IMPACT OF CONFLICT ON HIV/AIDS IN SOUTH ASIA

A BACKGROUND PAPER

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Preface and Acknowledgement

This report makes a rapid appraisal of the impact of conflict on HIV/AIDS in Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan and Sri Lanka. It is intended as a strategic document, written from the perspective of policy professionals and decision makers outside the health sector. Given its tight timeframe, the report has had to rely on desk research and local fieldwork in Delhi. The author has benefited greatly from discussions with a wide range of experts and other key informants. Given a space constraint, the effort has been to make the analysis brief while dealing with a necessarily complex, hitherto neglected, subject. More research, wide-ranging fieldwork and detailed analysis would be needed to do full justice to the matters at hand. The present exercise is a preliminary stocktaking and a first attempt to construct a knowledge base on an important operational issue.

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LIST OF ABBRVIATIONS

AHRN	Asian Harm Reduction Network
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante - Natal Centre
CSD	Centre for Social Development
CSW	Commercial Sex Workers
DSD	Discrimination, Stigmatisation and Denial
FATA	Federally Administered Tribal Areas
GOI	Government of India
FTZ	Free Trade Zone
HIV	Human Immunodeficiency Virus
MHDC	Mahbub ul Haq Human Development Centre
IDU/IVDU	Intravenous/Injecting Drug Use/User
NACO	National AIDS control Organisation
NEN	North East Network
NHDR	National Human Development Report
NWFP	North Western Frontier Province
NGO	Non-Governmental Organisation
PLWH/A	People Living with HIV/AIDS
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCRC	UN Convention on the Rights of the Child
UNHCR	UN High Commissioner for Refugees
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNIFEM	United Nations Development Fund for Women
UNODCCP	UN Office for Drug Control and Crime Prevention
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

The impact of armed conflict on public health (Murray, 2002) and the more specific impact of conflict on HIV/AIDS (USIP, 2001) have remained unexplored in the South Asian context. The region is home to many long-running and understudied conflicts. More recently, the military and nuclear confrontation between India and Pakistan (Stern, 2000; Bidwai and Vanaik, 2000) led to a former US President describing South Asia as 'the most dangerous place' on earth. However, most of the conflicts in the region are of an intra-state rather than an inter-state nature. Even the conflict between India and Pakistan over Jammu & Kashmir (J&K) has an important intra-state dimension, which the rhetoric on cross-border terrorism often tends to bypass. Conflicts in South Asia have tended to be viewed by policy makers largely as 'obstacles' to development, to be removed by the adoption of strong regulatory measures. The linkage between conflict and development has only recently acquired prominence in policy dialogue (Dreze, 2000). This paper makes a rapid assessment of the impact of conflict on the spread of HIV/AIDS in Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan, and Sri Lanka. It does not look into specific epidemiological trends except to the extent of providing a backdrop to the discussion on the main theme. Different countries in the region are experiencing different kinds of conflicts with differing impacts on the empirical HIV/AIDS situation. Due to constraints of time and space, some countries in the region may have received less attention here than others. This report mainly seeks to provide an overview of the issue with a view to facilitating a more comprehensive discussion.

The paper begins by providing a context to the situation in which conflicts have increasingly come to have an impact specifically on the growing AIDS crisis in the region. The strategic context of the region is examined in which there is a growing epidemic, often characterised as the 'hidden epidemic' (Reid and Costigan, 2002), that is, the emerging HIV/AIDS scenario among injecting drug users (IDU) in this and the Southeast and East Asian region. This epidemic owes much to increasing drug trafficking from the 'Golden Crescent' (Pakistan-Afghanistan-Iran border) and the 'Golden Triangle' (Myanmar-Thailand-Laos border), two of the largest producers of illicit opium

in the world. South Asia is also criss-crossed with drug trafficking routes emanating from these two regions, which is leading to the rapid spread of the 'hidden epidemic'.

Drug trafficking, the paper argues, in combination with arms trafficking and money laundering, aggravates the conflict scenario in this region. These phenomena are described in the criminal justice literature as 'multinational systemic crimes' (Martin and Romano, 1992). Patterns of illicit drug use are becoming globalised and 'standardised'. Complex global production and distribution networks, diversified marketing, new and emerging markets constitute a thriving and dynamic scene. Drug control measures are thus always a pace behind the market (AHRN, 2001). Changing patterns in the production, trafficking and use of heroin, especially in the Golden triangle region of Myanmar, northeast India, Thailand, China, and Laos has led to a series of HIV epidemics among IDU across Asia. The extent of this epidemic in the 'Golden Crescent' region of Afghanistan, Iran and Pakistan as well as in India appears substantial. Few countries in the region have been able to implement appropriate drug prevention and treatment strategies. Drug policy has concentrated on interdiction and suppression of the drug trade, which with the lack of treatment options, has led to drug use becoming a hidden phenomenon. These phenomena contribute to the aggravation of a complex internal conflict situation in the countries of the region.

The paper then briefly examines the conflict scenarios in the individual countries of the region in the context of the HIV/AIDS crisis. It then explores the situation in the vulnerable northeastern subregion of India, regarded here as the 'epicentre' for the transmission of HIV/AIDS through injecting drug use. The seven states in this area are inhabited by over 300 indigenous major and minor tribal communities, which are spread across India's international borders with neighbouring countries. Although only four of these states, namely Assam, Manipur, Nagaland and Tripura are today affected by active conflict, the remaining three states of Meghalaya, Mizoram and Arunachal Pradesh are by no means immune. They have had a history of conflict in the past and are for reasons geography, social demography, ethnicity and politics, deeply affected by the ongoing conflict in the other four. The paper then explores the gender dimension to the impact of conflict on HIV/AIDS. This is followed by an analysis of the impact of conflict on HIV/AIDS among children, refugees and internally displaced persons (IDPs). Finally, the

paper brings out the policy implications of the study and makes a set of recommendations.

RECOMMENDATIONS

A number of case studies on the impact of conflict on HIV/AIDS in individual countries of the region need to be taken up to examine their policy implications.

Governments in most conflict-affected countries are not responding adequately to the threat of HIV/AIDS, for want of commitment and capacity building. They are also underestimating the threat of HIV/AIDS in conflict-affected areas. UNGASS Declaration of Commitment (June 2001) recognised that populations destabilised by armed conflict are at increased risk of exposure to HIV. UN Secretary General has called for a total contribution of $ 7-10 billion per year. Only $ 1.8 billion has been pledged by May 2002. International financing to fight HIV/AIDS is absent from countries affected by conflict. The emphasis on HIV/AIDS as a 'security' threat is mainly related to the threat it poses to military forces. Attention must be paid to the threat to 'human security', especially that of women and children that arises from HIV/AIDS. Guidelines on HIV/AIDS interventions in conflict situations (UNAIDS et al, 1996) must be pro-actively implemented. Coordination among humanitarian agencies needs to be stepped up. The ideal of integrated, multi-agency initiatives at country level is must be realised (Save the Children, 2002).

In the light of recent findings (Csete, 2002; HRW, 2002), steps must be taken to develop and implement a formal plan for a budgeted programme of monitoring of and regular public reporting on violence and abuse against marginalized groups at high risk of HIV/AIDS. National AIDS Control Organisations in the region, state level AIDS control organisations funded by national agencies, central and state government ministries of Home, Public Security, Police, NGOs and others should be involved in these exercises. Police officers at all levels should be trained on the fundamentals of HIV transmission and care for persons with AIDS and sensitised to the importance of HIV/AIDS prevention among high risk groups.

Steps must be taken to promote a rights based approach to the AIDS crisis in the light of the provisions of the International Covenant on Economic, Social and Cultural Rights. Article 12 of the Covenant in particular provides that everyone should enjoy

the right to 'the highest attainable standard of physical and mental health'. This is quite apart from the duty to respect civil and political rights, which are also similarly covenanted by the UN.

Inter-sectoral training programmes must be organised to broaden the knowledge, understanding and skills of drugs and AIDS workers, opinion leaders, various ministry personnel and public sector workers, researchers, NGOs and others. The quality of training for direct service providers in the field should be enhanced. A strategic approach to training, identifying who needs what training and for what specific purpose, including training of trainers should be adopted.

Security forces deployed in conflict-affected regions, in some situations, can be utilised to adopt humanitarian interventions to deal with serious outbreaks of illnesses such as HIV/AIDS when the official medical agencies posted there are unable to intervene for security reasons. In some conflict-affected areas in India, for example, the medical personnel on the rolls of the Border Security Force have successfully visited sensitive conflict zones and provided emergency assistance to villagers afflicted by an epidemic of encephalitis. The villagers are known to have welcomed and cooperated with such humanitarian interventions. The possibility of undertaking such exercises on a sustained basis should be examined. This would go some way in addressing the important issue of improving security forces-civil society relations in conflict-affected areas.

Education and advocacy should be taken up on a much larger scale to influence the authorities dealing with drug control and drug demand reduction. They should be involved as partners in the prevention of HIV incidence among IDU on the basis of the memorandum of understanding between UNAIDS and the United Nations Drug Control Program (UNDCP). NGOs should be assisted to empower communities to advocate and to influence the national policy and the practices of public security and police officials (AHRN, 2001).

Working relationships with segments of bureaucracy such as the police and public security must be built up to gain influence over IDU lives. Police behaviour towards the IDU is one of the strongest determinants of whether they will be vulnerable to the transmission of HIV. Working with police increases their awareness of the impact of

their practices, and provides them with a larger range of options for what they often see as a no-win situation (HRW, 2002; Csete, 2002). An issue highlighted in recent studies (UNAIDS, 2001; HRW, 2002; Csete, 2002) is that of the continued practice of discrimination, denial and stigmatisation in relation to HIV/AIDS in different social and administrative contexts in the South Asian region. Conflict in South Asia, thus must be viewed as a much more comprehensive phenomenon than has been possible to do so far. It deserves much greater attention from the development and other angles than has been given to it by official agencies.

HIV/AIDS is a significant threat to soldiers and their partners. Conflict frequently leads to increases in HIV transmission rates and sensitivities around the deployment of peacekeeping forces can obscure the realities of transmission. Open dialogue and debate among the armed forces, civil society and governments on the relationship between armed conflict and HIV/AIDS is a prerequisite for prevention and care programming (Foreman, et al, 2002).

In South Asia, colonial bureaucratic legacies, resource limitations and other institutional hindrances prevent the development of optimum strategies for organisational change to address conflict and HIV/AIDS-related challenges. Pilot projects and experimental studies need to be undertaken to bring about policy changes and program development. The theory and methods developed in the discipline of organisation research can help change organisational design, structure and functioning. South Asian initiatives must be promoted to achieve organisational change and to develop a credible model for large-scale programs and for systematic change through consensus building, operations research and research utilization activities. A general paradigm for institutional change is necessary (Phillips, et al, 2002).

SECTION I: INTRODUCTION

Context

AIDS was first identified in South and Southwest Asia in the 1980's. Initially seen as a disease of the western world, it was not considered a priority issue of concern for the region. By the 1990's however, it had become clear that HIV and AIDS were spreading dramatically in many developing countries, including countries in South and Southwest Asia. The subsequent decade has shown that the epidemic is disproportionately affecting developing countries and is fuelled by poverty, gender inequality and social marginalisation. UNAIDS estimated that over five million people were living with HIV and AIDS in this region.

The Asia pacific region has overtaken Africa in recording the fastest growing rates of new HIV infections in the World. In the last four years there has been more than a 100% increase in the incidence of HIV infection in the region.

Country	Number of people living with HIV/AIDS, end 2001	Total population 2001 (thousands)	Risk Factors and Vulnerable Groups
Afghanistan	--	22,474	IV drug users; refugees/displaced persons; unscreened blood
Bangladesh	13,000	140,369	Returning nationals; persons engaging in casual sex or having multiple partners and their spouses; commercial sex workers and their clients and through them their spouses or partners; IV drug users
Bhutan	<100	2,141	Returning nationals
India	3,970,000	1,025,096	Persons engaging in casual sex or having multiple partners and their spouses; IV drug users; commercial sex workers and their clients and through them their spouses or partners; recipients of blood transfusions and organ transplants.
Iran (Rep. Of)	20,000	71,369	IV drug users; returning nationals; unscreened blood
Maldives	<100	300	Foreigners and returning nationals; recipients of blood transfusions; IV drug users

Nepal	58,000	23,593	IV drug users; persons engaging in casual sex or having multiple partners and their spouses; commercial sex workers and their clients and through them their spouses or partners
Pakistan	78,000	144,971	IV drug users; persons engaging in casual sex or having multiple partners and their spouses; commercial sex workers and their clients and through them their spouses or partners
Sri Lanka	4,800	19,104	Persons engaging in casual sex or having multiple partners and their spouses; foreigners and returning nationals; commercial sex workers and their clients and through them their spouses or partners

Sources: UNAIDS 2002; Jayasuriya, 2001; see also Fact Sheet I for data on drug users and IDU.

The South and Southwest Asia region is home to almost one third of humanity. In such a large population, small differences in the rates can make for a huge increase in the absolute numbers of people with HIV. Reported figures related to HIV/AIDS tend to present in incomplete picture of the epidemic. In many countries, the surveillance capacities are weak. Opportunistic diseases, including tuberculosis and other infections, often cause sickness and death in people who have HIV. Moreover, many people do not want to know or reveal their HIV status, because of the blame and shame attached to AIDS. Most of the countries in the region, with the exception of India, are considered to be in an early phase of the epidemic, with low levels of HIV. This, however, should leave no room for complacency. The experience of India shows that the face of the epidemic can change dramatically and quickly.

According to UNAIDS, India is currently at the stage of concentrated epidemic, defined as 5% prevalence amongst people practising high-risk behaviour. From a concentrated epidemic, it takes generally 3 years for HIV to spread to the general population and reach a critical level, defined as “prevalence of 1-2% in the general population”. This is already said to be the case in five states in India.

AIDS as a Development Issue
UNDP defines sustainable human development as development that promotes growth along with the equitable distribution of its benefits, embodies the principles of participation and equity, and protects the life opportunities of future generations, as well as present generations. The factors, which are obstacles to this vision of development, fuel the spread of the epidemic. These factors include social and economic inequality, gender disparity, political instability, civil disorder and absence of good governance.

UNDP, 1999

Poverty

South Asia is fast emerging as the poorest, the most illiterate, the most malnourished, the least gender sensitive - indeed, the most deprived region in the world.

MHDC, 1997

Widespread economic and human poverty remain pervasive problems in the region, with slow growth in per capita income, great unevenness in the distribution of the benefits of growth, and persistent gender disparities. The region is home to 515 million people, out of 1.3 billion globally, who live in absolute poverty, defined as an income of $ 1 per day or less. Most countries here have limited infrastructure for education, health, social services, and facilities such as power, water and sanitation. Rapid urbanisation has led to huge urban slums and squatter settlements, housing 25-60% of residents of some cities.

Indian, Pakistan and Bangladesh have shown some poverty reduction trends in recent years due to economic growth. However, the numbers of poor people in Nepal have continued to grow. Sri Lanka, which has a high level of human development, is faced with the phenomenon of jobless growth. Employment growth rates (1.6 percent in 1990-3) have not kept pace with the economic growth rate (5.3 percent in 1990-3), leading to a large number of people with education but no jobs, and commensurate social and economic problems.

Chronic poverty is further exacerbated by disasters, such as recurrent floods in Bangladesh, and by civil strife, such as in areas affected by conflict between the Singhalese and Tamils in Sri Lanka, in the northeastern states of India, in Jammu& Kashmir, and in Afghanistan, which has been plagued by war and internal strife for the past two decades. As a result most of the population of Afghanistan has very limited access to education, health care and other facilities, and few income alternatives. Studies undertaken by UNAIDS show that wars and armed conflict generate fertile conditions for the spread of HIV/AIDS.

The uneven distribution of wealth and power, structural poverty and lack of sustainable livelihoods has provided the impetus for the rapid spread of HIV in the region. They have created and nurtured conditions, which increase vulnerability and susceptibility, particularly of poor people, to HIV and AIDS.

