DDR activities and seek financing for HIV/AIDS efforts from available AIDS funding sources, either directly or in partnership with an experienced NGO or government agency. However, should funding not be forthcoming from AIDS funding sources, DDR leaders must ensure that the essential HIV/AIDS activities discussed in the previous chapter are catered for with DDR funds.

Implications of the poverty-AIDS link also suggest that DDR leaders should consider the following in relation to economic reintegration support:

1. Transferring education and training opportunities to a family member in situations where the ex-combatant with AIDS is unable to work due to his or her illness; and

2. Prioritizing reintegration assistance—if funds are limited—for areas and groups most at risk of contracting and passing on the AIDS virus (peri-urban areas, rural areas with significant in-out migration for work, areas bordering neighboring countries with high HIV/AIDS prevalence, and younger ex-combatants).

The practice in the MDRP, as with other DDR programs, has been, where possible, to support reintegration through community initiatives rather than by exclusively targeting ex-combatants. DDR funding can therefore have an impact on the overall well-being of an area. By supporting areas and groups hard-hit by AIDS with activities that address poverty, DDR programs can play an important role in the fight against HIV/AIDS as they support reintegration of ex-combatants into their community.

Note for DDR Managers
WAR, RAPE AND HIV/AIDS

Gender violence—rape in particular—is unfortunately a reality in many conflicts. "War affects men and women differently . . . More men die in battle than women. But women and girls are deliberately targeted for rape, torture, sexual slavery, trafficking, and forced marriages and pregnancies." [FROM COMMENTS BY JUDY A. BENJAMIN BASED ON RESEARCH IN SIERRA LEONE]

Ex-combatants in MDRP discussion groups in each of the four countries reported that a significant level of violence against women had occurred during conflict. In the Republic of Congo, ex-combatants spoke specifically of women being raped to revenge acts committed by men. And, in Burundi, in response to a question about the numbers of ex-combatants frequenting commercial sex workers, one young man said quite openly:

"We did not need money for sex, we had guns." *(BURUNDI)*

The brutality and violence of rape can result in cuts, bleeding, and tearing of tissue that can facilitate transmission of the AIDS virus, if either the male perpetrator or the woman victim has the AIDS virus. If the virus is not present, then the woman has one less consequence of the rape to endure. She must though, of course, continue to struggle on with the psychological and mental challenges of rape, the possibility of social rejection, potentially an STI, and other repercussions.

It is important to note that while MDRP ex-combatants readily admitted that violence against women was a widespread reality during wartime, few reported violence during reinsertion and reintegration. Only three groups—two in urban areas and one in a rural area—reported any significant violence (including domestic violence as well as rape in one of the urban areas) against women during reintegration. Some ex-combatants seemed actually perplexed, even slightly offended, that the question would be asked in reference to their lives back in their communities. One ex-combatant responded, apparently somewhat bewildered by the idea of rape within his home community, "but it is against the law." Armed group (AG) ex-combatants in one area in Burundi indicated a sort of self-policing in place in that if an AG ex-combatant was involved in violence against a woman, other ex-AGs would hear about it and reprimand the perpetrator. AGs in this one area were concerned that their chance for successful reintegration not be jeopardized by the wrongful acts of a few.

Violence against women was discussed in MDRP discussion groups as a risk factor for AIDS; it was not a focus. The interesting information gathered in only a very brief discussion of gender violence suggests that much more could be learned from ex-combatants using similar participatory methods focusing on the topic directly—information that could be used to develop strategies to address gender violence and information on the challenges ex-combatants face settling back into healthy sexual relations with their partners.

Note for DDR Managers
REFUGEES AND INTERNALLY-DISPLACED PERSONS

Those who escape conflict—people who cross international borders seeking refuge and internally-displaced persons (IDPs) who seek safety within their own country—are often thought to be particularly vulnerable to contracting the HIV/AIDS virus, and potential core transmitters of the AIDS virus as they move from one place to another. But, just as with ex-combatants, the situation of refugees and IDPs in relation to AIDS varies considerably depending on circumstances. Where they come from, the path and the means they must take to escape conflict, and the conditions within the camps where they settle are all factors that determine to what extent refugee and IDP populations are affected by the AIDS epidemic. A recent twenty-two country study by UNHCR has shown that data does not support the assertion that refugee populations inherently have high levels of HIV sero-prevalence. In certain cases, refugee populations have considerably lower levels than their surrounding host communities. As well, programs within refugee camps often result in refugees having both the information and the means to protect themselves and their families from the AIDS epidemic.

Affirmation of the effect of refugee camp AIDS programs came from an unexpected source during the MDRP study: a young irregular force ex-combatant in a Burundi discussion group was particularly well-informed about AIDS. It turned out that he had learned about AIDS on a trip to a Tanzanian refugee camp where he had gone to recruit young men for the Burundi conflict. During the few days he spent in the camp, he had participated in an AIDS education session, hence his knowledge of AIDS.

The situation for internally-displaced persons also varies from country to country. Returning IDPs may have equal, lower or higher knowledge of HIV/AIDS to those who never left depending on whether they were exposed to HIV programs. However, while attention to IDPs needs has significantly increased over the last decade, a considerable number of IDPs still do not have access to assistance programs. Therefore, it is possible that IDPs in a given country will not have had access to information about HIV/AIDS. Women in Africa are especially vulnerable to HIV/AIDS; mothers caring on their own for children tend to be even more so.

The vulnerability of IDPs in Burundi was underscored by an ex-government soldier during MDRP discussion groups. The soldier said …

Women in [IDP] camps are easy targets
because they have no information whatsoever about AIDS. *(Burundi)*

Soldiers guarded IDP camps in Burundi and this ex-combatant recounted how they took sexual advantage of the women inside the camps. Burundi data on condom use also bears out the vulnerable situation of internally-displaced persons. In response to a question inquiring about condom use during their last sexual encounter in which money or goods had been exchanged, condom use was reported by almost eight out of ten commercial sex workers (77.1%), more than four out of ten young women (45.2%), but, alarmingly, by only one out of one hundred internally-displaced persons (1.2%).

Sources: HIV/AIDS Among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action, UNHCR 2004.

Internal Displacement: Global Overview of Trends and Developments in 2005. Internal Displacement Monitoring Centre, Norwegian Refugee Council, March 2006; and, HIV/AIDS and Internally Displaced Persons in 8 Priority Countries, UNHCR, January 2006.

Draft Rapport de l'Analyse de Situation et de la Réponse Pour la Planification 2007-2011. Burundi Sept. 2006.

