

FACTSHEET → HIV and failing states

HIV and failing states: the issue

Poor infrastructure and limited resources in developing countries create challenging environments for provision of key services such as voluntary testing and counselling, CD4 and viral load testing and provision of antiretroviral therapy (ART). Maintaining provision of these services is even more difficult within failing states.

The failing states environment not only poses a challenge for continuation of HIV related services but also increases the likelihood of increased rates of HIV transmission through blood and sexual routes of transmission, and PMTCT due to lack of antenatal care. This can be due to reduced capacities within the state to protect people from HIV transmission, a lack of sterile medical equipment, the adoption of harmful behaviour by individuals living in disaster contexts and increased sexual violence.

Definition

Official definitions of failing states vary but common characteristics include instability, increased crime and violence often leading to regional or national conflict or civil war, internal displacement and the inability of the government to fulfil core functions.

Vulnerability within failing states

- **Fragility and conflict affect women, men, boys and girls differently.** It is widely acknowledged that fragility most negatively affects the poorest and the most vulnerable groups in society, particularly women, people living with HIV, adolescents and children. In failing states and humanitarian contexts, pre-existing vulnerabilities and inequalities become exacerbated and discriminatory practices and attitudes will likely be compounded.
- The detrimental impact of conflicts and disasters, such as the loss of homes, incomes, families and social support, can also lead to **engagement in 'survival sex'**. Women and girls in particular may be compelled or forced to exchange sex in order to secure their own or their families' lives, escape to safety or gain access to food and services. Adolescent girls and boys may also find themselves in situations that they are not equipped to deal with and they may suddenly have to take on adult roles without preparation, without positive adult role models or traditional support networks. The loss of livelihood,

education, security and the protection provided by family and community further places adolescents at risk of poverty, violence and sexual exploitation and abuse.

- Fragile states are associated with poor infrastructure and absent or impotent national accountability mechanisms resulting in **the breakdown of societal norms and impunity for perpetrators of sexual violence**. Significantly, failing states or those affected by conflict will have weak or barely functioning health systems and therefore are unable to provide essential reproductive and sexual healthcare for women and girls, including responding to the needs of survivors of sexual violence. Abuse-related injuries can range from bruising to broken bones, penetrative injuries from knives and other objects in addition to forced pregnancy, induced abortion or contracting a sexually transmitted infection, including HIV.¹
- Within the first six months of contracting HIV there is a far greater risk of transmitting the virus due to elevated viral load levels. In failing state scenarios the combination of higher numbers of newly infected people, lack of testing facilities and increased vulnerability of exposure to the virus increases the probability of localised epidemics.

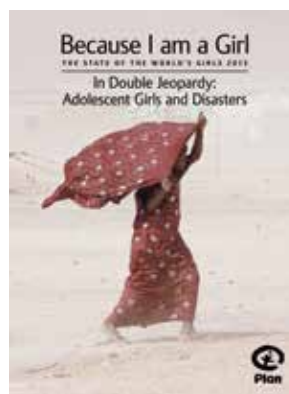
Maintaining services

- People already living with, and affected by, HIV and AIDS in humanitarian contexts are particularly vulnerable to the impacts of instability. This is because the ongoing impacts of HIV and AIDS – such as the stress on families, communities and state coping mechanisms – are already being felt. The severe disruption and dislocation common within failing states greatly exacerbates these existing vulnerabilities by further weakening the resilience of people living with HIV to cope with the effects of the disaster and in turn with the ongoing impacts of HIV and AIDS in their lives.
- If people living with HIV are unable to maintain adherence to their treatment due to lack of access to antiretrovirals (ARVs), clean water and food then they face the prospect of coping with increased risk of opportunistic infections and drug resistance.
- Humanitarian agencies must therefore specifically consider how people living with, and affected by, HIV and AIDS are being affected within failing states and modify their programmes in order to address these specific vulnerabilities which are both short and long term.
- Voluntary testing and counselling and self-help group services play an important role in supporting people living with HIV and in reducing transmission of HIV. Where the state is unable to provide these vital services the burden falls on local voluntary groups or humanitarian agencies.