Poor people are forced by economic imperatives into living conditions and occupations in which risk to life and health are endemic: lack of sanitation, crowded unhygienic living conditions, poor or non-existent health facilities, malnutrition, and scant attention paid by employers to the occupational safety of workers. In the daily struggle with poverty and alienation, the risk of HIV infection is often as a lower priority than coping with immediate threats to survival.

A Culture of violence

'Today, violence has become part of state-society relation in South Asia, as ethnically diverse states struggle to accommodate the multiple needs of their communities. In India, for instance, between 1980 and 1984 alone, the army was involved in internal security operations on 369 different occasions. The region was not always a violent neighbourhood. Prior to the colonial period, diverse religious and ethnic communities lived in relative harmony. The open hostility between Hindus and Muslims is a recent phenomenon. Similarly, Sri Lanka did not display major conflicts between the majority Sinhalese population and the Tamils until recently.

The underlying causes of internal conflicts have seldom been addressed. The most contentious issues revolve around ethnic status, religion, language, demarcation of land, distribution of assets, and the absence of meaningful employment. In India and Pakistan, religion lies at the centre of the most severe conflicts. Communal rioting came to a head

in India during the Ayodhya incident of 1992, when a mosque was razed. Nearly 2,000 people died in the ensuing violence that touched many major urban centres, including Bombay. Minority Christians have been the targets of violence in both India and Pakistan. Religious fundamentalism has sometimes been supported by the state to counter political opposition. The distribution of wealth and imbalances in regional growth has also traditionally fuelled discontent. When times are hard, the sense of injustice is often borne along ethnic, religious, and caste lines. Recently, the criminalization of politics, which has seen a vast underworld of smugglers, killers, drug barons, and gangsters being used by politicians to influence elections, has also fanned the flames of communal violence…..Violence thrives in poor societies where politics is weakly institutionalised, law and order is fragile, and where the parallel economy is strong. South Asia, at least for the moment, fits the bill perfectly'. (MHDC, 1999)

Key Challenges

Situations of conflict, violence and political and social instability accelerate the spread of HIV/AIDS and threaten to push South Asia deeper into poverty, infect millions more and roll back decades of development gains. The issue needs to be addressed to examine ways to prevent, control and treat HIV/AIDS in areas and populations affected by conflict. When conflict erupts, social patterns are disrupted, behaviours change and large populations are often displaced. Women and girls become more vulnerable to sexual exploitation and gender violence at a time when health services and means of preventing the infection may be unavailable. Systematic rape and torture are often used in conflicts to promote ethnic cleansing and to spread fear.

The effort to combat HIV/AIDS in conflict situations builds on several UN Security Council resolutions, including Resolution 1308 adopted in July 2000, where the Council recognized that the HIV/AIDS pandemic is also exacerbated by conditions of violence and instability, which increases the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care. Efforts to prevent, control and treat HIV infections must become a standard component of humanitarian response in conflict and post-conflict situations. In many countries, the young-people who could fight the deadly epidemic in the future are being infected. Generations are being lost to HIV/AIDS. Meaningful development cannot be

restarted during conflict, which is the primary impediment in the fight against AIDS. Even when peace comes, the scars left by conflict continue to impede progress. When infrastructure, hospitals and clinics are destroyed, communities suffer until they are rebuilt. Experts have suggested that:

HIV/AIDS prevention and treatment should become a standard component of response to armed conflict, as should reproductive health services;

A set of guidelines for assistance under such circumstances should be developed;

Voluntary counselling and testing (VCT) services should be widely available with confidentiality. Safe handling of blood should be ensured at all levels.

Special security measures should be put in place to protect women and girls from sexual and gender-based violence.

Measures to reduce the risk of mother-to-child transmission should be implemented;

Reproductive health services should be provided to adolescents who may engage in risky behaviour or experience sexual violence.

Collection of health data should be undertaken at all stages of the conflict;

Combatants and other uniformed services should be sensitised to promote gender equity and respect for women's rights and be trained to avoid infection of themselves and their partners.

National and international legal frameworks should be strengthened to combat impunity and the tactics of systematic rape and abuse of women and girls.

Income-generating opportunities as well as skills training and education should be made available, especially to the young, to fight hopelessness and risky behaviours including prostitution for survival.

Health care providers should be trained in gender-sensitive approaches to service delivery and in the social and health risks associated with conflict situations.

Additional funding should be allocated to address the deadly interaction of HIV/AIDS and armed conflict;

Advocacy should be undertaken to sensitise both donors and developing countries to the HIV/AIDS catastrophe that follows in the wake of armed conflicts.

The following factors contribute to the spread of HIV during conflict situations:

Sexual violence: Rape is often used as a weapon of war and women are often perceived as bounty. In refugee camps and other settlements with displaced people, women and girls face the loss of personal security and risk getting raped while carrying out daily duties such as collecting firewood or water.

Breakdown in social structure and legal protection: Sexual relationships become more transitory and may involve a greater number of partners. Young people become more sexually active and marry at a much earlier age in the absence of leisure, education and employment opportunities. In such circumstances women and young girls are often sexually abused and not protected from sexual violence, resulting in a vicious circle of impunity.

Health infrastructure: The impairment or destruction of health infrastructures means that accesses to condoms in limited, sexually transmitted infections (STIs) are not treated and drugs are not available to prevent mother-to-child transmission. Also, and especially in temporary health care facilities, trained staff and confidentiality are hard to find as are care and support for HIV infected persons. Moreover, soldiers and members of uniformed services are more likely to receive health care and treatment than their families. Women and girls have especially limited access to health facilities and confront more public discrimination because of the absence of medical and social support.

Gender inequity: The low status of women and girls in many countries make them vulnerable to sexual and gender-based violence, discrimination and HIV infection because their ability to negotiate safe sex or abstinence becomes even more limited during times of insecurity and strife.

Basic needs and economic opportunities: Women and children sometimes exchange sex for food, resources shelter, protection and money.

Education and skills training: More women and girls engage in risky behaviours because a lack of education and skills training leave them with few options and income-generating opportunities.

Military and peacekeeping forces: Armed forces tend to have higher rates of HIV infection than populations at large and there is often large power gap between them

and refugee women and children. The soldiers often know little or nothing about HIV/AIDS transmission and how to prevent infection.

Displacement: During armed conflict, large populations are often displaced, while health care services are destroyed, closed or become unreachable. Most social services such as schools and health education also shut down, leaving communities bereft of the very institutions that form the core of social cohesion and interaction. During displacement, people from different regions and backgrounds are mixed up, personal security deteriorates while sexual and gender violence becomes more frequent as social norms and patterns are changed, even dissolved by the desperate situation that people face. When the conflict ends or slows, both civilians and combatants return to their home communities, sometimes carrying the virus.

Strategic Setting

South Asia straddles two of the largest narcotics producing regions in the world: the 'Golden Crescent' and the 'Golden Triangle'. Populous and poor, South Asia has a flourishing illegal narcotics trade. A number extremist and terrorist organisations operate in the region. The terrorist is often a drug producer, trafficker and seller as well as arms trafficker and money launderer. Assassinations of political leaders by terrorist organisations, drug peddling, arms diffusion and money laundering have become serious social and political problems in the region (UNDCP, 1998). Such crimes have been described as "multinational systemic crimes" (MSCs), that is, "crimes by various kinds of organisations that operate across national boundaries and in one or more countries simultaneously" (Martin and Romano, 1992). MSC is a collective term, referring to a variety of criminal behaviour systems. These crimes emanate from political, economic, religious and other historical and structural roots and involve diverse and conflicting cultural and social systems in different regions of the world. The 'Golden Triangle' region, the Andean region of South America and the Middle Eastern region, are three contemporary settings of such crimes. MSCs, by definition, transcend national boundaries. Conventional crime control measures do not apply to them. Issues of jurisdiction, sovereignty, common purpose and regional cooperation, are involved. The use of force, common in dealing with domestic crime, is inadequate to deal with multinational crime, which expands its networks in an increasingly borderless world. Few

organisational models are available in the traditional literature for the study of MSCs. The emergence of MSCs underlines the end of conventional approaches to the understanding of "human security" and calls for the adoption of broader perspectives from social sciences.

A review of drug trafficking in South Asia (UNDCP, 1997) has noted that the globalisation of the world economy and the liberalisation of trade in goods and services have aggravated the problem of drug trafficking. While precise estimates do not exist, indications point to an upward trend in the extent and magnitude of trafficking in the region, cutting across sea, land and air routes. India is a leading transit point to the US and European countries, for illicit drugs originating in the 'Golden Triangle'. This is the context in which injecting drug use has been rapidly spreading in the Southeast and East Asia as well as South Asia. A recent study shows that while there is 'much evidence of burgeoning or mature epidemics of HIV among injecting drug users' in these regions, little recognition of it is to be seen in the national AIDS strategies or the multilateral or bilateral agencies' work plans' (Reid and Costigan, 2002).

Characterising Conflict

The concept of conflict is complex and multi-dimensional. It is often associated with physical violence but some have argued that violence occurs to any self-conscious structure when that structure is destroyed by an external agency (Rao, 1988). Violence may be visible and overt or invisible and covert. There is the 'violence of politics' and 'the politics of violence'. Both kinds of violence are seen in South Asia. While visible and situational violence requires law and order solutions, invisible, structural violence calls for social-structural changes. Conflict is sometimes understood as 'inherent conflict', viz., conflict that is inherent in the relationships between men and women in everyday life (Welbourn, 1998). In our context, we must define conflict in a rights based framework. We may look at it an aggravated form of social tensions, which prevents people from the full enjoyment of their human right to a long, healthy and productive life. Some characteristics of conflicts in South Asia are i) complexity in terms of their multiple forms and levels, which occur simultaneously (Afghanistan, India, Pakistan), nuclear conflict (India, Pakistan), communal, caste and class violence and 'low intensity conflict' (India), cross border terrorism (India-Pakistan), intra-ethnic tensions (India and

Pakistan); ii) longevity of conflict; iii) neglect of the developmental impact of conflict; iv) 'low intensity' or 'episodic' nature of conflict (Sri Lanka, India); iii) continuity of conflict with other forms of violence, such as political, criminal, inter-personal etc.(India); iv) largely intra-state rather than inter-state character of conflict (Pakistan, India); v) open conflict confined within particular areas (India, Sri Lanka, and, till recently, Nepal); and vi) considerable physical destruction (all countries).

Conflict and Development

Conflict and violence in South Asia, are often viewed as law and order problems and their development implications neglected (Subramanian, 1992; Dreze, 2000). UN documents view conflict as a violent physical and social confrontation between inter-state or intra-state entities, inhibiting people from the full enjoyment of their human rights in terms of the UN International Covenant on Economic, Social and Cultural Rights (1966). Conflict is akin to an 'emergency', described as 'a sudden or long-term occurrence that may be due to epidemics, to natural or technological catastrophes, to strife, or to other man-made causes demanding immediate action' (UNHCR, WHO, UNAIDS, 1998).

Conflict has become a crucial development concern in South Asia today. The nuclear confrontation between India and Pakistan has led to a displacement of development concerns by "national security" concerns. In 1998, one of these two nuclear nations spent about two percent of its $469 billion GDP on defence, including an active armed force of more than 1.1 million personnel. In the same year, the other nuclear nation spent about five per cent of its $61 billion GDP on defence, yielding an active armed force only half the size of the former (Stern, 2000). The proportion of civilian casualties in conflicts around the world has risen to over 80 per cent during the 1990s. Terrorism is an important aspect of contemporary conflicts. South Asia witnesses both inter-state as well as intra-state conflicts. Intra-state conflicts, which are larger in number, are socially divisive and undermine the integrity of the nation states leading to a vicious cycle of violence and social disintegration. Warring factions resort to loot, drug trafficking, environmental plunder, arms smuggling and other international crimes. Much of this escapes notice in literature on development.

Sources of Conflict

Scholars have identified several factors, which aggravate conflict situations in South Asia. These include the project of nation-building, the failure of multi-party representative democracy, poor governance, the emergence of sectarian and

fundamentalist ideologies, globalisation, wide dispersal of arms, militarization and military expenditure, depletion of natural resources, development induced displacement, drugs trafficking and associated phenomena and so on.

Large parts of the region, which today consist of independent nation-states, were once part of the same imperial politico-administrative arrangement. Decades after decolonisation, a situation of conflict, both inter-state and intra-state, pervades many of these states. The conflict situation in Afghanistan, with serious regional, political, ecological, social and human security implications spills over into the adjoining states of Iran and Pakistan with the movement of huge numbers of Afghan refugees across the frontiers. The recurrent conflict between Pakistan and India, assuming a nuclear dimension, has attracted super-power intervention. The internal conflict situation in the Indian state of Jammu & Kashmir has impacted on human development and humane governance scenario in the state.

Further afield, a serious conflict situation (both covert and overt) prevails in the northeaster region of India, the site of a historical confluence between India, Bangladesh, Myanmar, Thailand and China. The region is an ethnic and cultural mosaic and melting pot and has witnessed, over the centuries, an interaction of indigenous communities, castes, races and religions. Porous borders facilitate the easy movement of people across frontiers, facilitating cultural and social contact but also the movement of drugs, arms, money and insurgent groups. These have a bearing on internal developments in the adjoining countries. The northeastern states of India are to be viewed as a single conflict-prone unit with many ethnicities, risk factors and cross-border problems promoting the spread of HIV/AIDS. Regional migration is a major issue in the northeastern states involving India, Bangladesh, Nepal, Bhutan and Myanmar (Hazarika, 1994; 2000). The ethnic conflict in Sri Lanka has long had an impact on the delicate political and social balance in adjoining Indian state of Tamil Nadu. The internal conflict situation in Nepal has implications for migration of ethnic Nepalese into India and Bhutan. Finally, many forms of internal conflict, involving caste, class, community, religion, language, region characterises the nations of this region (see for India, GOI, 2002).

The expanding heroin trade in the 'Golden Triangle' has brought a wave a HIV/AIDS in the northeastern subregion of India. Manipur, as a conduit for drug trafficking, could play

a key role in the spread of the infection throughout the rest of South Asia. Affected by insurgency and terrorism, the seven Himalayan border states of India are among the poorest in the country and are largely closed to outsiders in view of their strategic location along the international border. A number of migrants pour out of Myanmar into India via Manipur where the rate of HIV infection among drug users jumped from zero in 1988 to nearly seventy percent in 1992.

The conflict in Afghanistan and the violent movement in the Indian state of Jammu and Kashmir (J&K) have led to the growth of a number of terrorist organisations in the region. Sectarian conflict, tribal feuds, ethnic confrontations and power politics in Pakistan and Afghanistan have led to the emergence of many networks of terrorist and drug traffickers in the Indian border states of J&K and Punjab. Similarly, in Sri Lanka, the terrorist organisation, the Liberation Tigers of Tamil Eelam (LTTE), is known to be involved in global networks of narcotics and arms trafficking. In the northeastern subregion of India, anti-state organisations such as the United Liberation Front of Assam (ULFA), the National Socialist Council of Nagaland (NSCN) and the People's Liberation Army (PLA) of Manipur and others are connected to networks of trans-border narcotics and weapons exchange. Intelligence sources indicate that narcotics trade has been lucrative enough to give rise to a multitude of insurgent groups in the Indian state of Manipur. The large Tamil population of Moreh, a town in Manipur bordering Myanmar, is suspected to possess links with the LTTE in Sri Lanka.

An unprecedented spread of light weapons in the hands of non-state actors in countries of South Asia has led to the aggravation of inter-state and intra-state tensions (Karta, 1997 a, b and c). The borderline between inter-state tensions and rising crime, armed intra-state conflict and the global proliferation of weapons are being rapidly obliterated. In development terms, wide-ranging material and psychological deprivations are associated with conflict including entitlement failures, health crises, physical violence and forced displacements. Conflict also disrupts development prospects by destroying the productive infrastructure, public services, settlement patterns, environmental resources, social capital and the institutions of governance (Dreze, 2000).