CHAPTER 4: A comprehensive DDR response to AIDS

WHAT ELSE MIGHT DDR PROGRAMS DO TO ADDRESS HIV/AIDS

When possible, DDR programs should consider going one step further than the essential elements outlined in Chapter 3 to further decrease the likelihood of AIDS interfering with reintegration and to increase ex-combatants' active participation in the fight against AIDS, which can facilitate their reintegration back into their communities.

1. Adapt program to evolving epidemic and varied risk levels

Additional interventions would not need to be provided in all places to all ex-combatants, but should rather target groups and areas most at risk of HIV/AIDS. The MDRP discussion groups showed that combatant experiences and knowledge can differ considerably; potential exposure to HIV/AIDS varies depending on where combatants serve, the situations they encounter during conflict, and their risk behaviors. Knowing who is most at risk for HIV/AIDS is important in order to effectively target interventions.

Input from ex-combatants suggests that, while some risk behaviors are consistent across groups—unprotected sex for example—others vary widely. Risk behaviors will vary by age, by marital status and by area of resettlement. For instance, young ex-combatants are reported to engage in higher risk sex than older counterparts, as are ex-combatants resettling to urban areas versus those who return to rural areas. Knowledge about HIV/AIDS and prevention measures also varies widely with regular army personnel with better knowledge and irregular forces with little or no information (see Table 1 in Chapter 1).[37] Additional effort that targets young and/or urban ex-combatants, particularly among former irregular forces, could yield significant benefit in terms of HIV/AIDS prevention. However, each program will be different and should be adjusted based on actual data on the different target groups.

AIDS epidemics also change over time and it is important to be aware of how the virus is spreading in order to focus AIDS activities where they can have the most effect. Most risk behavior only leads to AIDS when the AIDS virus is present, so it is important to know the movement of the virus in order to make sure ex-combatants at most risk of contracting or passing on the HIV virus are reached with prevention programs.

To stay responsive to the AIDS situation, DDR leaders need to maintain contact with those leading the fight against AIDS. They need to have a sense of sero-prevalence changes in places and within groups where ex-combatants are exposed and to periodically gather information directly from ex-combatants to understand the levels of risk and risk behavior. Qualitative tools—like the ones used in the MDRP study—are simple, easy-to-use and provide important information on risk behaviors and risk groups (see Annexes F and G).

Information gathered from ex-combatants along with information available through the national AIDS program can provide DDR officials with an overall picture of the AIDS situation in relation to ex-combatants. With this understanding DDR leaders will be able to prepare for management of HIV/AIDS among ex-combatants, to target prevention efforts, and to assess impact of DDR initiatives in HIV/AIDS.

[37] The complete risk assessment by phase of demobilization according to ex-combatants in MDRP discussion groups is included in annex B.

2. Address factors that put women at greater risk

Women (both ex-combatants and partners) are at particular risk of contracting AIDS. Women are physically more likely to contract HIV as the virus passes more easily from a man to a woman. More importantly, according to experts, women have little control over their sexual relationships. In many situations, women are not in a position to say no to sex or to insist—or even suggest—a condom be used, though they may be well aware that they risk contracting HIV. This has led to what is called the "feminization of AIDS" in Africa, with three out of four HIV-positive Africans between the ages of fifteen and twenty-five being women.[38] Both male and female ex-combatants in MDRP discussion groups concurred that it is difficult for women to protect themselves—noting that women do not know where to get male condoms, that condoms are thought to be only for promiscuous women, and that it is not uncommon for a woman to be beaten by her partner just for having a condom.

The well-being of female ex-combatants should be a primary concern for DDR programs. Both male and female ex-combatants spoke of the difficulty some women ex-combatants had settling back into their communities and that, as a consequence, some had assumed or continued sexual patterns that placed them at increased risk of contracting HIV.[39]

Female ex-combatants and the wives/partners of returning ex-combatants also face the risk of being infected by their husbands. Referring to this risk, one AIDS researcher has called marriage one of the most dangerous places for women in Africa to be.[40] With no way to get a condom and no "right" to use one, a married woman has no way to protect herself from a husband who could be infected.[41] Angolan female ex-combatants were especially straightforward about the risk of women contracting HIV from their husbands or partners-- speaking of "maridos bandidos"—husband bandits—who have women on the side. The Angolan women went on to lament the lack of a condom that women could use.

"Why can't they make a condom for women?"
(ANGOLA)

In spite of the fact that there is a condom for women, it is not available in many countries.[42] And generally where it is available, few women know about it and even fewer know how to use it.

Women need protection from HIV/AIDS now. Providing information about the female condom during demobilization and making it available to ex-combatants kits is part of the basic DDR essential HIV/AIDS package. DDR programs should consider going one step further by exploring with partner NGOs if and how the ex-combatant network could be an effective means to disseminate information about the female condom and promote its use.

DDR programs and partner organizations should also explore the potential role of male ex-combatants in helping to change the factors that put women at risk of AIDS. One simple way to start this process would be to introduce the issue of women's vulnerability and the feminization of AIDS as a participatory, problem-solving discussion in DDR HIV/AIDS education sessions. As ex-combatants become aware of the problem, identify and then embark on ways in which they can be part of a solution for women, the common image connecting ex-fighters to war-time abuses against women—true in some cases but not all— should start to fade.

3. Give priority to urban areas where risk is highest

Urban areas of large cities where ex-combatants settle should be first in line for AIDS prevention activities during reintegration. Because of movement to and from cities, the number of people, living conditions and lifestyles in urban

[38] See note on the epidemic on page 20.
[39] Whether the female ex-combatant is more or less affected by the AIDS epidemic than the wider population of women is not clear, however. This was not a focus of the dialogue with ex-combatants in the MDRP study and studies that look directly at this issue were not available. The issue needs more exploration.
[40] See Marielena Zuniga, "The Feminization of AIDS" originally published in The Soroptimist of the Americas magazine, April 2004. http://www.iwhc.org/resources
[41] On a positive note, a group of ex-combatants in Burundi reported that upon their return home, their wives had refused to have sex without a condom. The men went along with their wives' wishes. Working with women to insist on condom use by their husbands had been a strategy of Society for Women Against AIDS in Africa (SWAA), an NGO, working in the area where ex-combatants resettled. See website: www.swaainternational.org
[42] Program leaders are concerned with the cost of the female condom. Plus many seem to have decided—contrary to successful program experiences in many places—that women will not accept the female condom or be able to use it correctly.

areas, large cities and their surroundings are almost always a focal point for the AIDS epidemic. The pattern of AIDS in many countries has been to enter at a national border, progress via the main transport routes to the capital and other main cities, and then fan out to other areas of the country. Once present in an urban population, the virus can spread quickly due to the dense concentration of people and urban ways of living. One of the first actions, then, in combating an AIDS epidemic is to prioritize urban areas for prevention activities. DDR should link returning ex-combatants to ongoing community-based HIV/AIDS initiatives in urban neighborhoods or, if no programs exist, partner with local organizations to start up prevention and outreach in cities home to significant numbers of returning ex-combatants. At a minimum, information about local services in urban centers should be readily available to ex-combatants at local reintegration offices and reintegration offices should ensure ex-combatants are aware of this information.

