The link between HIV/AIDS & CRSV

1. During conflict, HIV risk prevalence is likely to be aggravated by: exchange of blood due to violent conflicts and rudimental mass casualty handling; pervasive culture of conflict-related sexual violence and predation; sexual exploitation; high risk transactional sexual encounters with multiple sexual violence perpetuators; breakdown of social support systems, interaction between civilians and combatants known for high risk behaviours; mass migration and mixing of populations; breakdown of health promotion and care systems; poverty; among others, aggravate the nature and intensity of HIV risk drivers and factors (Mock et al, 2004)[1].

2. In conflict, post-conflict and peacekeeping environments, these factors and drivers of HIV vulnerability are interwoven into post-conflict social networks (Klot and DeLargy, 2013)[2].

3. Sexual coercion and violence particularly increases susceptibility to HIV to the degree that non-consensual sex is associated with extensive genital trauma and coital injuries to both victims and perpetuators, especially young women, girls, and other vulnerable populations (Klot and DeLargy, 2013).

4. WHO/UNAIDS (1997)[3] and CDC (2014)[4] studies on the relationship between ulcerative sexually transmitted infections (STIs) and HIV evidenced that presence of sores or breaks in the skin create open routes for easy HIV transmission and infection.

5. The situation is further aggravated by continued violent anal and vaginal sex practices with multiple sexual violence perpetuators, including anonymous sexual partners; and having sex when under the influence of drugs or alcohol which lowers inhibition and may result in greater sexual risk-taking.

6. Klot and DeLargy (2013) further noted that heightened risk may also be associated with the probable infectiousness of perpetuators, the incidence and prevalence of sexual violence, including mass rape and possible presence of sexually transmitted infections.

7. Widespread conflict-related sexual violence in communities with higher prevalence of HIV could be a major driver of the epidemic within and across populations.

8. Conflict-related sexual violence does not disappear upon signing peace agreements, as evidence suggests that sexual violence and violence against women may increase in the aftermath of conflict (Physicians for Human Rights, 2002)[5]. This dimension extends HIV-related susceptibility to general populations during reintegration and recovery.
9. The situation is exacerbated as many victims and survivors of sexual violence experience other multiple forms of violence across the various conflict stages, i.e. before conflict, during conflict, in protected area, throughout resettlement and total recovery.

[1] Mock A. B., Duale S., Brown L. F., Mathys E., O'Maonaigh H. C., Abul-Husn N. K. L., and Elliott S. (2004). Conflict and HIV: A framework for risk assessment to prevent HIV in conflict-affected settings in Africa.
[2] Klot J. and DeLargy P. (2013). Sexual violence and HIV/AIDS transmission
[3] WHO/UNAIDS. (1997). Sexually transmitted diseases: policies and principles for prevention and care
[4] CDC. (2014). STDs and HIV – CDC Fact Sheet
[5] Physicians for Human Rights (2002). War-Related Sexual Violence in Sierra Leone.

10. In many post-conflict environments, women and girls who have experienced sexual assault, rape or sexual exploitation, are also vulnerable to expulsion by their families, face social marginalisation, and therefore become vulnerable to further exploitation, unstable relationships and continued coercive sex. Such events perpetuate a cycle of vulnerability, and make worse when episodes include infection with HIV.

11. Reponses need to pay attention addressing these multiple factors by ensuring appropriate education, structure to improve livelihoods, holistic psychosocial and healthcare, etc. There is need to explore the continuum of broader social ecological (multilevel and multifaceted) context for effective responses.