Militarization

This aspect can be looked at from two angles: the expenditure on the military; and the size of the armed forces. Military expenditure in South Asia today is higher than in any other part of the world (see Table VI). Perceived security threats have led many South Asian governments to spend significantly on the strengthening of police forces, prevention of terrorism activities, security provision for political figures, and measures to address organised criminal activities. Military expenditure eats into social sector spending; allocations to social sector spending in South Asia are also significantly low (MHDC, 1998; 2000)

Conflict and Quality of Life

Armed conflicts disrupt productive activity and economic growth. Disruption of communications, reduced trade, capital flight, population displacement, heightened uncertainty, institutional breakdown, fiscal bankruptcy and a crippled administration are characteristic of conflict situations. In such situations, the quality of life often declines even if economic growth often takes place. Entitlement crises, collapse of public services, forced displacement of population, breakdown of social fabric, political reparation and personal trauma take place in conflict situations. Not only do the adverse effects of conflict continue beyond the conflict; they contribute, in turn, to the persistence of conflict.

Conflict and Social Change

Conflicts increase social divisions and marginalize the underprivileged. They also undermine social achievements and ethnic harmony. After decolonisation, South Asia has witnessed inter-state and intra-state conflicts on a sustained basis. These conflicts emanate from and are aggravated by a variety of historical, demographic, political, social, religious and other factors. 'Conflicts' and ethnic violence in South Asia are also often a means of conducting democratic politics. In fact, ethnicity has become a potent means of mobilisation along religious, caste, territorial and class lines to enhance electoral clout of political formations.

Crisis of Governance

South Asia faces a crisis of governance which could halt the region's democratic progress and the well being of its millions (MHDC, 1999). The signs of crisis are seen in nuclear rivalry and military expenditure, weak coalition governments, debilitating political

demonstrations and strikes, urban chaos, and breakdown of mutual trust among communities. Recent developments include governmental instability and the rise of parties with exclusionary and extremist agendas, electoral uncertainty, reshuffling of political alliances, the spectre of insurgency, the persistence of military rule, the shutting down of daily life through crippling strikes, civil wars, corruption, social exclusion and inefficient civil services.

Formal institutions of governance have often bypassed the voiceless majority who suffer from multiple deprivations on account of their income, creed, gender, or religion. They have not only been excluded from the benefits of growth but have also not gained political empowerment. Some of the worst consequences of their exclusion are seen in the high rates of crime and violence throughout the region.

The bulk of public spending in South Asia is directed away from social and development expenditures towards providing non-merit subsidies, making up for losses of public corporations, maintaining a large army of civil servants, and providing for external defence. With the notable exception of Maldives, social sector expenditures in South Asia remain low at less then 5 per cent of GDP. This is at a time when a large proportion of expenditure is spent on low human priority areas.

Endemic deprivations become the breeding grounds for crime and violence in South Asian societies are increasingly polarised. The threat of crime and violence pervades all over South Asia. Besides being ravaged by a two-decade old civil war, Sri Lanka has the region's highest rate of murders and armed robberies with 9 murders and 20 armed robberies per 100,000 people. Similarly, Bangladesh recorded the region's highest rate of car thefts with 261 car thefts per 100,000 vehicles. The most vulnerable in South Asia remain the most abused. Bangladesh had the region's highest rate of rapes with 10 rapes per 100,000 women (1996). Out of all the rape victims in Punjab (Pakistan) last year, more than half were minors. Since 1994, there have been 23,000 dowry deaths in India. Also, there are more than 100,00 child prostitutes in South Asia. Violence against women and children in selected conflict affected states in India has shown disturbing features in the recent period (see Tables III & IV and Figures 3 & 4). A report of the Government of India (GOI, 1993) indicated that crime syndicates and mafia organisations had

established firm connections to government functionaries and political personalities at different levels.

SECTION II: CONFLICT AND HIV/AIDS: COUNTRY SCENARIOS

Afghanistan

Almost no statistics are available for Afghanistan, where a generation has grown up during decades of war and civil strife. The country has experienced widespread loss of human life, destruction of social and economic infrastructure, environmental degradation, high levels of unemployment, and food insecurity and malnutrition. Millions of refugees live outside Afghanistan, and millions are internally displaced. Large tracts of land are contaminated with landmines and unexploded ordnance. One million houses need rebuilding. It is estimated that the under-5 mortality rate is 257/1000. Only 5 percent of the rural population have access to safe water. Only 24 percent boys and very few girls attend school. A high number of men and boys are in highly mobile, militaristic situations (ADB, 2001).

Afghanistan was the world's largest opium producer at the time of the US-led military attacks on the country in October 2001. The main source of opium, morphine and heroin in Iran, Pakistan, India, and central Asia, and of heroin in Europe, is Afghanistan. The civil strife and lack of an effective central government allowed the Taliban to emerge in 1994. In the late 1990s, Afghan farmers were making over US$100 million dollars growing poppies (moving away from agriculture and livestock trade) with the Taliban authorities collecting a minimum of US$20 million in taxes. However, it is reported that after the US military attack, the price of opium in Afghanistan has dropped from US$1200 to US$176 per kilogram (Reid and Costigan 2002)

There is no national AIDS policy or any known strategies in place in Afghanistan. Prior to 1992, a limited government survey, mostly in Kabul, reported no cases of HIV/AIDS; subsequently, there are no records due to the limitations of health facilities and absence of a surveillance system in the country. HIV prevalence in Afghanistan is almost unknown. To date, only 10 cases of HIV/AIDS have been reported (WHO, 2002). However, there are unofficial reports of AIDS in the country, as well as amongst the refugee communities in the neighbouring countries. The low level of HIV awareness, the prevailing socio-economic situation, and the widespread drug use are conditions in which HIV is known to spread.

Bangladesh

Bangladesh is a densely populated, largely rural society. The estimated annual growth rate of the urban population of 5 percent indicates a high rate of migration from rural to urban areas. Some of the demographic factors leading women to become victims of HIV/AIDS are low median age at first marriage, taboos surrounding sexual relations, nutritional status, breastfeeding, access to health facilities, antenatal care, women's status and double standards, and poor knowledge of AIDS (Baden and Wach, 1998). There are many factors in Bangladesh which facilitate the spread of HIV/AIDS epidemic: the low socio-economic status of women; pervasive poverty and unemployment; high mobility and migration; trafficking of women; injecting drug use; commercial blood donation and use of unscreened blood; known high prevalence of STDs and low acceptability of condom use.

Sentinel surveillance of HIV/AIDS was started in Bangladesh in 1998, and systematic and consistent HIV prevalence data is not yet available. The UNAIDS estimate of number of people living with HIV/AIDS in 2001 was 13,000.

A low intensity conflict between Islamic state security forces and Buddhist tribal guerrillas is reported to be on in the Chittagong Hill Tracts (CHT) region of the country (Manchanda, 2000; Chenoy, 2002). While the actual number of conflict related deaths are not high, the impact of the conflict on the daily life of the CHT inhabitants is said to be huge. Throughout the twenty odd years of fighting between the Bangladesh security forces and the armed tribals, the region was effectively cut off from the rest of the country. About one third of all the military in the country was said to have been deployed in the CHT to protect 40, 000 odd Bengali settlers who had been transplanted to the region and to put through counter insurgency measures. Human rights agencies report human rights violations against local inhabitants. As a result of military repression, about 80, 000 Buddhist tribals took refuge in the Indian state of Tripura across the border. These were repatriated to Bangladesh under a Peace Accord signed in 1997. In CHT, easy access to small arms has led to an increase in incidents of abduction, highway robbery, killing and extortion by disaffected tribal youth. Reports also indicate that sectarian and extremist groups are active and that the safe havens and operating bases

obtained in Bangladesh by militant groups from India pose a threat to internal stability and security.

Bhutan

The human development indicators in Bhutan show that the country has been making progress (UNDP, 2000). The population is primarily rural. Since most of the arable land is already in use, population pressure and free inheritance laws have prevented some households from meeting their subsistence needs. This has led to rural-urban migration. Thimpu, the country's capital city, has been growing fast. The border with India is open and large numbers of people move freely in both directions. A growing number of Bhutanese travel abroad frequently. Militant groups from the neighbouring Indian state of Assam, such as the United Liberation Front of Assam, (ULFA) and the Bodo Liberation Tiger Force (BLTF) are reported to have found safe havens in the border areas of Bhutan, giving rise to a situation of instability. As powerful neighbours surround the country, the state has to rely on ethnic Bhutanese sentiments to build the concept of nationhood in Bhutan though at the cost of ethnic minority interests (CEMARD-Bhutan, 2001). As a result, a number of Bhutanese citizens of Nepali ethnicity have been forced to seek shelter in Nepal. They are yet to be repatriated.

India

By the end of 2001, an estimated 4 million + people in India were HIV-infected (Reid and Costigan, 2002; UNAIDS, 2002). NACO figures show that HIV seropositivity rate has been steadily increasing in the country. Weaknesses in the sero-surveillance system, bias in targeting groups for testing, and the lack of availability of testing services in several parts of the country, suggest a significant element of underreporting (UNAIDS, 2001a). Three states – Maharashtra, Tamil Nadu and Manipur – account for nearly 75 per cent of reported HIV infections.

The risk factors in India are easily listed: widespread income and human poverty and illiteracy; concentration of economic activity in towns and cities, which fuels rural-urban migration; large number of migrants in the age group 15–24, in which the largest number of infections are occurring; gender disparity and low status of women which increases their vulnerability; increasing drug abuse and injecting drug use in the north-eastern

region and elsewhere; poor safety of blood and blood products; and large incidence of STDs among men and women.

In 2000, HIV infections were reported to be high in major cities. In Imphal, capital of Manipur, infections increased form 61 percent in 1994 to 85 percent in 1997. Prevalence rates nearing or about the critical level of 10 percent in many areas are causing public health concerns. HIV infections from IDUs to their non-injecting wives increased from 6 percent in 1991 to 45 percent in 1997 (Panda et al, 2000). In spite of this, there are no government funded and implemented programmes linking HIV/AIDS with drug abuse. The government does consider drug related HIV risk as serious but health policy makers across the country are reportedly not clear about the strategy of harm reduction and its appropriate use in the context of India (UNAIDS and UNDCP 2000).

The conflict situation in India extends to a variety of areas and contexts. No exhaustive analysis can be undertaken here for reasons of space but we may briefly note the broad context and features. Inter-state conflict in India, overt and covert, is at present restricted to the state of Jammu and Kashmir (J & K). The state witnesses, however, a strong element of intra-state conflict as well. Overt intra-state conflicts are also to be seen at present in the four northeastern states of Assam, Nagaland, Manipur, and Tripura. The remaining three states of Meghalaya, Mizoram, and Arunachal Pradesh do not at present display overt and active conflict but were historically part of the conflict scenario in the region. For reasons of geography, demography, ethnicity and politics, they share the impact of conflict in the other four states in various ways, including by being transit routes for the militant groups. Poverty, inequality, perceived injustice and so on, are among the causes of conflict. Regional disparity, identity and ethnicity issues are also dominant in the region. In mainland India, there are often conflicts based on various factors and causes such as religious, caste, class, linguistic, regional and other differences. (Schofield, 2000; Misra, 2000; Hazarika, 1994; Swami, 1999; Human Rights Watch, 1998; Engineer, 1989; Das, 1990; Chenoy et al, 2002; Hameed et al, 2002; PUDR, 2002; Communalism Combat, 2002; Chattopadhyay, 2002).

Conflicts in India are generally seen as “low intensity” warfare. This description, however, conceals serious ramifications of the violence for families, children and communities. Not only are civilians and non-combatants killed in the fighting, their lives

are marred by being caught between two opposite parties, by the virulent state security operations, the militarization of justice, the curbs on individual freedom and the lack of trust among people living through violence. A large number of people are internally displaced as a result of conflict. Currently, according to one estimate about 500,000 people are permanently displaced as a result of some conflict within India. (USCR, 2000). This figure is separate from the figure of those internally displaced as a result of development projects. A study by the Indian Institute of Public Administration, New Delhi, revealed that for every large dam (of which there are 3,300 in India), 44,182 people are displaced. A large proportion of the displaced (57.6 percent in the case of the Sardar Sarovar Dam) are tribal people. When Dalits (or the so called Scheduled Castes), are included, the figure rises to 60 percent. Tribals constitute about 8 percent of the Indian population and the dalits about 15 percent. The disproportionate burden borne by the weaker sections of the Indian population is obvious. Different figures, from about 21 million to a staggering 50 million displaced people in India, are given (Roy, 2001; Parasuraman and Unnikrishnan, 2000). For reasons of space, we analyse in this report, only conflicts occurring in selected Indian states, which are currently witnessing overt and active conflicts, namely J&K and the northeastern states. For reasons already mentioned, we include all the seven northeastern states of India as 'conflict-affected' for the purpose of this report (see Tables I, II and Figures 1& 2; see also Table V for some human development/HIV indicators for selected conflict states in India).

Conflict in India entails the transformation of family structures, through the loss of members, through the processes of dislocation and displacement or through impoverishment and the loss of property. These changing structures have detrimental consequences for the relationships and emotions of family members. Children face the threat of death and injury and the loss of opportunities for education. Conflict has negative implications for children's emotional health. Particular protection concerns arising out of conflict- orphaned children, the participation of young people in violence, the vulnerability of young people to HIV/AIDS and the use of child labour in hazardous and exploitative conditions- are issues that matter.

A survey of 140 men and women from Srinagar and Jammu in the conflict-affected state of J&K reveals the kind of violence the population has been exposed to (Jayratha, 2001).

Experiences of Conflict in Srinagar and Jammu

Characteristic	Event	Srinagar Frequency (%)	Jammu Frequency (%)
Militant Events or Combat Operations Experienced	Land Mine	18.6	1.4
	Grenade Attack	40	4.3
	Shelling	17.1	1.4
	Bomb Blast	32.9	15.7
	Riots	18.6	11.4
	Open Fire	34.3	8.6
	Cross Fire	38.6	4.3
	Civilian Targeted attack	24.3	5.7
	Harassment	48.6	11.4
Stressful Events Experienced	Lack of food and water	21.4	8.6
	Lack of Shelter	7.1	4.3
	Ill health without medical care	21.4	7.1
	Being close to death	32.9	7.1
	Forced Isolation	21.4	5.7
	Forced Separation from family/friends	28.6	7.1
	Imprisonment	7.1	-
	Murder of family/friends	24.3	1.4
	Murder of strangers	32.9	5.7
	Torture	25.7	11.4
	Kidnap/Abduction	12.9	-
	Sexual Assault	14.3	-
	Any Other	4.3	2.9
Injury	To Self	14.3	5.7
	Injury to Relative	48.6	8.6
	Death of Relative	37.1	8.6

Source: Jayratha, 2001

As mentioned, conflict in India has affected education. In J & K, a total of 891 schools have been destroyed; 2997 adult and non-formal education centres have been closed due to financial constraints and staff shortages; 10,000 registered Hindu teachers left the state; school attendance dropped on average from 210 days in a year to 60 in 1993; the pass percentage of students (class 10) declined from 33 percent in 1986 to 24 percent in 1994; For class 12, the percentage declined from 49.7 percent in 1986 to 26.5 percent in

1994; there is huge backlog of un-conducted examinations for students (Bose 2000; Madhosh 1996).

The impact of conflict on health is less understood. Health indicators are often not collected during times of upheaval. In Jammu & Kashmir, anecdotal reports suggest that health services have suffered because of the insurgency. Immunisation campaigns have not been carried out for the last few years and the capacity of government to reach into inaccessible and politically sensitive areas to conduct these campaigns is low.

The relationship between conditions of conflict and the spread of HIV/AIDS. Researchers have stated that in Assam the conditions of militancy, with groups of sexually active young men constantly on the move, away from the control of their families, has contributed to the spread of HIV/AIDS. In Manipur, the spread HIV/AIDS has been related to population movements form conflict-induced displacement, to the rapid urbanisation created by these movements, to the influx of large numbers of military personnel with demands for prostitution. (Kumar and Dagar, 1999; NEN, 2000; CSD, 1999)

India's evolving national policy on HIV/AIDS control, in its different phases, is clear and well articulated (UNAIDS, 2001b). However, observers have identified a 'long list of shortfalls' and other 'socio-cultural stereotypes and norms, organisational inefficiencies and weaknesses, and lack of political will to undertake major public health and educational reforms and to tackle poverty' (Sethi, 1999; Ramasubban, 1998). It has been noted that 'disease surveillance is among the weakest links in the health infrastructure and planning chain' (Ramasubban, 1998). Another scholar observes that HIV/AIDS-related DSD is a scourge upon Indian society. 'It serves as a badge of shame, bringing the reputation of basic social institutions into question. DSD must be dealt with if India is to effectively tackle its broader crisis of possibly 3.7 million HIV infections. Failure to act now, this research would suggest, will have the severest consequences' (UNAIDS, 2001). Major challenges, including those relating to training, for public health and public security professionals (Csete, 2002) and a variety of others, await response in India.