4. Consider work migration patterns when assessing exposure and risk

Economic migration patterns (generally of men seeking work) are a possible pathway, or bridge, for HIV to spread from high risk urban areas to rural areas of a country. Owing to the lack of opportunity in rural areas, many ex-combatants migrate to cities to find work. After a period of time, they return to their families in the rural area. Once earnings run out, the cycle is repeated and the men return once again to the city for work. This creates a permanent mixing between certain rural areas and cities. These men, who generally migrate on their own, are at high risk of contracting HIV/AIDS in the city and taking it back to their wives at home.[43] In areas where there is significant in-out migration for work, DDR programs should consider working with partner organizations to develop a two-pronged approach in HIV/AIDS education, reaching ex-combatants at their home-base in rural areas and in the neighborhoods where they reside and work in the city. Reintegration programs that cater to or include migrant ex-combatants should also ensure that HIV/AIDS sensitization is incorporated in the reintegration support.

The ex-combatant network represents an important resource for tapping into the flow of work migrants. Many rural men, not just ex-combatants, migrate for work. While this trend and its potential impact on the spread of AIDS is well known, it is not always a simple matter to identify the men who migrate and provide them with the HIV/AIDS information and services they need. In the city it is difficult to know who migrates in and out; in the rural area it is difficult to reach those who migrate as they are dispersed across the countryside. Ex-combatants however can be reached through the DDR program and are a potential channel into the networks of economic migrants. To help stem the spread of HIV/AIDS, local DDR offices should be ready to collaborate with AIDS organizations and use the ex-combatant network to link to rural men migrating for work.

5. Add malaria prevention and family planning to demobilization programs

Malaria and reproductive health are both closely linked to HIV/AIDS. Researchers think that double infection with HIV and malaria may be fueling the spread of both diseases and recommend a coordinated response.[44] Malaria can lead to a rise in the amount of HIV in the blood of someone already infected with HIV/AIDS. According to recent research, higher levels of HIV in the blood may make HIV more transmissible to a sex partner. People living with AIDS are also more prone to severe malaria. For these reasons, experts recommend that people getting treated for HIV should, first, be tested and treated for malaria and, second, get insecticide-treated bed-nets to protect themselves against malaria-infected mosquitoes.[45]

As for reproductive health, the majority of HIV infections are sexually-transmitted or associated with pregnancy, childbirth and breastfeeding. Making sure then that pregnancy only occurs when planned makes sense. Contraception—recently called "the best-kept secret in HIV prevention"—is an effective way to prevent mother-child transmission of HIV by providing medical treatment to female ex-combatants living with HIV who do want to have a child.[46] Providing information about family planning during demobi-

[43] Several of the men in the Congo Brazzaville discussion groups had come to Brazzaville to work and were living away from their wives.

[44] One cannot get HIV through a mosquito bite. See http://www.emro.who.int/aiecf/web26.pdf and Laith J. Abu-Raddad, Ph.D., Padmaja Patnaik, Ph.D. and James G. Kublin M.D., M.P.H. Dual infection with HIV and malaria fuels the spread of both diseases in sub-Saharan Africa. Science: Dec. 8, 2006.

[45] Malaria kills more than a million people a year, with around 90 per cent of the deaths occurring in sub-Saharan Africa. In addition, an estimated 350–500 million clinical malaria episodes occur annually. Some believe the interaction of malaria and HIV may be one of the factors behind the explosive growth of AIDS in southern Africa.

[46] Cohen, Susan A. Hiding in Plain Site: The Role of Contraception in Preventing HIV. Guttmacher Policy Review, Winter 2008, Vol 11, No 1.

lization will also encourage dual protection—simultaneous protection from unwanted pregnancy and from HIV and other STIs—for all male and female ex-combatants.[47] Dual protection is strongly recommended for situations where men and women are at risk because of the high-risk behavior of their partners, and where sexually active people are in settings where the prevalence of STIs and HIV is high, both situations common to ex-combatant settings.[48]

6. Prepare disabled ex-combatants for high risk situations

The disabled ex-combatant is also at risk of contracting HIV/AIDS, according to ex-combatants in MDRP discussion groups.[49] While disabled ex-combatants reported less frequent sexual relations than other ex-combatants, they also indicated that very few disabled use condoms when they do have relations. One reason, according to discussion group participants, is that during demobilization the disabled concentrate on the many problems they will face returning home due to their disability and thus fail to focus adequately on HIV/AIDS information. Disabled ex-combatants in Burundi also spoke of being targeted by women upon their return home because of their disability and the extra money they, as disabled, had received at demobilization.

Mainstreaming disabled ex-combatants during demobilization (i.e. including the disabled in information sessions and reintegration activities along with other ex-combatants) is a good strategy and should continue, according to those in MDRP discussion groups. These groups recommend, however, that DDR programs add a separate session during demobilization to discuss issues specific to the disabled ex-combatant: what he or she can expect from others upon return home, and ways to deal with the social aspects of their reintegration. Disabled ex-combatants also suggest that DDR programs explore ways to follow-up with the disabled ex-combatant back in his/her home community on HIV/AIDS issues. DDR programs generally put a significant amount of effort and resources into successful reintegration of the disabled ex-combatant. Going one more step and making sure the disabled ex-combatant has the information, the skills and the access to services he or she will need to remain free of HIV/AIDS makes good sense.

7. Promote ex-combatant involvement in the fight against AIDS

Ex-combatants are in a good position to play a role in preventing the spread of HIV/AIDS. In many places, soldiers are respected and considered leaders within the community. They can help to change the perception of the disease and to disseminate much needed information about the disease to members in their communities of return. They can be ideal role models of positive behavior in AIDS and help reduce the stigma associated with the disease. Ex-combatants from the losing side of conflict can serve as entry points into their home community networks, which are likely to be among the more difficult for government—the winning side—and NGOs to access. Moreover, as all join together in the fight against AIDS, the lines between winning and losing sides will likely blur, facilitating reintegration, reconciliation and acceptance of returning fighters to the community.