Sexual violence and HIV

- **The relationship between sexual violence and HIV risk is clearly established and multi-faceted, involving multiple pathways**, in which violence serves both as a driver of transmission, and at times a consequence of being diagnosed as HIV positive. In other words, the link between sexual violence and HIV is in part directly biological – as women may be exposed to HIV during rape – and partly mediated through the impact that gender inequalities and sexual violence has on women’s sense of self, health-seeking behaviour, and in particular control over their bodies and their self-esteem.
- **Failing states and humanitarian settings with high incidents of sexual violence, can provide a particularly fertile environment for the transmission of HIV**, with recent studies emphasising that HIV incidence as a result of rape will increase both at the individual level, and in certain settings, at the community level.² Female genital mutilation/cutting (FGM/C) can render survivors of sexual violence at even greater risk of exposure to HIV.³ Therefore, in countries experiencing conflict where the incidence of FGM/C is high, women may be more vulnerable to HIV as rape is likely to damage their genital tissue, increasing their risk of sexually-transmitted infection.
- **Rape and other forms of sexual violence occur with greater frequency and brutality** during and after disasters and periods of armed conflict. High levels of sexual violence have occurred in several African and Asian emergency settings and can take many forms, from sexual harassment, exploitation and abuse, coerced relationships with rebel soldiers and army commanders, to sexual slavery and mass rape.⁴ The risk of intimate partner violence is also heightened in periods of instability and conflict.⁵
- Contrary to popular belief, surveys conducted in post-conflict settings suggest that **levels of sexualised violence against males during conflict are much higher** than is generally assumed or publically admitted. The findings of the Refugee Law Project John Hopkins research⁶ confirm that violence against men can take a number of forms: broad categories include anal and oral rape, genital torture, castration and forced sterilisation, gang rape and sexual slavery or being forced to rape others. The research, screening and documenting of male refugee survivors from the Eastern Democratic Republic of Congo, suggests that in some refugee populations, more than one in three men have experienced sexual violence in their lifetime.
- **Men and boys who have been victims of sexual violence, particularly anal rape, are highly susceptible to HIV**. However, internalised feelings of shame, fear of stigmatisation, and legal frameworks and social services that do not recognise men as victims prevent the majority of victims from seeking health services following an attack.

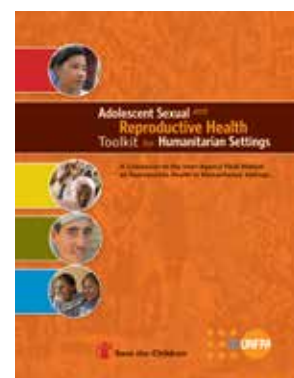
- **Traumatic events that take place in humanitarian contexts can harm young people’s mental health and well-being, increase vulnerability to a range of higher-risk behaviours (such as unsafe sex, and use of alcohol and other drugs), and undermine their sexual and reproductive health (SRH)**. These events also increase the likelihood of HIV transmission and compound the challenges for adolescents living with HIV. Adolescents are further marginalised, falling between the cracks of programmes addressing the needs of children and adults respectively.
- Plan’s *Because I am a Girl: State of the World’s Girls 2013*⁷ report on adolescent girls and disasters highlights that **very little is being done in terms of sexual violence response in emergencies**:



“Less than half of humanitarian agencies reported that they are following gender-based violence protocols in their programming for sexual and reproductive health and rights. This indicates that adolescent girls in internally displaced persons camps and shelters are not being adequately protected against violence”

Adolescent sexual and reproductive health and vulnerabilities faced by adolescent girls in particular remain a largely neglected concern. This gap in response is partly addressed by the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*⁸ by UNFPA and Save the Children, which provides concrete recommendations to ensure SRH and HIV services are accessible to young people. However, it is vital that adolescents be considered and specifically targeted for SRHR programme interventions as part of a comprehensive child protection and health response.

- Due to the highly sensitive nature of sexual violence and the likelihood that survivors will be rejected by their family due to the stigma assigned to rape, **few women seek, or are able to seek, medical care within 72 hours of the incident or even within the first month**. This has severe consequences for the timely provision of post-exposure prophylaxis.



Refugees from Central African Republic in a camp in Cameroon.



Plan Cameroon, Mobile Health and Outreach Clinics - an integrated response to SRH and gender-based violence

Plan Cameroon, in partnership with UNFPA, is delivering youth-friendly, integrated SRH care and education to adolescent refugees through mobile health clinics, community education and outreach. The project, implemented on the Cameroon and Central African Republic border, targets both adolescent refugees living in camps and the urban displaced population, reaching out to the most marginalised and difficult to reach communities.