India in Human Development Reports 2001 & 2002

	Human Development Index Value	Urban Population (% of total)	Population Under-Nourished (%)	Infants with low birth weight (%)	Maternal Mortality Ratio(per 100,000 birth)	Arms Import (US$ mn)	Total armed forces
HDR 2001	0.406	28.1	21	33	410	566	1173000
HDR 2002	0.407	27.7	23	26	540	1064	1303000

Source: Bibek Debroy, *The Indian Express* (August 1, 2002)

Iran

The geographic location of Iran and its long common border with the countries of the 'Golden Crescent' (Afghanistan and Pakistan), which produce a large proportion of the world's heroin, confront the country with the problems of drug trafficking and concomitant drug addiction and HIV/AIDS. The HIV/AIDS situation in Iran may be more serious than generally assumed. The concern of the government appears to be the spread of infection from injecting drug users to the general population.

Iran has become a major bridge linking the drug production zone in 'Golden Crescent' to the lucrative consumer markets of the Persian Gulf, Turkey, Russia and Europe. Currently, the major trafficking routes into Iran can be found in the provinces of Khorassan, Sistan and Baluchistan, areas with harsh climatic conditions and rugged mountainous terrain. In these areas, there are numerous border skirmishes between state agencies and drug traffickers. In 2000, a total of 1532-armed confrontations occurred. In the last two decades, over 3000 law enforcement officials have been killed and 10000 disabled. In 2000, 142 law enforcement personnel and 904 drug traffickers have been killed in armed clashes (Reid and Costigan, 2002).

About 45% of the Iranian population is under the age of 14; and 26 % are between 15 and 30 years of age. Unemployment levels are estimated to be 14 % (about 6 million people) and the per capita income has dropped sharply. In recent years, there have also been increases in internal migration, urbanisation, crime and social problems: ingredients that can foster vulnerability to the risk of drug use. A study conducted for UNFPA (Usmani, 2001) stated that in nearly 65 percent of the HIV/AIDS cases detected during the

previous 12 years, the transmission was in intravenous drug users. The factors that would facilitate the spread of HIV/AIDS included drug use, which is a growing problem in Iran. The first AIDS case was identified in 1986. In 1999, the Ministry of Health had estimated that there were 60,000 people infected with HIV or AIDS. In 2001, of those infected with HIV, 1,841 were identified as drug users with IDU the source of transmission (74.8 percent). Many of those identified as infected, were found in prisons. Thus, the majority of those infected are IDUs: this is due to the widespread sharing of contaminated needles and syringes. Although a national policy exists and HIV infections are the highest among IDUs, there is said to be a general lack of coordination between the national Aids policy and the National Drug Control HQ. The main focus of government policy appears to be to control the nation's blood supply and prevent HIV transmission through medical injections (Reid and costigan, 2002).

Maldives

The nation consists of a narrow chain 1200 islands (200 inhabited), half with a population of 1000 or less. As a result of the wide socio-economic disparities between Male and the outer islands, there is a high rate of internal migration to the capital. Limitations on senior level educational institutions and health facilities have meant that a large number of students and patients go abroad, mainly to neighbouring countries. Other mobile groups include unskilled and skilled labour and tourists. Tourism has been an important growth area with an annual growth rate of about 19 percent.

The first case of HIV in Maldives was identified in 1991. In December 1998, the reported number of people with HIV was <100. Though the number of reported cases is small, many factors make for vulnerability: high mobility, especially of migrant labourers, students, businessmen, seamen and tourists; high percentage of population below the age of 15; the rise of drug use among the young; the high divorce and remarriage rate; and the large number of people who need medical assistance from neighbouring countries, with attendant risk of infection from blood transfusion.

Nepal

Nepal has a long, open border with India, with a large volume of traffic in both directions, including trucks bringing in goods. There is also an increasing flow of migrants in search of livelihood, from the mountainous areas to the capital Kathmandu,

the cities of the plains, and into India. Young migrants in particular, removed form the social constraints of traditional communities, are susceptible to high-risk behaviour, including drug use.

The condition of women in Nepal is a major contributing factor to the vulnerability of the country to the spread of the HIV infection. Though women have benefited form some changes in marriage and inheritance laws, many discriminatory laws still remain. For example, the law on property rights favours men in its provisions for inheritance, land tenancy, and the division of family property. Discrimination is particularly pronounced in rural areas, where religious and cultural traditions, lack of education, and ignorance of the law, remain severe impediments to women's basic rights, such as the right to vote or to hold property in their own names.

The female literacy rate remains very low, and women in Nepal have limited earning potential, tending to concentrate in low productivity work. They also have a poor health status and very high maternal mortality rates caused by early marriage, poor child spacing, greater work burdens throughout the life cycle than men, poor diet and nutrition and limited access to health care. Violence against women is a serious and entrenched problem.

In such circumstances women are in a very weak position to protect themselves from HIV/AIDS infection. Moreover, many fall prey to well-organised networks of traffickers, who take advantage of their ignorance and economic and social deprivation to recruit them primarily for prostitution in India. Estimates of the totals number of girls from Nepal engaged in sex work in India range from 20,000 to 100,000. It is estimated that 5,000 to 7,000 girl children annually are trafficked form Nepal to the brothels of Indian cities. There are also an estimated 5,000 to 15,000 women in prostitution in Kathmandu, with 20 per cent under 16 years of age.

Since the mid 1990s, an explosive increase in HIV infection is reported to have occurred in Nepal (Reid and Costigan, 2002). Official figures indicate that 75 percent of HIV positive people are youths aged between 15 and 29 years. In the absence of effective public health interventions, HIV prevalence in Nepal may, over the next decade, increase to about 2 percent of the 15 to 49 year old population. This means that 100,000 to 200,000 young adults would become infected with HIV.

Nepal is currently witnessing serious internal conflict as a result of a Maoist insurgency led by communist party of Nepal (Maoist), which affects 42 out of the 75 districts in the country (Manchanda, 2002). The failure of the democratically elected government to deliver, especially to women and ethnic minorities, appears to have proved a powerful force encouraging support to the Maoist-led insurgency in the state. Development activity is reported to have come to a virtual standstill. More than 70 percent of such activity in Nepal is donor-aided. The impact of the current conflict on HIV/AIDS situation in the state is likely to be serious.

Pakistan

In Pakistan, vulnerability for the spread of the HIV infection, would include poverty; patterns of labour migration both within the country and to other countries, injecting drug use; low literacy, especially among women; low socio-economic status of women; low levels of acceptance of condom use; and limited access to STD treatment, especially for women.

Pakistan is now considered a minor producer of opium. However, it is a large importer of opiates and a major transit country for precursor chemicals trafficked to Afghanistan's heroin laboratories. A common way of smoking marijuana is to mix it with pharmaceutical tablets and burning it on coal. The fumes are inhaled. This is popular among the Afghan refugees on the streets of Pakistan.

HIV/AIDS was first discovered in Pakistan in 1987. The infection, though, is said to be spreading rapidly in Pakistan and India (World Bank, 1997). Pakistan's location and its sub-groups with recognised lifestyle risk factors can produce an expanded HIV epidemic. Due to an influx of HIV expatriates deported from other countries, the country witnessed a rapid increase of HIV infections in the mid-1990s. Internal migration is another important factor.

Observers note that several socio-economic factors have contributed to the polarisation of Pakistani society and the strengthening of extremist elements. Political decisions by those in authority, the use of unemployed youth and others undergoing religious studies in *madrassas* (traditional schools of learning), for involvement in the conflicts in Afghanistan and Kashmir, are seen to have promoted the growth of extremism, resulting in the *jihadi* (holy war) culture. The armed *jehadis* are said to number 200,000, about one

third of the regular Pakistani army. Over a million young people, inclined towards *jihad*, are said to be behind the 200,000 strong *jihadis*. According to an Amnesty International report, there are at least 20,000 child soldiers in this group (International Centre for peace Initiatives, 2002), Pakistani population has about 35 million in the age group of 15-29 years. A little over a half of this section could be young men and almost 10 percent of all young men are students or recent graduates of *madrassas*. The actions of this group will be determined by a variety of economic, social, political and other factors. The group is restless, turbulent and belligerent and would wish to capture power by force bypassing the electoral path. In the long run, Pakistan's modern institutions could come under the pressure created by the unemployed. However, in the short run, Pakistani elites are opting for modernity against orthodoxy, development over discord, peace over conflict and friendship with neighbours over support for insurgency movements.

The religious extremist elements in Pakistan are not a homogeneous group. There are internal conflicts among them, which have taken a violent turn in the recent period. However, the influence of external forces over competing internal groups is said to have encouraged the growth of sectarian conflicts in Pakistan. The army is likely to remain a dominant institution in Pakistan, even while sharing power with the political forces in the country. India is Pakistan's main security concern and the core issue of the conflict remains Kashmir. The creation of an enabling atmosphere for conflict resolution between the two countries will depend on the strength of political will displayed by both countries. Further, the existence of ethnically biased or sectarian entities vying for regional and national power has fostered conflict, such as in Sindh; local tensions are exacerbated by political parties that support particular factions as a means of gaining national legitimacy (Mohammed, 1994). State control is severely limited in areas such as Federally Administered Tribal Areas (FATA) and urban slums and 'dacoit' strongholds of the Sindh province, where clan spokesmen, criminal leaders, landlords and local activist sometimes incite violence.

Pakistan has been referred to as the 'arms bazaar' of South Asia. There are 1,998,600 licensed weapons in NWFP alone. Any type of weapon can be purchased in NWFP. The sources of arms in Pakistan are domestic production; the Afghan pipeline; stocks from Afghanistan; and legal sources (Karta, 2001)

Sri Lanka

Sri Lanka ranks highest of all the countries in the region in the UNDP Human Development index. However, it faces high unemployment, leading to very high levels of migration, and remittances from migrant workers are an important aspect of the economy. There is also considerable internal migration to the cities and internal displacement due to the ongoing conflict in the north and east of the country. Sri Lanka has also been a target of sex tourism.

The first incidence of AIDS was reported in a foreign visitor in 1986, and the following year the first Sri Lankan with AIDS was diagnosed. According to UNAIDS, 4,800 people are living with HIV/AIDS.

Sri Lanka is the only Asian country where the number of female migrants exceeds that of the male. Each year approximately 160,000 people leave Sri Lanka for employment abroad, of which 70-80 percent are women, mostly between 18 and 40 years of age. 80 percent are married, and migrate to secure basic family needs or enhance family income. In their place of work, primarily in domestic work in the Middle East, they have low social status and are extremely vulnerable, experiencing many forms of exploitation, including sexual abuse. Available statistics indicate that 58 percent of the reported HIV persons are returned housemaids from the Middle East.

Women also constitute 80 percent of the workers in the FTZ at Kandy. The vulnerability of these women is indicated by the high rate of unwanted pregnancies and high prevalence of sexually transmitted diseases (STDs) amongst them. There is strong evidence of a close link between conflict, drug smuggling and increasing HIV infection in the context of Sri Lanka. The escalation of ethnic violence in the 1980s around the demand for a separate state for the minority Tamil population in the north and east of the country has produced evidence of a link between drug smuggling and arms trafficking and applications for asylum. Heroin traffickers were prevented from using land routes during the Afghan conflict in the 1970s. Sri Lanka strategic location between the ‘Golden Crescent’ and the ‘Golden Triangle’ has made it a natural choice as a transit point. The island’s popularity as a trans-shipment point for narcotics from South Asia has been growing. Sri Lanka’s 1,100 miles of coastline cannot be adequately patrolled since the country’s naval forces are heavily involved in the conflict with the Tamils. Large

consignments of cannabis and heroin from Karachi and other cities in Pakistan are believed to reach coastal cities and the capital of Sri Lanka for shipment to destinations outside the region.

There are reports that heroin has become the drug of choice to entice members of minority ethnic group to become part of an international smuggling operation, the proceed of which are being used to supply arms as well as to better their future prospects.(Jayasuriya, 1995).

SECTION III: INDIA'S NORTHEASTERN SUBREGION: EPICENTRE OF TRANSMISSION OF HIV/AIDS

Drug Use and IDU

In view of the increasing conflicts, wide and increasing addiction to drug abuse and injecting drug use (IDU) in the context of increasing prevalence of HIV infection, this report attaches special importance to the transmission of HIV/AIDS through intravenous drug use (IDU) in South Asia. It is now estimated that more than 10 percent of HIV infection worldwide, or 3.5 million people, are due to injecting drug use. Of all the different ways that the virus can be passed on, directly injecting a substance contaminated with HIV into the blood stream is by far the most efficient way, more so, in fact, than through sexual means. Together, drug injecting and HIV form an explosive combination (Deany, 2001). The most rapid increases in HIV among IDUs, have been in Nepal, India, Thailand, Myanmar, Iran and China. These countries yet lack expertise in developing policy and programmatic responses to deal with injecting drug use; they have, so far, focused more on the long-term eradication of drug supply and drug use than on the pressing problem of HIV transmission. Since the relationship between IDU and HIV transmission is different in each location, changes to policies and programmes have to be developed separately through a process of ongoing analysis, consultation and trailing of responses.

It may be said that development problems foster drug problems. Marginalized communities in remote areas who have limited control over their own economic and social development, tend to become natural habitats for the cultivation, trafficking and consumption of narcotic drugs. And new patterns of drug use are often influenced by the interplay of macro social, economic and political factors. Rapid diffusions in drug use and drug injecting have occurred since 1990, paralleled by major social dislocation and change. Shifts to private economic production in the context of declines in gross domestic product have led to unemployment, increases in income differential and poverty, and rapid expansion of criminal economies.

The lack of a supportive policy environment is to be considered a challenge in controlling HIV among injecting drug users. Although drug use is driving the HIV/AIDS epidemic in many countries, the relationship between HIV and drug use is yet to become a focus of

national AIDS and drug control policies. Since HIV/AIDS is considered an essentially health issue, drug policies have often developed differently from HIV/AIDS control policies (Deany, 2001).

India's Northeast

India's northeastern states contain over 300 major and minor tribal communities of varying sizes, which began to experience the accelerated pace of modernisation and development later than the other mainstream communities in India. These tribal communities tend to witness high levels of drug addiction when undergoing 'development' and 'growth', which come to them compressed and ready with unaccustomed rapidity. They become aware of their distinct ethnicities and individual identities and begin to articulate them forcefully. They may not be opposed to 'development' but rather to its pace and direction. The militant movements often witnessed in tribal societies are an outcome of a complex mix of protest, adjustment and change (Rustamji, 1983). State policies contribute to them more than is generally appreciated. These policies and their politics need to be evaluated carefully by policy makers.

Salient features

India's northeastern states comprise the seven states of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland and Tripura. The subregion is sensitive and strategic bordering Nepal, Bhutan, China, Myanmar and Bangladesh. It is close to the 'Golden Triangle' in the Myanmar-Thailand-Laos border, one of the largest opium and heroin producing regions in the world. Manipur has been a main conduit for the flow of drugs from the 'Golden Triangle'. With a total population of about 38 million (2001 census), the states have about 4 percent of India's population and about 7 percent of the country's total land area. Assam, the largest state with a population of over 26.5 million, constitutes about 70 percent of the total population of this subregion.