Experience in Rwanda demonstrates how ex-combatants can play an important, constructive role in HIV/AIDS in their communities of return. A number of ex-combatants are involved in HIV/AIDS outreach with local NGOs. Other sero-positive ex-combatants are active in associations of people living with AIDS. These ex-combatants are articulate, well-informed and clearly committed to both their work and their community. They speak of how their involvement helped in the return home and their experience is testimony to how taking part in the fight against AIDS can facilitate integration. Some MDRP discussion group participants even said that in many ways integration had been easier for HIV-positive ex-combatants, as they were able to find a place for themselves and become involved in community activities immediately upon returning home.[50]

DDR should facilitate involvement of sero-positive ex-combatants in organizations of persons living with HIV/AIDS (PLWHA) and link ex-combatants interested in working in the fight against AIDS to organizations in their communities of return involved in AIDS activities. DDR

[47] Dual protection includes (1) consistent and correct use of a male or female condom, (2) use of a condom and another highly-effective contraceptive method, (3) avoidance of all kinds of penetrative sex, and (4) use of a contraceptive method plus mutual monogamy among infected partners.
[48] MAQ Exchange Materials: Dual Protection Notes. JHPIEGO http://www.maqweb.org/maqslides/powerpoint/Theme3/DP/Dualprotectionnotes.pdf
[49] MDRP team spoke with disabled ex-combatants in Burundi and in Angola, and with an ex-combatant working with disabled ex-combatants in Rwanda.
[50] Ex-combatants in discussion groups in both Burundi and Angola expressed interest in becoming involved in HIV education and outreach.

programs can also make sure government and NGOs are aware of the potential for ex-combatants as a channel into community networks in both rural and urban areas.

As AIDS organizations come to realize the positive potential of ex-combatants in the fight against AIDS, the focus for initiating AIDS interventions will move from DDR programs to AIDS organizations. And as ex-combatants become more involved in fighting for their communities against AIDS, their ties within the community will grow, thereby facilitating the work of reintegration.

Annexes

ANNEX A: DDR HIV/AIDS Study Framework

CONFLICT

- HIV/AIDS SITUATION
  - sero-prevalence in general population by age and gender
  - sero-prevalence within high-risk groups
- RISK BEHAVIORS OF EX-COMBATANTS
  - frequency of at-risk behavior
  - multiple partners
  - contact with IDPs and refugees
  - commercial sex workers/ transactional sex
  - gender violence
  - condom use
  - men having sex with men
  - intravenous drug use
  - possibility of transmission through inadequate medical care

DEMOBILIZATION
[time at site a factor]

- HIV/AIDS SITUATION AT DEMOBILIZATION SITE
- RISK BEHAVIORS OF EX-COMBATANTS
  - frequency of at-risk behavior
  - multiple partners
  - contact with IDPs and refugees
  - commercial sex workers/ transactional sex
  - gender violence
  - condom use
  - men having sex with men
  - intravenous drug use
  - possibility of transmission through inadequate medical care
- MDRP HIV/AIDS PROGRAM
  - inventory of activities
  - who are implementers
  - level of coordination with national AIDS authorities
  - financing of HIV/AIDS activities
  - reporting of HIV/AIDS activities
  - lessons learned to date, remaining challenges

REINSERTION
[defined as month following demobilization]

- HIV/AIDS SITUATION ALONG ROUTE, AT HOME
  - sero-prevalence in general population by age and gender
  - sero-prevalence within high-risk groups
- RISK BEHAVIORS OF EX-COMBATANTS
  - frequency of at risk behavior
  - multiple partners
  - contact with IDPs and refugees
  - commercial sex workers/ transactional sex
  - gender violence
  - condom use
  - men having sex with men
  - intravenous drug use
  - possibility of transmission through inadequate medical care
- AVAILABILITY OF/ACCESS TO ESSENTIAL SERVICES
  - condoms
  - STI detection and treatment
  - voluntary counseling and testing
- MDRP HIV/AIDS PROGRAM
  - inventory of activities
  - who are implementers
  - level of coordination with national AIDS authorities
  - financing of HIV/AIDS activities
  - reporting of HIV/AIDS activities
  - lessons learned to date, remaining challenges

POINT OF REINTEGRATION

- HIV/AIDS SITUATION IN COMMUNITY OF RETURN
  - sero-prevalence in general population by age and gender
  - sero-prevalence within high-risk groups
- RISK BEHAVIORS OF EX-COMBATANTS
  - frequency of at-risk behavior
  - multiple partners
  - contact with IDPs and refugees
  - commercial sex workers/ transactional sex
  - gender violence
  - condom use
  - men having sex with men
  - intravenous drug use
  - possibility of transmission through inadequate medical care
- AVAILABILITY OF/ACCESS TO/USE OF ESSENTIAL SERVICES
  - condoms
  - STI detection and treatment
  - voluntary counseling and testing
  - treatment
  - support groups
- MDRP HIV/AIDS PROGRAM
  - inventory of activities
  - lessons learned to date, challenges remaining

ANNEX B: Level of Risk for HIV/AIDS at Each Phase of Demobilization by Risk Factor as Classified by Ex-Combatants

ANGOLA, BURUNDI, REPUBLIC OF CONGO

In focus groups, ex-combatants in Angola, Burundi and the Republic of Congo ranked the extent to which members of their combatant group had engaged in a certain high-risk behavior, or been exposed to a high-risk situation, for HIV/AIDS at each phase of DDR: conflict, demobilization, reinsertion and reintegration. Their rankings —from no risk at all of contracting HIV/AIDS (no one engaged in the high-risk behavior or exposed to a high risk situation) to high risk (almost all engaged in a high risk behavior or exposed to a high risk situation)— are presented in the table that follows by ex-combatant group, by risk factor or risk situation, and by phase of demobilization. Understanding ex-combatant at-risk behavior is important in order to target groups most at risk of contracting HIV/AIDS and to develop effective prevention and treatment strategies.

The data indicates similarities across groups and countries as well as occasional differences. For example, with very few exceptions, the risk of unprotected "at-risk" sex in the weeks after demobilization—reinsertion—was assessed by the ex-combatants as "medium" or "high" in each of the three countries. Discussion group participants indicated that during this time, sex was frequent, often with multiple partners, at times with commercial sex workers, and that condoms were rarely used. Overall, discussion group findings suggest that things tend to calm as the ex-combatant returns to life within his/her community. Ex-combatants in Burundi and the Republic of Congo said that high-risk sexual behavior decreases once ex-combatants settled into their communities. In Angola however, input from ex-combatants suggested that risk levels in most places either remained constant from demobilization to reintegration or in some cases increased.[51]

The extent to which ex-combatants engaged in sex with commercial sex workers (CSWs) varied considerably by group in each country, with some reporting ex-combatants in their group never or rarely engaging in sex with CSWs and others reporting frequent sexual contact with CSWs by members of their group. Risk of exposure to HIV/AIDS as a result of inadequate medical care also varied considerably. All but one Angolan groups estimated that there was little to no risk of contracting AIDS via this route during the war since army personnel had access to good health services. Once back in their communities, however, lack of access to adequate medical care was reported as a problem for groups in two Angolan communities. Of note in the focus group results in all four countries (including Rwanda) is the reported level of male-male sex. In their groups when discussing how to rank the level of risk by risk factor, some participants did state that male ex-combatants did engage in sex with other males. As the table shows, however, all groups except one reported no male-male sex whatsoever among their counterparts at any phase of demobilization. The strong taboo concerning male-male sexual relations was very evident and in many of the discussion groups, the mere mention of this specific high risk behavior sparked a quick response as the following: "We don't have that in Africa, ma'am."