The mobile health clinics work closely with adolescents to ensure that services are accessible, acceptable and appropriate for all adolescents, including high-risk sub-groups. The clinics provide an out-of-hours service which is flexible to the needs of the target population, assessing adolescents who come to the service for protection and SRH issues. The adolescent beneficiaries are provided with access to comprehensive SRH services including HIV testing, counselling, provision of ARV treatment and clinical management of rape.

Box 1: Risks associated with sexual violence and HIV⁹

- Physically and sexually violent men are more likely to be living with HIV and to impose risky sexual practices on their partners. They are more likely to have multiple partners, to have sex more often, to practice transactional sex, to practice anal sex and to report symptoms of sexually transmitted infections.
- HIV-infected women are more likely to have experienced physical or sexual violence; and victims of violence are at higher risk of HIV infection.
- Being a victim of sexual violence can make women and men susceptible to risk behaviours that can lead to HIV infection.
- Forced sex in childhood or adolescence increases the risk of contracting HIV as it adds to the likelihood of:
 - engaging in unprotected sex
 - participating in transactional sex
 - having first consensual sex at a younger age
 - having multiple partners.

Interventions and best practice

While key principles and strategies for intervening to address HIV in failing states are becoming increasingly clear, the evidence for what constitutes best practices is still emerging. The following are examples of effective interventions to address HIV in failing states:

- Initial rapid needs assessments should identify levels of susceptibility to HIV transmission among different groups and the impacts of HIV and AIDS on the lives of the disaster affected population. Assessments should explore how an emergency response might minimise these risks and impacts.
- At a minimum, health services should actively identify survivors of violence and provide confidential and sensitive medical services to both female and male survivors. Clinical management of rape services should include treatment for physical injuries, pregnancy prevention and access to safe abortion* and post-abortion care if needed, testing and treatment for sexually transmitted infections and psycho-social support. HIV testing is vital and rapid HIV test kits should be routinely available. Health workers should make available post-exposure prophylaxis (PEP) for preventing sexually transmitted HIV infections and ART.
- Provision of targeted and integrated gender-based violence and sexual and reproductive health services should be made available for key populations at higher risk who may feel unable to access standard services.
- Assessments should be carried out, in collaboration between government and agencies, to determine the links between conflict, displacement, HIV and AIDS, and gender inequality in each humanitarian situation. Steps should be taken to ensure that all humanitarian programmes are responsive to issues documented in these assessments.

* Abortion may be against the values of some organisations.

This factsheet was authored by Plan UK for STOPAIDS following a thematic meeting held by STOPAIDS in April 2014.



Fadila fled the violence in Central African Republic and is now living in refugee shelter in Cameroon.

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Endnotes

1. Heise, L.L., et al. Violence against women: A neglected public health issue in less developed countries; *Social Science & amp; Medicine*, 1994. 39(9): p. 1165-1179.
2. Watts, C., Foss, A., Hossain, M., Zimmerman, C. Sexual violence and conflict in Africa: prevalence and potential impact on HIV incidence. *Sex Transm Infect*, 2010. 86(3):iii93-iii99.
3. Monjok E., Holmes L. Female Genital Mutilation: Potential for HIV transmission in sub-Saharan Africa and prospect for epidemiologic investigation and intervention. *African Journal of Reproductive Health*, 2007. 11(10):33-42.
4. 48 women and girls are raped every hour in the Eastern Democratic Republic of Congo. American Public Health Association 2011.
5. Heise, L.L., et al. Violence against women: A neglected public health issue in less developed countries; *Social Science & amp; Medicine*, 1994. 39(9): p. 1165-1179.
6. Wirtz, A.L., Dolan, C., et al. Sexual violence, HIV risk and prevention among male refugees in Ugandan settlements; (2014 forthcoming) cited in: Dolan, C.; *Into the Mainstream: Addressing Sexual Violence Against Men and Boys in Conflict: A briefing paper for the workshop held at the Overseas Development Institute*, London 14th May 2014.
7. Available at: <http://plan-international.org/girls/reports-and-publications/the-state-of-the-worlds-girls-2013.php?lang=en>
8. Available at: <https://www.unfpa.org/public/global/publications/pid/4169>
9. Sexual Violence Research Initiative, Medical Research Council, South Africa.

STOPAIDS is the network of 80 UK agencies working since 1986 to secure an effective global response to HIV and AIDS.