Demographic Features

(1) State	(2) Population (millions, 2001 census)	(3) Density	(4) No of major tribes (% in total population)	(5) Literacy (%)	(6) Population Growth (%)
Arunachal Pradesh	1.09	13	12(63.7)	41.59	3.19
Assam	26.5	340	23(12.8)	52.89	2.24
Manipur	2.38	107	29(59.89)	59.89	2.60
Meghalaya	2.30	103	17(49.10)	49.10	2.88
Mizoram	0.9	42	14(94.8)	82.27	3.40
Nagaland	2.0	120	29(87.7)	61.65	4.55
Tripura	3.0	304	19(30.9)	60.44	2.99
Total	38.17				

Source: GOI, 1999

As the largest and most populous state, Assam is the hub of economic activity in the subregion and links it to the rest if India by narrow strip of land on the Bangladesh border in the north. Population mobility and migration from neighbouring countries and from the rest of India into this subregion is an explosive political issue and a cause of much conflict. Over the last two decades, population growth in the subregion has been about 3.5 percent against the national average of 2.13 percent. Population growth was the highest in Nagaland (4.55 percent), followed by Mizoram (3.4 percent), Arunachal Pradesh (3.19 percent), Tripura (2.99 percent), Meghalaya (2.88 percent), Manipur (2.6 percent), and Assam (2.2 percent) About 26 percent of the total population of the subregion belong to a multitude of tribal communities (TDMS, 1995). The states of Arunachal Pradesh (63.7 percent), Meghalaya (85.5 percent), Mizoram (94.8 percent) and Nagaland (87.7 percent), are tribal majority states (Nerdatabank, 2002). In Tripura, another former tribal majority state, tribals today constitute only 31 percent of the total population as a result of a massive migration of people from neighbouring Bangladesh

across the international border (Subramanian, 2001). Poverty and unemployment, especially educated unemployment, are among the other major concerns in the region.

Poverty

Period	**N E states**		**India**	
	Rural	**Urban**	**Rural**	**Urban**
1973-74	52.67	36.92	56.44	49.01
1977-78	59.82	32.71	53.07	45.24
1983-84	43.60	21.73	45.65	40.70
1987-88	39.35	9.94	39.09	38.20
1993-94	45.01	7.73	37.21	32.36

Source: GOI, 1999.

Unemployment

A rapid appraisal of the trends in employment and unemployment in the northeastern subregion conducted in the mid-nineties (Subramanian, 2000) revealed significant features. Open unemployment in Assam, with 5.62 per cent of the labour force, was above the national average of 3.77 per cent. Incidence of unemployment among women was higher than the national average of 4.19 per cent in the states of Assam, Tripura and urban Nagaland. In Assam (26.5 million) and Tripura (3 million), open unemployment was the core of the unemployment problem. **The proportion of the educated among the unemployed was 41.84 per cent in Assam, 90.70 per cent in Manipur, 39 per cent in Meghalaya, 86 percent in Nagaland, 70 per cent in Tripura, 37 per cent in Arunachal Pradesh, and 90 per cent Mizoram.** The share of women in total employment was stationary during 1978-88 at 28 per cent. Employment of women was mainly in the rural and in the unorganised sector than that of men. Growth of employment during 1981-1991 was not available in Assam, Mizoram and Arunachal Pradesh. The figures were 1.76 per cent in Manipur, 2.17 per cent in Meghalaya, 6.23 per cent in Nagaland and 2.69 per cent in Tripura.

Conflict situation: A Review

The historical background to the conflict situation in the northeastern subregion is quite different from that of the other parts of India. During the colonial period, the subregion was kept effectively 'excluded' or 'partially excluded' from governance, creating a

‘development lag’ between the rest of India and the subregion. After independence, the development of the subregion was taken up seriously after the Chinese aggression of 1962. The tribal communities in the subregion were slow to adjust themselves to the independent Indian state. The insurgency in Nagaland, based on identity issues, is the oldest in the northeast. This was followed by the insurgency in Mizoram. At present, the state of Assam, Manipur, Tripura and Nagaland are affected by active conflict and militancy. In the other states of Mizoram, Arunachal Pradesh and Meghalaya conflict is not overt but remains below the surface. An active conflict in Mizoram was resolved in the mid-1980s through negotiations with the government of India. Insurgent elements from the other states, however, transit through these three states from time to time. Prolonged neglect and a sense of injustice and alienation arising from legitimate developmental demands are broadly behind the conflict. The political and electoral leverage of the member’s of parliament (MPs) elected from the subregion is limited because of their small number in comparison to those of the more populous states in India’s national parliament. A pervasive sense of crisis, alienation, loss of identity and backwardness on the part of tribal and non-tribal communities here is a conspicuous feature.

During discussions (TDMS, 1995), among women’s groups in the subregion, the following issues were identified as of concern.

Basic Issues

Livelihood and Employment
Violence and Peace
Human Development
Legal Awareness
Women in Decision Making
Health

The most important issues in our context are violence and peace and the health of women. The health status of the population of the entire subregion is deplorable. Women’s physical and mental health is marked by discrimination and disregard. Most

women here consider pain, fatigue and discomfort to be a synonymous with womanhood and so to be endured.

Sex Ratio

State	Sex-ratio
Arunachal Pradesh	859
Assam	923
Manipur	958
Meghalaya	955
Mizoram	921
Nagaland	886
Tripura	945
INDIA	929

Source: TDMS, 1995

Three of these states (Tripura, Meghalaya and Manipur) have a higher sex ratio than the national average, while Assam, Mizoram, Arunachal and Nagaland have figures below the national average. Women's inferior health status finds expression in female foeticide, infanticide, high mortality rate, lower life expectancy, lower literacy, higher morbidity and adverse sex ratio. Violence against women and children in this conflict-affected subregion is increasing steadily (see Tables III & IV and Figures 3 & 4).

Further, field studies revealed (TDMS, 1995) that the health infrastructure in all the northeastern states has suffered as a result conditions of unrest and violence. Manipur is today the most affected by HIV/AIDS. However, its existing health support system is inadequate to meet the demand. Another seriously affected state is Nagaland. A study in 1994 conducted by the Institute of Population Sciences, revealed that only 41 percent of Naga women had heard about HIV/AIDS, even as the disease spreads rapidly in the state. Women's organisations in the region feel that health facilities and resources are misutilised or under-utilised as a result of a situation of conflict and unrest.

Conflict in the northeastern states is aggravated by i) drug trafficking, money laundering and arms trafficking; and ii) continuous population migration from neighbouring countries and the rest of India. While Bangladesh has the highest population density of 1000 persons per square kilometre (ADB, 2001a) in the world, the neighbouring

northeastern states are relatively thinly populated with porous borders. Political instability or conflict often leads to cross border population movements of considerable magnitude. Case studies illustrate the impact of population movement from Bangladesh into Tripura, a tiny tribal dominant northeastern state (Subramanian, 2001), leading to its transformation into a non-tribal dominant state resulting in the emergence of tribal insurgency and ethnic conflict.

Adequate database does not exist to examine in detail the impact of conflict on HIV/AIDS in this subregion. We may, however, briefly consider the situation in some of the states.

Manipur

The expanding heroin trade in the 'Golden Triangle' region has brought a wave of HIV/AIDS infection to the northeastern states. Manipur is the one of the smallest of the eight northeastern states with a population of 2.38 million (2001 Census). Tribal people constitute 34 per cent of the total population. The majority community is Hindu and makes up more than 60 per cent of the total (Tarapot, 1997). Since its incorporation into India in 1949, Manipur has witnessed considerable social and political turmoil, with several clashes between different tribes, mainly Nagas and Kukis. In addition, the state has a number of militant organisations. Ethnic movements and insurgency in Manipur and, in the other northeastern states, have to an integral part of the any discussion on HIV/AIDS. Many factors related to conflicts have a direct or indirect impact on the course of the epidemic. Since Manipur borders Myanmar, it has become an integral part of a worldwide drugs trafficking network. Access to a plentiful supply of pure and cheap heroin, peer pressure among the youth, frustration and unemployment have led to high prevalence of narcotic drugs use. The injection of heroin reached epidemic proportions in the 1980s.

An important demographic feature in Manipur is the large number of female-headed households. In 1998, 87 and 134 per thousand respectively for rural and urban areas were female-headed households. Labour force participation rates for women are higher than for men. The spread of HIV/AIDS in the northeastern subregion has been the result mainly of injecting drugs use (IDU). Manipur has between 40 to 50 thousand drug users (Tarapot, 1997), half of them injecting drugs users. (Samson, et al. 1998). Moreh, a town

in Manipur on the border of Myanmar, is the main entry point of smuggled heroin. Many other routes for drug trafficking have also opened as a result of police surveillance on Moreh. The outbreak in Manipur closely followed the pattern of increasing seropositivity among IDUs in Thailand, another 'Golden Triangle' country. Subsequent surveillance revealed that between 1991 and 1993 the prevalence of HIV in IDU samples varied from 64 to 73 per cent (Sarkar et al 1993). The table below indicates the prevalence rate in selected groups of IDUs, pregnant women, STD clinic attendees, TB patients and blood donors between 1994 and 1998.

Prevalence of HIV/AIDS in selected Groups in Manipur

Sentinel Group	**1994**	**1995**	**1996**	**1997**	**1998 (1st round)**	**1998 (2nd round)**
IDUs	55.7	54.19	64.13	76.9	67.63	72.78
Pregnant women	0.8	0.45	0.67	1.32	1.18	1.69
STD clinic Attendees	4.8	3.9	8.17	4.85	4.48	5.79
Blood donors	2.1	1.35	1.49	1.22	0.77	1.30
TB patients	3.3	6.16	11.85	8.3	12.04	12.19

Source: State AIDS Cell: *Epidemiological analysis of HIV/AIDS in Manipur*.

The table shows that HIV prevalence has been increasing in Manipur. The data is limited to information collected at particular sites. The general preference in Manipur, as elsewhere in India, is for people to seek help from private rather than public health agencies.

Meghalaya

Meghalaya has a population of 2.30 million (2001 Census). The state has a predominantly tribal population with three major tribes: Garo, Khasi and Jaintia. The non-tribal population of about 15 per cent consists of Assamese, Bengalese, and Nepalese

and Bangladeshis, who make up a significant subpopulation. Cross border migration with implications for the spread of HIV is an important issue. Increasing tension between tribals and non-tribals has led to frequent violent conflicts. Socio-political unrest in Meghalaya is different from that seen in the other northeast Indian states, especially in terms of the intensity and the resulting dislocation. Tribal dissatisfaction, the demand for separate states for the different tribes, and clamour for equity are important causes (Pakem, 1997).

A common theme is the presence of 'outsiders', reflected very strongly in the way the HIV epidemic in the perceived in the state. The first case of HIV infection was detected in a student from Manipur (1990).

Mizoram

Mizoram is one of the smallest states of India. 37 per cent of population is the under age of 35. The state consists primarily of a tribal population of different clans of the Mizo tribe (95 per cent). The state has an international border with Myanmar and Bangladesh. Considerable cross-border migration with Myanmar takes place. Socio-cultural and ethnic similarity between the populations of Myanmar and Mizoram has resulted in harmonious intermixing.

Drug trafficking across the common border with Myanmar occurs with ease. There are seven major road links between two countries. Drug consignments go to Bangladesh, Tripura and Assam. Despite heavy security the borders remain porous to movement of heroin. Insurgency activity, associated with struggle for self-determination, continued till 1986. A peace accord was signed with the government of India 1987. In the subsequent period, the HIV/AIDS epidemic came to light. Mizoram is highly urbanised with 46 per cent of the population in urban areas with a high rate of literacy. The health achievements of the state are impressive from the national point of view. HIV infection was first detected in 1990 among IDUs. HIV prevalence was found to be 9 percent in the IDUs population, most of them resident in the capital city. In 1992, HIV was detected among those attending STD clinics. HIV prevalence increased form 1.1 per cent in 1991-92 to 4.2 per cent in 1997-98. Among IDUs, prevalence remained between 5-6 per cent during that time (Zohmingthanga, 1999). Among blood donors, HIV transmission spread from

IDUs to heterosexual population. Vulnerability to in HIV states is through injecting drug use, commercial sex work, truck drivers and so on.

According to an informed observer (Chhuanliana, 2001), the practice of drug use was initially introduced to Mizoram by a small number of ethnic Mizos living in Myanmar and the neighbouring Indian state of Manipur in the late seventies and early eighties, and also by students who had gone to big cities in different parts of the country. In the beginning, high-income groups were affected. Later, young people from middle and lower income groups also took to the habit partly due to the glamorisation of drug culture and peer group pressure. For many with an uncertain future, it was an escape from harsh reality. The practice of injecting drug use was initially confined to the city of Aizawl but has rapidly spread to other towns and villages. At present, the problem affects all social and economic strata of Mizo society. After the state government's crack down on heroin trade in the late eighties, addicts took to intravenous injection of Proxyvon.

Economic backwardness, low per capita income, rising unemployment, poor infrastructure for development, non-existent recreational facilities for young people and an uncertain future are the features that characterise Mizoram after years of the insurgency. It has a very high literacy percentage, free society and strong community structure. The youth are exposed to modern day technology, making them see what other people in other countries are having. A very wide contrast between their dream world and reality, and uncertainty of the future make them vulnerable to drug use and its related harm.

Assam

A recent UNFEM-sponsored report on gender issues in HIV/AIDS in this conflict-affected state brings out important insights (North-East Network, 2002).

The report is based on a limited sample and focus group discussions. The respondents were mainly from the lower socio-economic strata of society. It finds that the state government has a long way to go in sensitising civil society and the public services in meeting the challenge of HIV/AIDS. The researchers found it difficult to locate HIV positive persons for interviews. When they eventually met a few, they were found to be ignorant of their condition. Lack of guidance and counselling was evident. During focus group discussions, the women were found to be largely ignorant; they viewed sex as only

a matter of physical relations between men and women; their initial awareness about menstruation came from elders and friends and mixed feelings of fear, shame, depression and surprise marked their first experience; and their knowledge of reproductive processes and of sexual intercourse came form friends, the media and women's magazines. They had no knowledge of condom. Their knowledge of HIV/AIDS was limited. Their vulnerability to HIV/AIDS arose from sexual harassment, abuse and forced sex work. They were harassed at the workplace, home and public hospitals. Health care professionals treated sex workers badly. Commercial sex was rampant but no one took up the cause of safer sex in the context of HIV/AIDS. Sex workers had no knowledge of their vulnerability to the HIV infection.

Blood banks were in a deplorable condition with no refrigeration or trained personnel. The Elisa count machine was not working in one blood bank. Infected blood was often donated. Poor electricity supply often damaged the working of one blood bank. While several government and private facilities had been licensed to operate blood banks, they functioned in a clandestine manner to avoid scrutiny for their lack of minimum standards and safety norms. Even a referral hospital did not have trained staff. Private clinics conducted HIV tests without proper facilities and trained staff. No counselling took place and there were no counsellors. Sanitation was very poor. HIV/AIDS related DSD was widespread. Conservative socio-cultural norms and practices prevented any meaningful discussion of HIV/AIDS. On account of the conflict situation, educational institutions functioned unsatisfactorily. Young men became restless and unhappy, took to drugs and commercial sex and became vulnerable to HIV infection. They did not know the use of condoms. Drugs from Manipur reached Assam easily.

This report, in combination with others on the situation in the rest of India (UNAIDS, 2001a; Jain, 2002), underlines the seriousness of the crisis of HIV/AIDS all over the country. The findings of these studies have serious implications for the formulation of national AIDS policies and programmes.

SECTION IV: THE GENDER DIMENSION

Gendered Impact

In South Asia, gender disparities show up in many different forms (Mukhopadhyay et al. 2001). The greater biological vulnerability of women is aggravated by a variety of ways in which women are discriminated against. Stigmatisation and discrimination against people of both sexes living with HIV/AIDS (PLWHA) is well known (UNICEF, 2000; UNAIDS, 2001b). It is also true that the extent of stigmatisation for people of both sexes varies across economic class and social strata. But given the way the dice is loaded against women in South Asia, women here, on an average, face greater discrimination than men in the context of HIV/AIDS.