Description of Ranking Process[52]

On a small piece of paper the facilitator makes a simple sketch/stick figure to represent a risk factor or a risk situation. For example, two male symbols next to each other represent male-male sex, a woman's symbol with a dollar sign next to it to represents commercial sex, a male stick figure with one arm raised standing over a woman stick figure on her back with her legs in the air represents violence against women or rape. As the facilitator explains each risk factor or risk situation, she shows the symbol or sketch and makes sure that all in the group understand. Then, proceeding through each phase of demobilization, the facilitator puts each symbol/sketch on the table next to the phase asking the group to rank engagement to the risk factor, or exposure to the risk situation, by "no risk", "some risk", "medium risk" or "high risk". The facilitator probes to understand the

[51] Discussion group participants in Rwanda also indicated considerable high-risk behavior during reinsertion with risk behaviors decreasing during the reintegration phase. The Rwanda data is not reported in this table as the questions used in Rwanda were slightly different. The discussion tool was pre-tested in Rwanda and modified prior to its use in Angola, Burundi and the RoC.

[52] This description is provided here to help the reader understand the table that follows. A facilitator's guide to use the tool can be found in annexes F and G.

group answer and make sure that opinions come out. She then marks the number of stars showing the level of risk on the paper with the sketch and leaves the paper on the phase. She then repeats the same process with another risk factor, completing all risk factors for each phase of DDR, before moving on to rank factors for the next phase.

Using small papers with simple symbols helps ensure that all in the group understand what is being discussed, gets groups actively involved (participants frequently picked up a paper to help debate and/or compare), and serves as a means to record group answers. At the close of the discussion group, the facilitator gathers the symbol papers and stores them by phase. Later they can be placed on a wall along with results from other groups forming a visual image of how risk varies between phases and across ex-combatant groups.

Comparison between groups on a specific risk factor is not valid as one cannot say, for example, that "a lot of sex" to a group in rural Burundi is the same as "a lot of sex" to an urban group in Burundi, or in Angola, etc. One can compare, however, how the level of risk changes for a specific ex-combatant group as that group moves through the DDR process with the change experienced by another ex-combatant group. The tool also suggests trends to be explored further, differences between urban and rural, differences between younger and older ex-combatants, etc. All this is important information for designing an effective DDR program in HIV/AIDS.

DURING WAR	Frequency of sex	Multiple partners	Without condom	Sex with sex workers	Men having sex with men	Rape	Intravenous drug use	Inadequate medical care **	Use of traditional healer	Sex with refugees/IDPs	Sex with peace-keepers
ANGOLA											
Luanda/Viana women	X X	X X X	X X	men XX	O	rural X urban XXX	O	O	X X X	X X	O
Luanda/Viana women	X	X	X X X	X X X	O	X X X	X	X X	X X X	O	X
Benguela men disabled	X	X	X X X	O	O	O	O	O	O	X	O
Benguela women disabled	X X X	O	X X X	O	O	X	O	O	O	O	O
Cubal women	X X	X X	O	O	O	O	O	O	O	O	O
Cubal all men	X	X	X X X	X X X	O	X X X	O	O	O	O	O
Cubal young men	---	---	---	---	---	---	---	---	---	---	---
Cubal older men	X	X X X	X X X	X X X	O	X X X	O	O	O	O	O
Bocoio all men	X	O	X X X	O	O	O	O	O	O	O	X X X (risk for women)
Bocoio young men	---	---	---	---	---	---	---	---	---	---	---
Bocoio older men	---	---	---	---	---	---	---	---	---	---	---
BURUNDI											
Rumonge men	X X X	X X X	X X X	O	O	XX or XXX	O	X	---	O	O
Bureri men	X X X	X X X	X X	X X X	O	X	O	O	---	X X	O
Gitega men	X	X X X	X X X	X	O	X	O	X	---	X	O
Gitega young men	X X X	X X X	X X X	O	O	X X	O	X	---	XX (risk for FAB) X (risk for PMPA)	O
Gitega disabled	X X	X X X	X X X	O	O	O	O	X X X	---	O	O
Gitega women	X X	X X	X X X	O	O	X X X	O	O	---	O	O
Bujumbura women	X X X	X X X	X X X	O	O	X X X	O	X X	---	O	O
REPUBLIC OF CONGO											
Brazzaville men, group 1	X X	X X X	X X X	X X X	X	X X X	O	X X	X X	X X	O
Brazzaville men, group 2	X X X X	X X X	X X X	X X	O	X X X	O	X X X	X X X	O	O

* no access to adequate medical care

O = no risk, X = some risk, XX = medium risk, XXX = high risk

REINSERTION	Frequency of sex	Multiple partners	Without condom	Sex with sex workers	Men having sex with men	Rape	Intravenous drug use	Inadequate medical care **	Use of traditional healer	Sex with refugees/ IDPs	Sex with peace-keepers
ANGOLA											
Luanda/Viana women	X X	X X	X X X	O	O	X X	O	O	X X X	O	X X
Luanda/Viana women	X X	X X	X X X	O	O	X X X	X	X X X	X X	X	O
Benguela men/disabled	X	O	X X X	O	O	O	O	X X X	O	O	O
Benguela women/disabled	X	O	X X X	O	O	O	O	O	O	O	O
Cubal women	X	O	X X	O	O	O	O	O	X	O	O
Cubal all men	---	---	---	---	---	---	---	---	---	---	---
Cubal young men	X X X	X X X	X X X	X X X	O	X X X	O	O	O	O	O
Cubal older men	X X X	O	X X X	X X X	O	O	O	O	O	O	O
Bocoio all men	---	---	---	---	---	---	---	---	---	---	---
Bocoio young men	X X X	X X X	X X	X X	O	O	O	X X X	O	O	O
Bocoio older men	X X	X X X	X X	X X X	O	O	O	X X	O	O	X X X (risk for women)
BURUNDI											
Rumonge men	X X X	X X X	X X X	X X X	O	O	O	O	---	O	O
Bureri men	X X	X	X	X X	O	O	O	O	---	X	O
Gitega men	X X X	X X X	X X	X X	O	O	O	O	---	X	O
Gitega young men	X X X	X	X X X	X	O	O	O	O	---	X	O
Gitega disabled	X or XX	X	X X	X	O	O	O	O	---	X X	O
Gitega women	X	X	X X X	O	O	O	O	O	---	O	O
Bujumbura women	X X X	X X X	X X X	O	O	O	O	O	---	O	O
REPUBLIC OF CONGO											
Brazzaville men, grp 1-under 30	X X X	X X	X X	X X X	O	X X	O	X X X	X	X X	O
Brazzaville men, grp 1-over 30	X	X X	X	X	O	O	O	X X	O	O	O
Brazzaville men, group 2	X X X	X X X	X X X	X X	X X	X X	O	X X X	X X X	O	O

* no access to adequate medical care

O = no risk, X = some risk, XX = medium risk, XXX = high risk

REINTEGRATION	Frequency of sex	Multiple partners	Without condom	Sex with sex workers	Men having sex with men	Rape	Intravenous drug use	Inadequate medical care *	Use of traditional healer	Sex with refugees/ IDPs	Sex with peace-keepers
ANGOLA											
Luanda/Viana women	X X X	X X X	X X	O	O	X X X	X X X	O	X	O	X (with Chinese workers) **
Luanda/Viana women	X X X	X X X	X X	O	O	X X X	X X X	O	X	O	O
Benguela men disabled	X	X or XXX	X X X	O	O	O	O	X X X	O	O	O
Benguela women disabled	X	O	X X X	O	O	O	O	O	O	O	O
Cubal women	X X	X	X	O	O	O	O	O	O	O	O
Cubal young men	X X X	X X X	X X X	X X X	O	X X X	O	O	O	O	O
Cubal older men	X X X	X X X	X X X	X X X	O	O	O	O	O	O	O
Bocoio young men	X X X	X X X	X X	X X	O	O	O	X X X	O	O	O
Bocoio older men	X X	O	X	X X	O	O	O	X X X	O	X X	O
BURUNDI											
Rumonge men	XX or XXX	X X	X X	X X	O	O	O	O	---	X	O
Bureri men	X	X	X X X	X X	O	O	O	O	---	X X	O
Gitega men	X X	X	X	X	O	O	O	O	---	X	O
Gitega young men	X X X	X X	X X	X	O	O	O	O	---	X X	O
Gitega disabled	X	X	X X	X	O	O	O	O	---	X X	O
Gitega women	X X	X	O	O	O	O	O	O	---	O	X X X
Bujumbura women	X	X	XX	O	O	O	O	O	---	O	O
REPUBLIC OF CONGO											
Brazzaville men, grp 1-under 30	X X X	X X	X X	X X X	O	X X	O	X X X	X	X X	O
Brazzaville men, grp-1-over 30	X	X X	X	O	O	O	O	X X	O	O	O
Brazzaville men, group 2	X X	X	X	X	X X	X	O	X	X	O	O

* no access to adequate medical care
** women in this group mentioned Chinese workers when asked about sex with peacekeepers

O = no risk, X = some risk, XX = medium risk, XXX = high risk

ANNEX C: Condom Use among Ex-combatants: Information and Ideas for DDR Partner NGOs

MDRP discussion group participants reported that most ex-combatants do not use condoms in spite of knowing the risk they run of contracting HIV/AIDS.

One reason for this, according to ex-combatants in the discussion groups, is that male condoms are not readily available, especially in rural areas. They also say that, while places to get condoms are limited in some areas, condoms are available almost everywhere if one knows where to go, or if one is willing to go looking for them. Many however—even men—are not inclined to go looking, and may even be reluctant to ask where to find condoms because of the stigma associated with condom use.

Cost is another reason that was mentioned several times: some do not use condoms because they can't afford them. Even though the price seems very low (for example, 50 Rwanda Francs—ten cents in US currency—for four condoms), discussion group participants said the cost was enough to discourage usage, especially for those living in rural areas.

Some ex-combatants mentioned problems with the quality of condoms; they say condoms often break during use. Experience in family planning programs shows that breakage is often a result of incorrect usage, and that it can be reduced through instruction in how to correctly put on a condom.

Less pleasure is another reason given by discussion group participants: sex is not the same with a condom as it is without one. This is often thought to be an exclusively male reason for not using condoms.[53] It is not only the men however; some women ex-combatants also spoke of their preference to have sex without a condom because the condom took away from pleasure. For example, according to one discussion group, women did not use condoms (during the reinsertion phase of the program) because they "étaient chaudes" ["were hot", in a sexual sense]. They had money in their pockets and they went out and enjoyed being with men.[54] When asked why condom use was higher during reintegration than during reinsertion, the women in this group responded that women had heard about AIDS via radio and had HIV-positive friends at the hospital and thus used condoms. They also said there was less sex in general during the reintegration phase because many women married.

"Men would not use them even if they had them because sex is not the same with a condom as it is without one."
MALE EX-COMBATANT IN REPUBLIC OF CONGO

"When you want a piece of candy, you don't eat it with the paper on."
SAYING USED BY WOMEN IN BURUNDI

Certain studies suggest that condom use is higher when a sexual encounter is considered to carry a very high risk of transmitting HIV/AIDS. In a study in Burundi, more than three out of four (77.1%) commercial sex workers and six out of ten soldiers (60%) said they had used a condom during their last sexual encounter involving an exchange of money.

While it is important that condoms are used in high-risk sex, there is a potential problem in that people may equate condom use with sexual encounters that do not meet established social norms—condom use equals "bad" behavior. Such considerations discourage condom use within a marriage or a stable domestic partnership, even when a condom may well be needed to protect one of the partners. When the MDRP team asked women about their experience negotiating condom use with their partners, women responded that men generally refuse. One woman said: "If you are married, they [husbands] say: 'You don't trust me.'" And, as discussed in Chapter 4 of these guidelines, proposing condom use can result in violence as the husband suspects the woman has been unfaithful.

In the Republic of Congo, discussion group partici-

[53] According to a young ex-combatant in RoC, in terms of pleasure, the female condom is much better than the male condom. After excusing himself for speaking of delicate matters, the young ex-soldier said that he had used a female condom with a partner and the experience was much better than when using a male condom.
[54] Draft « Rapport de l'Analyse de Situation et de la Réponse Pour la Planification 2007-2011 ». Burundi, Sept. 2006.

pants were asked their advice on the best ways to increase condom use among ex-combatants. They recommended the following:

- Make sure condoms are available in bars, nightclubs, the places where ex-combatants congregate and meet women or men.
- Ensure condoms are easily available in communities.
- Find ways to make the male condom more fun.
- Develop negotiation skills for condom use.
- Organize women to turn down sex without a condom.