As brought out in Section I, in conflict situations in South Asia, the vulnerability of women to HIV/AIDS gets further increased. The powerlessness of women and girls to negotiate safety in their sexual and social relations is a key issue in conflicts conflict situations, which are an increasing reality in the region. Such situations, involving mainly politically marginalized groups, impact on women in very special ways. The Beijing Platform For Action (PFA), 1995, states that in armed conflicts "women and girls are particularly affected because of their status in society and their sex". In such situations, patriarchal values are strongly reinforced. The human rights of civilian populations, especially women and children, are violated. The result of such conflicts are devastating, ranging form brutal killings of children, women and elderly, disabling others and in addition increasing the vulnerability of children to malnutrition, illness and death. Further, they worsen all the health indices negatively due to inadequate nutrition, unsafe drinking water and inadequate maternal and child health care.

Women play several roles in armed conflict situations: as armed activists, relatives of armed activists, relatives of state armed forces, shelter providers, victims of sexual and physical abuse and as peace-builders (Goswami and Dutta 1999; Manchanda 2001; Chenoy 2002; Butalia 2002). While the victimhood of women in conflict situations is to be emphasised, their agency should not be forgotten. Often, they form self-help groups, support counselling groups and others training women to negotiate safety in their

relationship. This vector of change must be nurtured to address the issues of violence, gender inequalities, trafficking and HIV/AIDS (Dhar, 2002).

Trafficking

Due to conflict, women tend to be exploited for the sex trade. Throughout South Asia men, women, boys and girls are trafficked within their own countries and across international borders in a clandestine slave trade. The number of trafficked persons is difficult to determine. It is estimated that about 1 to 2 million people are trafficked each year worldwide with the majority originating in Asia (over 150, 000 from South Asia). Conflict aggravates the causes including disparities, increased awareness of job opportunities outside, the penetration of mass media, inequalities due to caste, class and gender bias, lack of transparency in regulations governing labour migration, poor enforcement of human rights standards, and the profits reaped by the traffickers (Huntington, 2001; Sanghera, n. d.).

In the conflict affected areas such as J&K and the northeastern subregion in India, many issues arise in relation to women affected by armed conflict: the lack of protection of reproductive and sexual health rights of refugee and displaced women; the non-representation of women in conflict resolution activities; and the failure of state and non-state actors to adhere to humanitarian norms, in regard to the treatment of women and children in conflict. However, some post facto measures for women affected by conflict are in evidence. In Pakistan, a pilot project, Women in Crisis Home, coordinates inputs for women affected by conflict. In Bangladesh, a project for poor women who suffered due to the unrest in the Chittagong Hill tracts, was developed. In India, financial compensation for war widows was offered. In Sri Lanka, women have been participating in conflict resolution activities (UNIFEM, 2000).

UNIFEM has brought out a set of strategic objectives and actions stated in the Beijing Platform For Action along with certain persistent challenges.

Strategic Objectives and Actions

Increase the participation of women in conflict resolution at decision-making levels and protect women living in situations of armed and other conflict or who undergo foreign occupation.

Reduce excessive military expenditures and control the availability of armaments.

Promote non-violent forms of conflict resolution and reduce the incidence of human rights abuse in conflict situations.

Promote women's contributions to fostering a culture of peace.

Provide protection assistance and training to refugee women, other displaced women in need of international protection and internally displaced women.

Provide assistance to the women of the colonies and non-self-governing territories.

Persistent Challenges

Dearth of political leadership and statesmanship to foster or defend peace.

Women need to take greater leadership in building the lobby for peace.

Condition and status of women and girls in refugee camps and displaced persons settlements is deplorable.

Lack of Information on the physical, psychological, economic and social effects of conflict. (UNFEM, 2000)

SECTION V: CHILDREN, REFUGEES AND INTERNALLY DISPLACED PERSONS (IDPs)

Graca Michel's impressive global study on the impact of conflict on children brings out the fact that children are "under siege from HIV/AIDS" (Machel, 2001).

> Over the past five years, HIV/AIDS has changed the landscape of conflict for children more than any other single factor. The chaotic and brutal circumstance of conflict aggravate all of the factors that fuel the HIV/AIDS crisis. And HIV/AIDS reinforces the instability that prolong conflict, spreading death, suffering and social upheaval that deprive children of their most basic rights. Together they present the most serious threat to human security that the world has ever known.
>
> Graca Machel, 2001

A UNICEF study notes that fifty percent of those living with HIV/AIDS in South Asia are below the age of 29 (UNICEF 2001). The threat posed by conflict and HIV/AIDS to the young is being recognised as a 'double emergency' (Save the Children, 2002). It constitutes a violation of children fundamental right to life, protection and assistance under the UNCRC. About 40 percent of the total population of South Asia are estimated to be children. Children affected by conflict are huge in number. In conflict and related emergencies, high-risk sexual behaviour, including sexual bartering and sexual violence, contributes to the spread of HIV. In such settings, awareness of HIV/AIDS is low; denial and stigma widespread. Health services are severely under-resourced and do not offer adequate and effective care.

Children everywhere are socially and economically affected by conflict. The adversities they experience include material impoverishment, loss of infrastructure for health education, disruption of family relationships, loss of family members, increased reliance on their money-making capacity, displacement, lowering of status and social ostracism of their families. Young people who experience violence suffer the consequences for years. In many areas in South Asia, victims of militancy, who are socially isolated by conflict, who are not well compensated, socially reintegrated and reconciled, suffer long term emotional stress and frustration, making them vulnerable to drugs abuse or crime or HIV/AIDS. In J&K and some states in the northeastern subregion of India and elsewhere, children live their lives virtually under armed occupation forces. They get used to intimidation, armed control, fear, detention and curbs on freedom of expression. Children

also experience the ambiguity of living in a ‘grey zone’ facing targeting from both state and non-state actors. Their exposure to violence is high and they often become victims of attack. These conditions influence their social relations, recreational opportunities and emotional health; social relations become tense and explosive under the constant intimidation or humiliation of occupation.

In conflict-related emergencies, the HIV/AIDS epidemic is fuelled by sexual bartering- mainly rooted in poverty and powerlessness, sexual violence and exploitation, low awareness about HIV and the breakdown of health and educational infrastructure.

Sexual bartering in Nepal

In some camp settings such as the Jhapa camp for Bhutanese refugee in Nepal, women and girls go outside the camp to exchange sex for money with men in the local population. In such situation, condoms are rarely available, and women and girls lack the power to negotiate safe sex. HIV/AIDS prevention and care services are either non-existent or inaccessible.

Save the Children, 2002

Brutality and disrespect for dignity characterises conflicts and can serve to ‘normalise’ sexual violence against women and girls. Condoms are unlikely to be used, which increases the risk of HIV infection and transmission. Rape by soldiers and non-state actors in conflict situations is systematic. In democratic republic of Congo (DRC), 60 per cent of the arms forces are estimated to be HIV positive (USIP, 2001). In Colombia, it was found that child soldiers are especially vulnerable to HIV, either through sexual violence by older officers or through peer pressure that encourages risk-taking behaviour (Save the Children, 2000a).

Sexual abuse of children in Sri Lanka

Sexual abuse of children is a serious problem in the conflict-affected Anuradhapura districts in Sri Lanka. Incest is rife in families where mothers have migrated abroad for employment and girls, who drop out of school to work as child labourers, are often exploited. Some of the girls continue their lives as sex workers; others attempt suicide. The most vulnerable are very young girls made to have sex with older men. Wide spread rapes, domestic violence and sexual exploitation of young people in conflicts and post-conflict settings are a serious violations of children rights under UNCRC and greatly increase the risk of HIV transmission.

Save the Children, 2002

Knowledge is power

The lack of knowledge of HIV/AIDS in conflict situations increases vulnerability to infection, denies young people access to information and leads to discrimination. Low awareness arises since conflict undermines awareness raising and prevention efforts. Even where awareness is there, the daily reality of life under conflict diminishes the perceived the risk of infection.

> **Conflict impedes HIV prevention in Nepal**
> Even where HIV prevention work is underway, it can be easily disrupted by conflict. Efforts to raise to awareness about HIV/AIDS in Nepal's Achham district have been hindered by fighting between Maoist rebels and government forces. The programme had managed to reduce stigma in the district by enlisting volunteers. In September 2001, some 856 people were volunteers, half of them children. Since February 2002, most of the district has been under Maoist control. All NGO offices have been burnt down; infrastructure and government offices have been destroyed. NGO workers and volunteers are afraid to work, and the programme's impact is under threat. As a strong community-based programme with little input from outside, it is hoped that programme will survive amid conflict. The people of Achham district are determined that the programme will carry on as best it can
>
> Save the Children, 2002

Effective prevention depends on a holistic approach, using education and peer-based training, life skills for young people, voluntary counselling and testing (VCT), treatment of STIs, adolescent-friendly sexual and reproductive health services, empowerment of girls and women and economic development. In conflicts and emergencies, HIV prevention efforts are complicated by a lack of testing services. VCT is an important means of assisting prevention, allowing people living with HIV/AIDS to access care and support, and of combating stigma. In a survey of refugee settings worldwide, UNHCR found that VCT is not available in most places.

HIV care and treatment

The treatment and care of children living with HIV/AIDS in conflict situations have so far been left out of policy discussions. In countries undergoing conflict, care and treatment services are especially limited. There is also a massive shortage of treatment for opportunistic infections and anti-retroviral drugs. In conflict-affected countries, there is

increased need for blood transfusions. But blood is less likely to be screened, increasing the risk of HIV transmission.

HIV surveillance

In conflict situations, monitoring HIV prevalence and spread is difficult. To evaluate trends overtime, the population needs to be relatively stable and the sites where monitoring takes place consistent. Often, researchers are not able to travel because of security considerations.

Education

In conflict situations, educational institutions have often have been destroyed. School building, like teachers and children are targeted. A large number of schools have been destroyed in the conflict-hit state of Jammu and Kashmir in India (Bose, 2000; Madhosh, 1996). Young people have the right to knowledge and skill that reduce their vulnerability to HIV/AIDS. Sexual bartering rooted in poverty and powerlessness, sexual violence and exploitation, low awareness about HIV/AIDS, and the breakdown of vital state services increase the spread of HIV in conflicts and related emergencies. Each of these HIV risks corresponds to rights under the UN Convention on the Rights of the Child. Any adequate response to HIV/AIDS in these settings must take appropriate steps to combat HIV/AIDS.

Refugees and Internally Displaced Persons (IDPs)

In much of South Asia, the demarcation of boundaries of newly independent nations, emerging from colonial rule, was often arbitrary. The delineation of international borders by colonial powers in many cases, took little account of the geographical and historical realities of, and past linkages of community and kinship between them. As a result, national borders have become porous and difficult to secure. Moreover, the ethnic, linguistic or religious affinities of communities has led to constant cross border movements on a significant scale. These include economic migrants as well as refugees and asylum seekers (Hazarika, 2000). Refugees can be either those who flee from their country because of persecution and other political reasons or those who seek economic betterment. Refugees benefit from an established system of international assistance under international law.

UNHCR has stated that prevention and mitigation of HIV/AIDS is an essential component of the overall protection of refugees. While data on HIV prevalence in refugee situations are scarce, it is believed that refugees and other displaced populations are at increased risk of contracting the virus during and after displacement due to: poverty, disruption of family/social structures and health services, increase in sexual violence, and increase in socio-economic vulnerability, particularly of women and youth (UNHCR, 2002). UNHCR proposes to introduce comprehensive pilot programmes in refugee situations in South Asia, in Nepal at one location for 95,000 refugees and in Pakistan at three locations (Punjab for 50,000 refugees, Baluchistan for 150,000 refugees and NFWP for 1,000,000 refugees).

Persons of concern to UNHCR in South Asia

Name of country	Main origin/Type of population	Total in country
Afghanistan	Afghanistan (IDPs) Returnees from Iran Returnees from Pakistan	1,200,000 18,000 8,000
Bangladesh	Myanmar (Refugees)	21,000
Bhutan	-	-
India	Tibet Sri Lanka Myanmar Bhutan Afghanistan Other countries	110,000 110,000 42,000 15,000 19,000 1,000
Iran	Afghanistan (Refugees) (Note: According to Govt., the number of Afghans is estimated to be some 2.3 million) Iraq (refugees)	1,482,000 386,000
Maldives	-	-
Nepal	Returnees (from Bhutan) Tibetans (Refugees)	110,800 20,100
Pakistan	Afghanistan (Refugees) (Note: According to Govt., the number of Afghans is estimated to be some 3.3 million)	2, 198, 800
Sri Lanka	Sri Lanka (IDPs)	683,300

Sources: UNHCR, 2001; SAHRDC, 2001

Internally displaced persons (IDPs), unlike refugees, lack legal or institutional basis for protection and assistance from the international community. However, in 1998, the guiding principles of UN assistance to IDPs were formulated (Save the Children, 2002b).

Internal conflicts in South Asia have led to the emergence of thousands refugees and IDPs in almost all the countries. In addition to refugees, there are a large number of IDPs in India, mostly displaced by development projects, among others, dams. According to one estimate the figure is around 21.3 million (Parasuraman and Unnikrishnan, 2000). Another report puts the figure at around 50 million (Roy, 2001).

There are four areas of concern in dealing with the issue of IDPs. These are the absence of an established legal framework of international protection; the provision of ad-hoc, selective and largely inadequate assistance and relief; limited assess to international humanitarian agencies; and lack of independent witnesses to the suffering of the IDPs (Save the Children, 2000).

It is estimated that about 13 million children around the world are displaced within the borders of their own countries, uprooted from their homes by armed conflict, violence and the violation of human rights. These children are often "invisible" to the outside world. Frequently difficult to access, their numbers uncounted and their diversity unrecognised, they are often beyond the reach of international protection and assistance. Yet they are among the most vulnerable to human rights abuses (Save the Children, 2000).

In Asia, there are approximately 2.5 million internally displaced children including in Afghanistan, India, Sri Lanka and Myanmar. In Afghanistan, civil war and natural disasters have forced over three million people from their homes. About one million Afghan children are refugees in neighbouring states of Iran and Pakistan. Fighting in 1999 displaced approximately another 100, 000 children, bringing the total population of internally displaced children to about 600, 000 (Save the Children, 2000b).

SECTION VI: POLICY IMPLICATIONS AND RECOMMENDATIONS

The roots of conflict are said to lie in 'economic despair, social injustice and political oppression' (UNDP, 1993). Conflicts in South Asia are increasing in number and complexity. The situation appears likely to get worse before it gets better. There is evidence of increasing incidence of drug use as well as injecting drug use coupled with increasing prevalence of HIV infections, attested by international agencies and others (UNODDCP and UNAIDS, 2000; AHRN, 2001; and Reid and Costigan, 2002). The ground realities are often more complex and serious than indicated by official reports. Journalistic assessments show that HIV prevalence in several Indian states, in reality, may be much higher than indicated by official sentinel surveys (Jain, 2002). Another author suggests that 'epidemiological data remains the major weakness affecting policy planning and even today tells us virtually nothing about what is happening in the rural areas' (Ramasubban, 1998). For example, reliable anecdotal reports would seem to indicate a rapid rise in injecting drug use and HIV/AIDS in the conflict affected state of J&K although this is not evident from available official reports. A third author gives a detailed analysis of 'programme shortfalls' in India (which has the largest prevalence of the HIV in the region), with implications for the further spread of the virus (Sethi, 1999). South Asia is a region of considerable diversity and the governance record and administrative capacity differs widely from country to country and even within individual countries such as India, Bangladesh or Pakistan. It is not surprising that a wide gap often prevails between national policy pronouncements and ground realities. While personalities and international pressures are significant inputs into the policy process, the implementation on the ground is often determined by 'local policy culture'. Failures of national policies are often attributable to the 'general policy context' of lack of neutrality in officials, absence of public trust in bureaucracy, pressure of corruption and its acceptance by society, the existence of an alliance between the elite and the ruling party, non-accountability of technicians and the domination of patronage in the policy process (Khator, 1991; Jain, 2002). Given these realities, it would be prudent to address the

HIV/AIDS challenge in the South Asian context more seriously than has been the case so far.