DDR coordinators should encourage partner organizations to explore further why ex-combatants are not using condoms and then to address these issues in their programs. By using a simple qualitative tool similar to the one used during this mission, partner organizations could quickly identify which preventive behaviors were not being adopted and under which conditions, and learn about ex-combatants' ideas regarding how to best overcome these issues.

ANNEX D: Suggested Indicators to Assess DDR HIV/AIDS Components

Following are suggested indicators to evaluate the HIV/AIDS component of DDR programs.[55] The exact question to use is not specified here: DDR programs should use the same measurement tool or question as the country's national AIDS program. This will facilitate comparisons over time and between groups.

Knowledge Indicators

1. **Knowledge of HIV prevention methods**
   Definition: The percentage of all respondents who, in response to prompted questions, say that a person can reduce their risk of contracting HIV by using condoms or having sex only with one faithful, uninfected partner.

2. **No incorrect beliefs about AIDS**
   Definition: The percentage of all respondents who correctly reject the two most common local misconceptions about AIDS transmission or prevention, and who know that a healthy-looking person can transmit AIDS.

Stigma and Discrimination Indicator

3. **Accepting attitudes towards those living with HIV**
   Definition: The percentage of ex-combatants expressing accepting attitudes towards people with HIV, among all ex-combatants in group being demobilized.

Voluntary Counseling and Testing Indicators

4. **Ex-combatants receiving an HIV test and receiving test results**
   Definition: The percentage of ex-combatants who have voluntarily received an HIV test and received their results, among all ex-combatants in group being demobilized.

5. **Quality post HIV test counseling**
   Definition: The percentage of post-HIV test counseling sessions during demobilization that meet international standards for quality counseling.

Sexual Behavior Indicators

6. **Higher risk sex in the last six months**
   Definition: Proportion of respondents who have had sex with a non-marital, non-cohabiting partner in the last 6 months, of all respondents reporting sexual activity in the last 6 months.

7. **Condom use during last higher risk sex encounter**
   Definition: The percentage of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabitating partner, of those who have had sex with such a partner in the last 6 months.

[55] Derived from MEASURE: Survey Indicators Database (http://www.measuredhs.com/hivdata/ind_tbl.cfm). The MEASURE database offers an internationally-accepted, consistent method for measuring factors related to HIV prevention across countries. It uses indicators drawn from guides from UNAIDS, UNGASS, the Millennium Development Goals, PEPFAR, and the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis.

ANNEX E: Checklist for Review of DDR HIV/AIDS Program

To prevent HIV transmission, ex-combatants must be provided with information and skills and connected to essential services in their community of return.

Criteria 1:

Does the demobilization program provide for skills development relating to HIV/AIDS?

☐ yes ☐ no

What skills are being learned? Check all that apply.

☐ how to discuss safer sex with partner(s)
☐ how to refuse to engage in unsafe sex
☐ how to discuss condom use with partner(s)
☐ how to obtain condoms
☐ how to use a condom correctly
☐ how to dispose of a condom correctly
☐ how to recognize need for STD treatment

Criteria 2:

Does the demobilization program provide specific information—addresses, hours, cost, etc.—on the services and supplies available in the ex-combatant's community of return?

☐ yes ☐ no

For which services and supplies is information being provided?

☐ condoms
☐ professional STD treatment
☐ treated bed nets
☐ family planning services

A supportive environment—a situation or context which supports rather than hampers preventive behaviors—needs to be created for HIV prevention. Ex-combatants need to be able to access information, prevention and services upon return to their communities.

Criteria 3:

Does the demobilization program liaise with HIV/AIDS organizations to encourage prevention activities involving ex-combatants during the reinsertion phase?

☐ yes ☐ no

Criteria 4:

Does the demobilization program link ex-combatants to associations active in HIV/AIDS in their communities of return?

☐ yes ☐ no

Criteria 5:

Does the demobilization program follow-up to make sure that ex-combatants have not encountered difficulties accessing information, prevention and medical services for HIV/AIDS once reintegrated in their communities of return?

☐ yes ☐ no

If you answered NO to any question OR if you did not have clear and complete answers to any of the questions, this demobilization program probably has some weaknesses in terms of addressing HIV/AIDS. You will be able to improve the program by giving time and detailed attention to the issues raised in the questions.

* Adapted from tools found in a publication by Family Health International: Monitoring HIV/AIDS Programs: A Facilitator's Training Guide. This training resource includes three core modules on monitoring and evaluation plus modules on specific HIV/AIDS programs such as voluntary counseling and testing, behavior change and STI prevention. The manual can be found online in French and in English at: http://www.fhi.org/en/HIVAIDS/pub/guide/meprogramguide.htm

ANNEX F: Tool to Assess HIV/AIDS Risk during Demobilization of Ex-Combatants Guidelines for conducting Group Discussions

Introduction

This is a simple, easy-to-use discussion tool for gathering information about ex-combatant risk behavior and ex-combatant exposure to risk situations from the period of conflict through the three phases of DDR: demobilization, reinsertion and reintegration. Knowing who is most at risk of HIV/AIDS —as well as how, when and why they are at risk— is important in order to target and design interventions effectively.

Guidelines

Invite 10 to 12 ex-combatants to meet with you to share their insight regarding ex-combatant knowledge about HIV/AIDS and the risk of ex-combatants' contracting AIDS during the phases of DDR. The composition of the group is important-- as much as possible, the group should be homogeneous, that is to say, the participants of the group should have the same background, they should have things in common with other participants of the group. The more alike the members of the group are, the more willing they will be to talk openly about their experiences. Having a homogeneous group will also enable you to distinguish similarities and differences between various ex-combatant groups.

For example, participants in an ex-combatant discussion group should be from the same fighting force—all former soldiers or all former rebels, of the same gender—all men or all women, all disabled, or all sharing the same demobilization experience—all having demobilized at the same center around the same time. If you are able to conduct several discussion groups, you could form groups of young and old ex-combatants, urban and rural ex-combatants, ex-combatants that entered war as a child and ex-combatants who entered the war when they were adults, etc., in order to detect any differences in experience between the various groups. Conducting discussion groups with various groups will allow you to contrast and compare experiences, thus learning more about HIV/AIDS risk among the various groups and how it may be affected by the demobilization experience.