The time has come for governments in the region to recognise the existence of conflict and its undoubted implications for public health policies (Murray, et al.2002). Our rapid assessment indicates that political instability and conflict, in combination with poverty, illiteracy, poor health and low status of women, could accelerate the rapid expansion of HIV infection unless conflict itself is factored in as a significant variable into the AIDS control strategies and programmes by governments. Ironically, conflict as a significant variable in the rapid spread of HIV in the region does not merit mention in the policy documents in place in countries of the region (GOI, 2001). Conflict may be mentioned sometimes in policy discourse as a problem 'out there' but it is not integrated into the policy and administrative process as a significant variable. The colonial administrative legacy of not going into the causes of conflict and of treating it as a law and order issue seems dominant.

Conflict in South Asia is not confined to the states witnessing overtly armed conflict situations. For reasons of space, our study has been selective about the states affected by conflict in India. Several other states in India have witnessed conflicts. For example, 'developmental conflicts', conflicts around caste and class and socio-religious conflicts, have taken place, which have implications for the AIDS crisis. We have not gone into these for reasons of space.

Waiting for conflict to end and peace to begin is not an option in responding to the crisis. Nearly half of the 150 countries in the world have been described as 'unstable' (WHO, 2002a). HIV/AIDS, spread by conflict, is not only a health problem and it cannot be addressed by a humanitarian response alone. It is now seen as a threat to global security. It threatens all levels of security (ICG, 2001; Fact Sheets 2 and 3). It threatens personal security because it kills and undermines the lives of many people; economic security because it eats into the nations' workforce and production; communal security because it disables the police, civil servants, teachers and healthcare professionals; national security because military forces are weakened; and international security because such problems can never be confined within national boundaries.

Sustainable peace in the developing world, depends on i) the creation of a development framework explicitly acknowledging the structural conditions that promotes violence; ii) recognition that inappropriate and inequitable development projects and strategies need to be identified and institutional mechanisms created to deal with the conflicts that arise; iii) creation of a legal framework recognising the right to development for the victims of violence and underdevelopment; iv) setting up of an independent, international monitoring system to facilitate international operations in conflict situations and to ensure that the rights of conflict-affected communities are protected; v) giving voice to conflict-affected communities in determining the course of international action to prevent, mitigate and resolve structural and political violence; and vi) creation of an international framework to protect the right to development (Macrae & Zwi, 1994; Sengupta, 2001)

Timid and limited policy responses to conflicts cannot keep the HIV rates at low levels, considering that HIV prevalence, in India, for example, has risen by ten fold during the last decade from 0.4 million in 1991 to 4 million in 2000 (Habayeb, 2002) and that the problem can be aggravated by increasing conflicts. A shift from a health-based approach to a broad-based strategy and inclusion of HIV/AIDS in national development agendas is called for. A multi-sectoral framework should be adopted to channel development assistance to address the risk factors and promote effective control policies.

Drug use, aggravated by conflict, has become one of the major accelerants of the HIV epidemic in the Asian region. Enormous changes in drug production and use, massive rise in amphetamine type substances spreading throughout the Asian region, new populations, especially the young, becoming involved with illicit drug use and injection, continuing explosive epidemics of HIV among IDU in different areas of Southeast Asia and South Asia and rising numbers of people with the infection as a result of sharing contaminated injecting equipment are part of the emerging scene. The opium industry of Southeast Asia’s Golden Triangle-with Myanmar as its epicentre- continues unabated; many countries in the region are criss-crossed by trafficking and transiting routes linking drug production zones to lucrative global markets; and populations of drug users develop rapidly along trafficking routes, creating new drug markets and HIV threat in host countries. Injecting as a route of administration is recognised in all the countries and its popularity is increasing; sharing of equipment is common and the methods of cleaning

are often inadequate to prevent the transmission of blood borne viruses; and professional injectors operate in Pakistan, India, Bangladesh and Nepal (AHRN, 2001; Fact Sheet I). Myanmar, Nepal, India and Iran are among countries with high prevalence of HIV infection. In Iran, 75 percent of HIV infections can be traced to injecting drugs.

Increasing number of Asian women are using drugs; female IDU are increasingly involved in commercial sex work in Nepal, India, Bangladesh, Sri Lanka and Pakistan; throughout the region, the age of initiation into drug use is declining; there are insufficient treatment and rehabilitation centres in most countries to cater to drug users; and treatment recidivism rates commonly range from 70 to 90 percent of cases.

RECOMMENDATIONS

A number of case studies on the impact of conflict on HIV/AIDS in individual countries of the region need to be taken up to examine their policy implications.

Governments in most conflict-affected countries are not responding adequately to the threat of HIV/AIDS, for want of commitment and capacity building. They are also underestimating the threat of HIV/AIDS in conflict-affected areas. UNGASS Declaration of Commitment (June 2001) recognised that populations destabilised by armed conflict are at increased risk of exposure to HIV. UN Secretary General has called for a total contribution of $ 7-10 billion per year. Only $ 1.8 billion has been pledged by May 2002. International financing to fight HIV/AIDS is absent from countries affected by conflict. The emphasis on HIV/AIDS as a 'security' threat is mainly related to the threat it poses to military forces. Attention must be paid to the threat 'human security', especially that of women and children that arises from HIV/AIDS. Guidelines on HIV/AIDS interventions in conflict situations (UNAIDS et al, 1996) must be pro-actively implemented. Coordination among humanitarian agencies needs to be built up. The ideal of integrated, multi-agency initiatives at country level is yet to be realised (Save the Children, 2002).

In the light of recent findings (Csete, 2002; HRW, 2002), steps must be taken to develop and implement a formal plan for a budgeted programme of monitoring of and regular public reporting on violence and abuse against marginalized groups at high risk of HIV/AIDS. National AIDS Control Organisations in the region, state level AIDS control organisations funded by national agencies, central and state government

ministries of Home, Public Security, Police, NGOs and others should be involved in these exercises. Police officers at all levels should be trained on the fundamentals of HIV transmission and care for persons with AIDS and sensitised to the importance of HIV/AIDS prevention among high risk groups.

Steps must be taken to promote a rights based approach to the AIDS crisis in the light of the provisions of the International Covenant on Economic, Social and Cultural Rights. Article 12 of the Covenant in particular which provides that everyone should enjoy the right to 'the highest attainable standard of physical and mental health'. This is quite apart from the duty to respect civil and political rights, which are also similarly covenanted by the UN.

Inter-sectoral training programmes must be organised to broaden the knowledge, understanding and skills of drugs and AIDS workers, opinion leaders, various ministry personnel and public sector workers, researchers, NGOs and others. The quality of training for direct service providers in the field should be enhanced. A strategic approach to training, identifying who needs what training and for what specific purpose, including training of trainers should be adopted.

Security forces deployed in conflict-affected regions, in some situations, can be utilised to adopt humanitarian interventions to deal with serious outbreaks of illnesses such as HIV/AIDS when the official medical agencies posted there are unable to intervene for security reasons. In some conflict-affected areas in India, for example, the medical personnel on the rolls of the Border Security Force have successfully visited sensitive conflict zones and provided emergency assistance to villagers afflicted by an epidemic of encephalitis. The villagers are known to have welcomed and cooperated with such humanitarian interventions. The possibility of undertaking such exercises on a sustained basis should be examined. This would go some way in addressing the issue of improving security forces-civil society relations in conflict-affected areas.

Education and advocacy should be taken up on a much larger scale to influence the authorities dealing with drug control and drug demand reduction. They should be involved as partners in the prevention of HIV incidence among IDU on the basis of the memorandum of understanding between UNAIDS and the United Nations Drug

Control Program (UNDCP). NGOs should be assisted to empower communities to advocate and to influence the national policy and the practices of public security and police officials (AHRN, 2001).

Working relationships with segments of bureaucracy such as the police and public security must be built up to gain influence over IDU lives. Police behaviour towards the IDU is one of the strongest determinants of whether they will be vulnerable to the transmission of HIV. Working with police increases their awareness of the impact of their practices, and provides them with a larger range of options for what they often see as a no-win situation (HRW, 2002; Csete, 2002). An issue highlighted in recent studies (UNAIDS, 2001; HRW, 2002; Csete, 2002) is that of the continued practice of discrimination, denial and stigmatisation in relation to HIV/AIDS in different social and administrative contexts in the South Asian region. Conflict in South Asia, thus must be viewed as a much more comprehensive phenomenon than it has been possible for us to do in this report. It deserves much greater attention from the development and other angles than has been given to it by official agencies.

HIV/AIDS is a significant threat to soldiers and their partners. Conflict frequently leads to increases in HIV transmission rates and sensitivities around the deployment of peacekeeping forces can obscure the realities of transmission. Open dialogue and debate among the armed forces, civil society and governments on the relationship between armed conflict and HIV/AIDS is a prerequisite for prevention and care programming (Foreman, et al, 2002).

In South Asia, colonial bureaucratic legacies, resource limitations and other institutional hindrances prevent the development of optimum strategies for organisational change to address conflict and HIV/AIDS-related challenges. Pilot projects and experimental studies need to be undertaken to bring about policy changes and program development. The theory and methods developed in the discipline of organisation research can help change organisational design, structure and functioning. South Asian initiatives must be promoted to achieve organisational change and to develop a credible model for large-scale programs and for systematic change through consensus building, operations research and research utilization

activities. A general paradigm for institutional change is necessary (Phillips, et al, 2002).

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ANNEX 1: FACT SHEETS

FACT SHEET No. 1

Drug use and HIV Infections in South Asia

(1) Country	(2) Population (in millions)	(3) HDI Rank (1999)	(4) Access to health services (%of population) (1981-92)	(5) Female Adult Literacy rate (%) (1997)	(6) a) Number of drug users b)(IDUs)	(7) Number of HIV infections
Afghanistan	23	--	--	--	--	10
Bangladesh	129	150	26	27.4	a) 100,000-1.7 million b) 20 to 25,000	13,000
Bhutan	2.1	145	20	30.3	--	<100
India	1014	132	25	39.4	a) 5 million+ b)100,000+ in 5 cities	4 million+
Iran	68.6	95	27	65.8	a) 1.8 to 3.3 million b) 200 to 300,000	74.8 % of IDUs
Maldives	0.3	93	58	97	--	<100
Nepal	24	144	90	20.7	a) 40 to 50,000 b) 20,000	58,000
Pakistan	138	138	15	32.6	a) 4 to 4.8 million b) 180,000	78,000
Sri Lanka	19	90	10	87.6	a) 240 to 300,000 b) 30,000	4,800

Sources: 1) Columns 1-4 from NHDR ,GOI, 2001 and MHDC, 2001 (OUP, 2002);
2) For columns 5 & 6, Reid and Costigan , (1992), UNAIDS (1992)

FACT SHEET No 2

HIV/AIDS AND SECURITY
AIDS today is a threat to security

In regions where HIV/AIDS has reached epidemic proportions, it destroys the very fabric of what constitutes a state: individuals, families, communities, economic and socio-political institutions, and the military and police forces which guarantee the protection of state institutions.

AIDS and global insecurity coexist in a vicious cycle. Civil and international conflict help spread HIV as populations are destabilized and armies move across new territories. AIDS contributes to national and international insecurity, from the instability of societies whose future has been thrown into doubt to the high levels of HIV infection experienced among military and peacekeeping personnel. HIV/AIDS is cause and effect, initiator and beneficiary, of instability and conflict.

> "The HIV.AIDS pandemic is exacerbated by conditions of violence and instability, which increase the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care ... if unchecked, the HIV/AIDS pandemic may pose a risk to stability and security."
> *UN Security Council Resolution 1308 (17 July 2000)*

As the millennium unfolds, the impact of AIDS on international, national and community security has become significant, with many more people dying of AIDS than as a result of war or conflict. The AIDS epidemic is claiming not only human lives, but destroying structures of governance that ensure human security.

> **The 1994 UNDP Human Development Report** introduces a new concept of human security, which equates security with people rather than territories, with development rather than weapons. it examines both the national and the global concerns of human security.

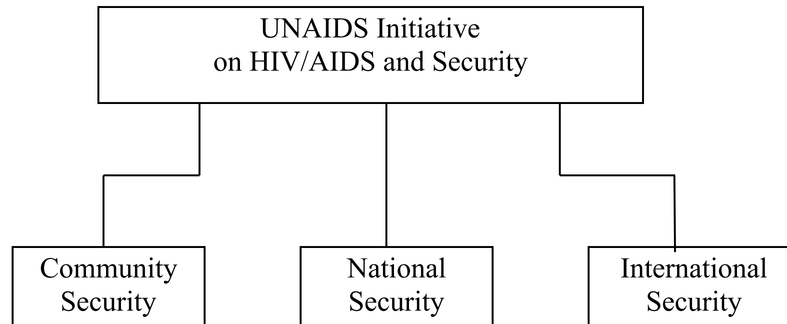
" There is a world of difference between the root causes of terrorism and the impact of AIDS on security. But at some deep level, we should be reminded that in many parts of the world, AIDS has caused a normal way of life to be called into question. As a global issue, therefore, we must pay attention to AIDS as a threat to human security, and redouble our efforts against the epidemic and its impact."

Peter Piot, UNAIDS Executive Director

Recognizing the security implications of HIV/AIDS, the UN Security Council made history in January 2000 when for the first time it debated a health issue. By subsequently adopting Resolution 1308 (2000), it highlighted the potential threat the epidemic poses for international security, particularly in conflict and peacekeeping settings.

UNAIDS INITIATIVE ON HIV/AIDS AND SECURITY

In follow up to the declaration of commitment on HIV/AIDS adopted during the UN General Assembly Special Session on HIV/AIDS (27June 2001) and the UN Security Council Resolution 1308 (17 June 2000), the UNAIDS Secretariat has established a global Initiative on HIV/AIDS and Security with the aim of strengthening partnerships with relevant Cosponsors and partners in response to HIV/AIDS as a security issue, particularly in countries affected by conflict.



UNAIDS Humanitarian Unit, February 2002

In response to this growing concern, the UNAIDS Secretariat established the UNAIDS Initiative on HIV/AIDS and Security, a global strategy focusing on the following key areas as outlined in the Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly Special Session on 27 June 2001:

(1) National security including Defense and civil Defense personnel;
(2) Community security including vulnerable populations affected by conflict;
(3) International security including peacekeeping operations.

Through strong leadership and key partnerships, the UNAIDS initiative or HIV/AIDS and Security and stability by strengthening capacity building and encouraging cooperation among developing countries.

International Crisis Group (ICG): HIV/AIDS as a Security issue

HIV/AIDS must be viewed as security crisis with the potential to affect peoples, states and the international community in a similar fashion to more traditional forms of conflict. This is the massage of a special ICG report, HIV/AIDS as a Security Issue, published in advance of the UN General Assembly Special Session on AIDS on 25th June 2001.

Source: UNAIDS Humanitarian Unit, July 2002.

FACTSHEET No. 3

HIV/AIDS AND CONFLICT
Conflicts and disasters contribute to the spread of HIV/AIDS

During war and conflict, civilians are often subjected to mass displacement, human rights abuses, including sexual violence, and are left in conditions of poverty that might force them to use commercial sex to survive.
The Declaration of Commitment on HIV/AIDS, adopted by the UN General Assembly Special Session on HIV/AIDS on 27 June 2001 "Calls on all United Nations agencies, regional and international organizations, as well as non-governmental organization involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmers and provide HIV/AIDS awareness and training to their personnel"
"By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular, women and children are at increased risk of exposure to HIV infection; and, where appropriate, factor, HIV/AIDS components into international assistance programmes."

UN General Assembly Special Session on HIV/AIDS, Declaration of Commitment on HIV/AIDS, 27 June 2001.

In response to the Declaration of Commitment on HIV/AIDS, the UNAIDS Initiative on HIV/AIDS and Security addresses HIV/AIDS among vulnerable populations affected by conflict, notably refugees, women and children.

Refugees and HIV/AIDS
Displacement is associated with interruption of social cohesion and relationships, promiscuity, inadequate shelter and commercial sex. There is growing evidence from war zones in Rwanda, Bosnia and Sierra Leone that war and forced migration are linked to the spread of HIV/AIDS. the impact of displacement and increased risk to HIV is particularly acute on women and children, who constitute 75 percent of the world's refugees.
The UN system provides active support to address HIV-related issues in emergency situations. In collaboration with UNAIDS, UNHCR has developed a Strategic Plan on HIV/AIDS for Refugees for 2002-2004 which is now operational in refugee camps in Kenya, Tanzania and Uganda as well in the context of the Mano River Union Initiative on HIV/AIDS, including Sierra Leone, Liberia and Guinea.