STEP 1. MAKE INTRODUCTIONS AND PRESENT PURPOSE OF DISCUSSION GROUP

- **Explain what you are doing. Ask their help in task.**
- **Clarify that not asking about their personal experiences** but want to talk to them as "EXPERTS" on ex-combatants and the ex-combatant process. Explain that they were selected for their insight and willingness to share perspective of demobilized ex-combatants.
- **Point out that HIV/AIDS is a serious subject.** Since AIDS is related to sexual behavior, you will talk about personal subjects. They need to be honest and frank.
- **Assure the group that the group discussion is confidential.** You will use what they say, but no one will know who said what. They, too, must not share what has been said in the group with others.

STEP 2. ASK GENERAL QUESTIONS ABOUT HIV/AIDS KNOWLEDGE/SERVICES AT EACH PHASE OF DEMOBILIZATION; Conflict—Demobilization—Reinsertion—Reintegration (unprompted questions):

- What did ex-combatants know about HIV/AIDS at X phase?
- How/where did ex-combatants get the information they had about HIV/AIDS?
- What HIV/AIDS/STI services were available?

FOLLOW GENERAL QUESTIONS WITH SPECIFIC QUESTIONS (prompted questions):

- **Prevention:** Did they learn about risk behaviors, ways to avoid infection? Which ones? From whom? How?
- **Other STIs:** Did they learn about other STIs? The relationship to HIV/AIDS, how to recognize need for treatment, where to go for treatment?
- **Condoms:** Were condoms distributed, instructions

on their use provided, and referrals to condom distribution sites provided? Do they know where to get them now? Are they easy to get?

- **VCT:** How was the VCT process? Were they given the choice to test or not? How long a wait to receive results? Were the test results clearly given? Was emotional support provided? Were they given information about follow-up? When/where to go for treatment, for subsequent testing?

- **Health services:** How easy was/is it to use health services? Did /do ex-combatants know about services available to them? How close are services to where they reside? Are most ex-combatants members of an insurance service (e.g. mutuelle in francophone countries)? Have/are most been using services at health centers? Have they been/are they being received well at health centers?

- **Follow-up:** What has been contact with demobilization program on HIV/AIDS since leaving demobilization center? Has there been contact/information from any other organizations? Which ones? What type of information/service/support has been provided?

STEP 3. CONDUCT GROUP ACTIVITY DESIGNED TO IDENTIFY RISK BEHAVIORS AT EACH PHASE.

- **Introduction:** Until now we have spoken about information and services that have been or are available to ex-combatants. Now we would like to talk about what a demobilization program should do to ensure that ex-combatants have the information they need to protect themselves and their families.

We would like you to help us to plan HIV/AIDS activities for a demobilization program. In order to know where to put money and efforts, we need to know who is most at risk of contracting HIV/AIDS, when and where.

- Briefly describe HIV/AIDS risk factors—use simple line drawings on A-4 paper to represent each risk factor as you speak.

Examples:

frequent sexual activity
multiple partners
sex without condoms
sex with commercial sex workers
sex in urban areas where sero-prevalence often higher
male-male sex
violence against women
transmission during medical care
intravenous drug use
contact with refugees, IDPs
contact with peacekeepers

- Have group rank risk at each phase of demobilization by risk factor. If the group judges there to be some risk for a risk factor, they place a card with one red star by the DDR phase concerned (a card with two stars if medium risk, and a card with three starts if high risk). If the group judges that there is no risk, then no card is placed next to that phase.

no risk (no card)
some risk (*)
medium risk (**)
high risk (***)

- When task is complete, ask group to take some time to reflect on the risks they have identified. After a couple minutes ask them what the program could do to minimize risk at each phase.

Ask final question: from their experience, which group of ex-combatants are most at risk of contract/spreading HIV/AIDS? Why?

TO CHECK THAT YOU HAVE UNDERSTOOD, SUMMARIZE WHAT THE GROUP HAS SAID ABOUT THE LEVEL OF RISK TO HIV/AIDS AT EACH PHASE OF DEMOBILIZATION.

Note: Keep a group record of the make-up and composition of each discussion group. Knowing something about ex-combatants in a group will help put their answers into context, and as a result, help to understand who is most at risk of contracting HIV/AIDS, and when. Consider gathering the following information on discussion group participants: gender; current age; age at entry into conflict as soldier/combatant; age at end of conflict; marital status; whether married before, during or after conflict; number of years since demobilization; and, the group with whom they fought. This information should be gathered for the group as a whole, thereby respecting the privacy of each individual within the group.

ANNEX G: Tool to Gather Ex-Combatant Input on Best Strategies:
Ex-combatants Propose Strategies for increasing Condom use

This is a simple discussion tool for obtaining the advice of ex-combatants on the best ways to encourage ex-combatants to use condoms. It can be easily adapted to obtain their input on other HIV/AIDS prevention strategies.

Invite a group of 10 to 12 ex-combatants to share their insight on HIV/AIDS prevention strategies (in this case, condom use). After a brief discussion on the purpose of the meeting and assurances that whatever is said is confidential, follow the steps below.

The composition of the discussion group is important. The more homogeneous the group, that is to say, the more the members of the discussion group have in common—background, age, gender, language, etc.-- the more willing they will be to talk openly and share their ideas. Having a homogeneous group will also enable you to distinguish similarities and differences between different ex-combatant groups.

STEP 1. Briefly describe problem: e.g. even though ex-combatants know they should use a condom to prevent AIDS, they don't.

STEP 2. Ask group help in determining what strategy will work in getting ex-combatants to use condoms.

STEP 3. Briefly describe possible strategies listed below. Have group add any strategies that they can think of that were not mentioned. As you describe each strategy, sketch a simple drawing or symbol on a piece of A-4 paper to represent the strategy. Make sure each ex-combatant knows what the sketch refers to.

Examples of possible responses to the problem noted above:

- make male condom more fun
- introduce female condom
- make sure condoms are available in bars, night-clubs, etc.
- promote friends watching out for friends
- ensure condoms are easy to obtain where ex-combatants live
- organize women to turn down sex without condom
- build women's (men's) negotiation skills to convince partner
- message to protect their future children from HIV/AIDS
- better quality condoms that don't break [suggested by ROC group]

STEP 4. Ask group to sort cards—each with a simple sketch representing one of the strategies—into piles as follows:

"Great" strategies

"Good" strategies

"Not so good" strategies

STEP 5. Ask group to explain reasoning

STEP 6. Summarize the group's decision, making sure that your understanding is accurate. Thank the group for their help

If time allows, before presenting possible strategies ask the group to brainstorm how to ensure a couple uses a condom. Suggest that to do so will require them to think about the reasons why couples often do not use condoms.

If enough participants and time allows, form small groups by age and have each group decide on best strategies for ex-combatants in their age group. When done, ask them to share and discuss their recommendations with the other age group(s).

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