HIV/AIDS among Women and Girls Affected by War
In circumstances of war and conflict, the vulnerability of women and young girls particularly rises as economic and social structures are weakened and violence, including

sexual abuse, increase. This was recognized by UN Security Council Resolution 1325, adopted in October 2000, which addresses the impact of armed conflict on women and girls, including the impact of HIV/AIDS in this context. In response to this growing concern, the Cooperation Framework signed between UNAIDS and UNIFEM (UN Development Fund for Women) in May 2001 includes a specific provision on AIDS awareness and gender sensitive training during humanitarian and peacekeeping operation.

> In Kigali, capital of Rwanda, the HIV prevalence among pregnant women form rural areas was 24 percent in 1995, as a result of rape and displacement during the 1994 genocide.

As a part of its programme on women and war, UNIFEM, with the support of UNAIDS, has established the position of an HIV/AIDS gender advisor in Sierra Leone to address the specific needs and reduce the vulnerability of women and girls, including refugees and sex workers, affected by HIV/AIDS and the long standing conflict in the region. This project is currently being envisaged in other areas affected by conflict.

Children Affected by Conflict and HIV/AIDS

Of the 17 countries which each have over 100,000 children orphaned by AIDS, 13 are in conflict or on the brink of emergency and 13 are heavily indebted poor countries. In addition, the spread of HIV infection during conflict is accelerated by the involvement of young people with military forces, who are themselves typically young and sexually active.

UNAIDS, UNICEF and Save The Children UK are conducting a study in the African great Lakes region to improve HIV/AIDS interventions among children and adolescents affected by conflict and post-conflict situations. this analysis will be followed up by programmes to build staff capacity in countries affected by conflict and HIV/AIDS.

The UN Secretary General's 2002 report to the UN Economic and Social Council (ECOSOC) on Humanitarian coordination includes for the first time a specific reference to the importance of addressing HIV/AIDS in humanitarian contexts.

The Inter-Agency Standing Committee (IASC) reference Group on HIV/AIDS in emergencies was reactivated in March 2002 with the task of : (1) Finalizing the revision of the UNAIDS/UNHCR/WHO Guidelines for a HIV Interventions in Emergency Settings; (2) Finalizing a minimum package for HIV/AIDS intervention in conflict and post conflict phases; (3) Strengthening coordination at field level; (4) Linking with other non-UN agencies; and (5) Mainstreaming HIV/AIDS into the OCHA Consolidated Appeals (CAP).

> Following a UNAIDS survey undertaken in 2001 as a follow-up to the Declaration of Commitment on HIV/AIDS, it was found that some countries (including 17 of those responding to the UNAIDS survey) have integrated strategies for responding to HIV/AIDS in emergency situations into their national AIDS plans. Among countries responding to the survey, Asian countries are most likely to have incorporated such strategies into national planning.

Source: UNAIDS Humanitarian Unit, July 2002.

ANNEX 2: TABLES

Table I: Selected Conflict-affected States in India: Incidents of Violence, 1997- 2001

States	1997	1998	1999	2000	2001
Arunachal Pradesh	10	2	45	74	46
Assam	427	735	451	536	458
Manipur	425	255	281	245	265
Meghalaya	14	16	52	73	70
Mizoram	1	--	4	14	01
Nagaland	380	202	294	195	128
Tripura	303	586	616	826	370
Jammu and Kashmir	3420	2932	3071	3074	4522

Source: Annual report 2001-2002, Ministry of Home Affairs, GOI

Table II: Selected Conflict-affected States in India: Strength of Police Forces (2001-2002)

States	Police Stations	Area (sq kms)	Population (millions)	Total police forces deployed
Arunachal Pradesh	66	83743	1.09	13800
Assam	240	78438	26.6	112846
Manipur	57	22327	2.4	30968
Meghalaya	26	22429	2.3	19162
Mizoram	31	21081	0.9	15600
Nagaland	45	16579	2.0	34774
Tripura	44	10486	3.2	28764
J & K	--	--	--	--

Source: Annual report 2001-2002, Ministry of Home Affairs, GOI

Table III: Selected Conflict-Affected States in India: Offences against Women (Indian Penal Code), 1991 & 1998

States	Rape		Molestation		Kidnapping & abduction		Eve Teasing		Dowry Deaths		Cruelty by Relatives	
	1991	1998	1991	1998	1991	1998	1991	1998	1991	1998	1991	1998
Arunachal Pradesh	32	32	33	46	30	38	1	1	0	0	0	8
Assam	427	744	190	648	819	1117	10	12	14	32	199	739
Manipur	13	13	47	13	81	60	1	0	0	0	0	0
Meghalaya	27	42	17	12	5	16	0	0	0	1	0	0
Mizoram	44	84	45	53	1	4	0	0	0	0	0	0
Nagaland	1	13	1	4	1	14	0	0	0	0	0	0
Tripura	57	73	82	73	68	39	4	0	7	10	41	115
Total	**601**	**1001**	**415**	**849**	**1005**	**1288**	**16**	**13**	**21**	**43**	**240**	**862**
Jammu & Kashmir	**124**	**178**	**282**	**516**	**415**	**629**	**143**	**361**	**9**	**9**	**3**	**18**
India	**9793**	**15031**	**20611**	**31051**	**12300**	**16381**	**10283**	**8122**	**5077**	**6917**	**15949**	**41317**

Source: NHDR, 2001, GOI

Table IV: Selected Conflict-Affected States in India: Offences against Women and Children (Special and Local Laws), 1998 (per million population)

States	Total (SLL)	Against Women	Against Children	Against SC's	Against ST's
Arunachal Pradesh	52.0	111.0	8.9	0.0	0.0
Assam	137.0	132.0	8.7	0.0	0.0
Manipur	269.0	36.0	2.9	0.0	0.0
Meghalaya	75.0	31.0	4.8	0.0	0.0
Mizoram	1427.0	156.0	54.4	0.0	0.0
Nagaland	369.0	20.0	2.5	0.0	0.0
Tripura	961.0	89.0	4.5	0.0	0.0
Jammu & Kashmir	**406.0**	**180.0**	**2.5**	**1.8**	**0.0**
India	**4534**	**135.0**	**6.0**	**26.4**	**4.4**

Source: NHDR, 2001, GOI

Table V: Selected Conflict-affected States in India: Some Human Development/ HIV Indicators (‘000)

(1) States	(2) Population (1999-2000) & (annual growth rate (1994-2000)	(3) Education (15+) Un-employment rate (%) as a current weekly status (1999-2000)		(4) Poverty population (%)	(5) Female Literacy Rate (2001)	(6) HIV prevalence (median)	
		Rural	Urban				
Arunachal Pradesh	1059(2.31)	2.2	3.7	33.47	44.24	STD ANC	0.10 0.00
Assam	26104(1.74)	18.2	14.8	36.09	56.03	STD ANC	0.61 0.00
Manipur	2315(2.65)	7.3	10.8	28.54	59.70	IDU STD ANC	64.34 11.60 0.75
Meghalaya	2237(2.66)	3.9	6.8	33.87	60.41	IVDU STD ANC	1.14 0.00 0.00
Mizoram	864(2.60)	4.3	5.0	19.47	86.13	STD ANC IDU	2.00 0.37 9.61
Nagaland	1877(5.1)	7.0	14.3	32.67	61.92	IVDU STD ANC	7.03 6.90 1.35
Tripura	3137(1.47)	4.2	8.2	34.44	65.41	STD ANC	1.34 -
Jammu & Kashmir	--	--	--	3.48	67.08	STD ANC	0.40 0.12
India	**1003971(1.95)**	**8.4**	**8.2**	**26.1**	**54.03**	**--**	**--**

Sources:

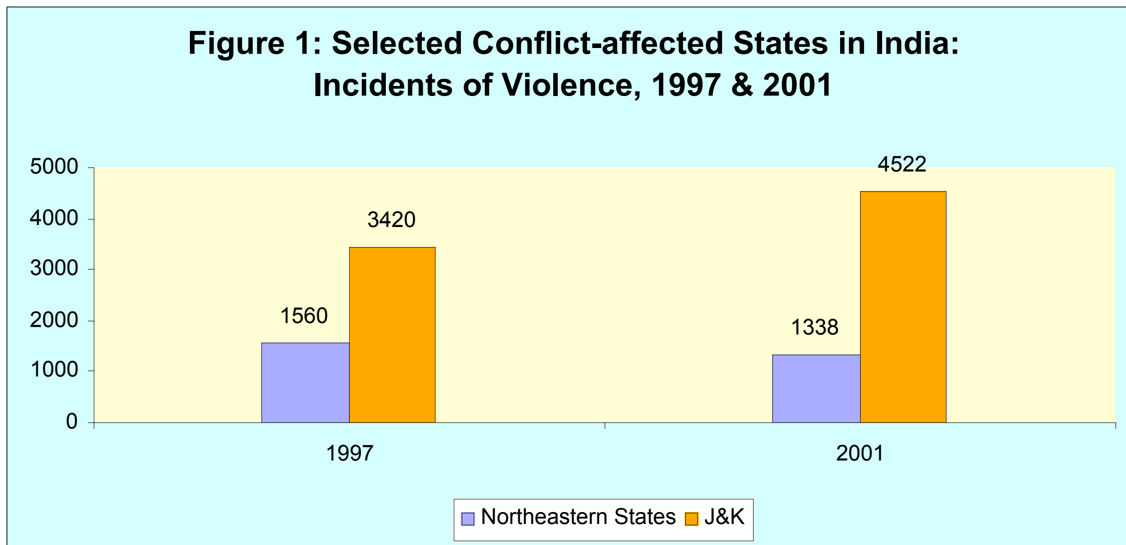
Columns 2 & 3; NSSO, 55th Round
Columns 4 & 5; NHDR, 2001, GOI
Column 6 ; “Combating HIV/AIDS in India 2000-2001”, NACO, GOI

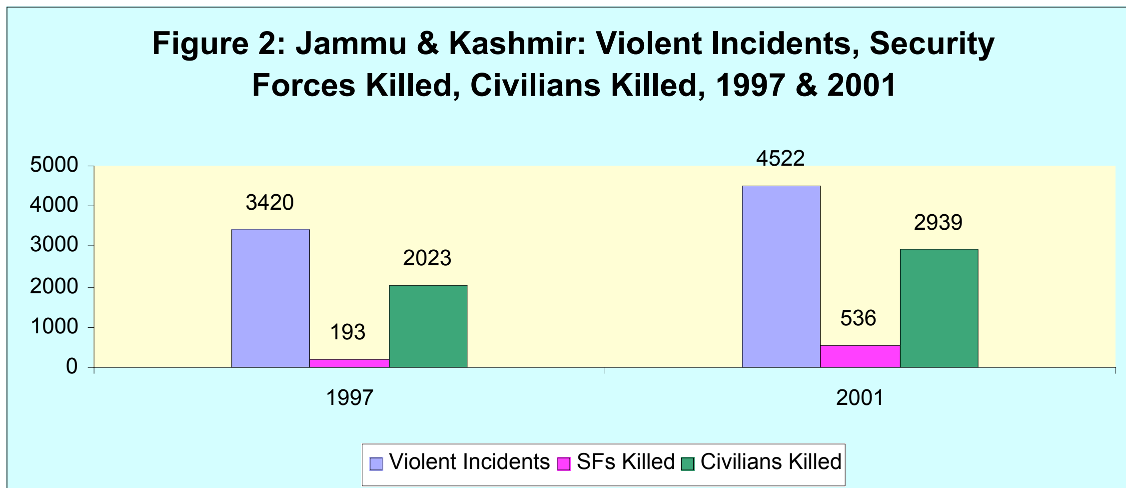
Table VI: Burden of military expenditure in South Asia

Indicators/ Countries	As a % of GDP			As a % of central government expenditure			As a % of education and Health spending		
	1985	1994	1997	1980	1994	1997	1985	1991	1997
Bangladesh	1.3	1.5	1.8	9.4	17.4	17.2	n/a	41.0	80.4
Bhutan	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
India	2.6	2.6	3.6	3.1	14.1	12.8	15.2	68.0	65.0
Maldives	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nepal	0.8	1.1	0.9	6.7	5.9	4.9	67.0	35.0	25.0
Pakistan	5.2	7.0	5.3	30.6	26.9	27.8	393.0	125.0	148.7
Sri Lanka	2.7	4.7	5.1	1.6	16.8	19.6	17.0	107.0	107.5
South Asia	2.4	3.4	3.2	15.1	14.7	16.7	113.0	72.0	74.0

Source: MHDC, 1999 (OUP, 2000)

ANNEX 3: FIGURES





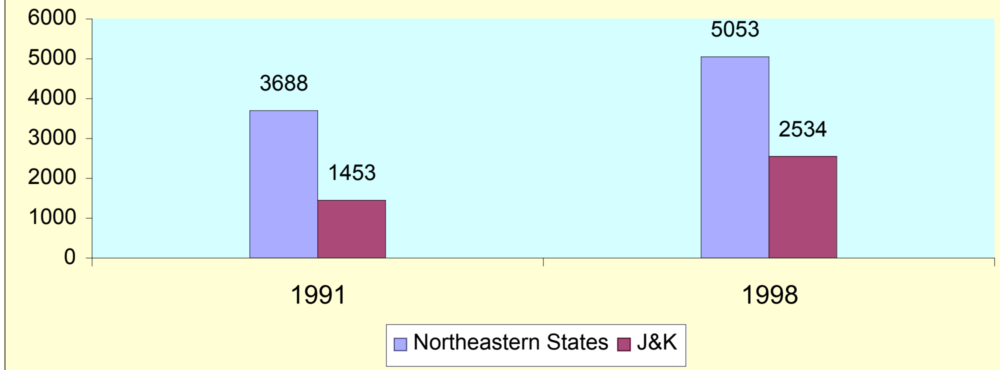


Figure 3: Selected conflict-affected states in India:
IPC offences against women in
(1991 & 1998)
6000
5000
4000
3000
2000
1000
0
3688
1453
5053
2534
1991
1998
Northeastern States
J&K

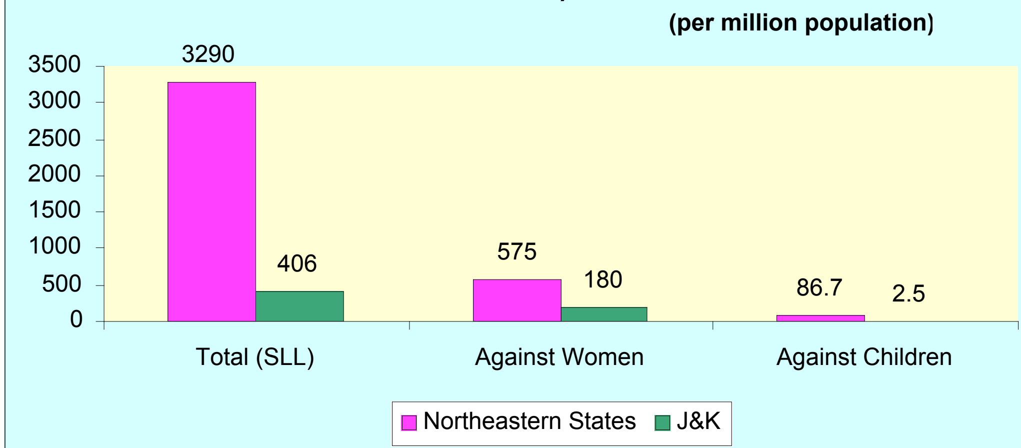


Figure 4: Selected Conflict-Affected States in India:
Offences against Women and Children (Special and
Local Laws), 1998
(per million population)
3500
3000
2500
2000
1500
1000
500
0
3290
406
575
180
86.7
2.5
Total (SLL)
Against Women
Against Children
Northeastern States
J&K