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HIV/AIDS, DEMOCRACY AND GOVERNANCE IN AFRICA: A SPECIAL EDITION ON POLICING

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Recent News

1) Donors meeting under the G8 Chair of Germany pledged $9.7bn over three years to the Global Fund for AIDS, Tuberculosis and Malaria in Berlin in September 2007. This represents, for the period 2008-2010 the largest single financing for a health initiative (on the basis that PEPFAR and large private funds such as the Bill and Melinda Gates Foundation provide for much longer funding periods without committing disbursements up-front.) This is part of a major effort to move to annual commitments of up to $8bn by 2010. The conference represents a personal success for former UN Secretary-General Kofi Annan, who chaired the process, Angela Merkel's German Government, and the new Executive-Director of the Global Fund Dr Michel Kazatchkine, former French AIDS Ambassador, who took over from Professor Sir Richard Feacham who retired in April 2007. On a more political level, it represents something of a return to form for the Global Fund, who suspended disbursements in 2005 to review the progress of commitments already made, as well as suspending and then having to review the payment and disbursal of $367m to Uganda in the same year.

2) On September 5, 2007, Gordon Brown, the UK Prime Minister, launched an International Health Partnership. The partnership (of rich countries, poor countries, donor agencies and NGOs) is focused on the health related Millennium Development Goals (one, four, five and six) by supporting co-ordination, planning and accountability within health systems. The headline commitment here (rather than just pledging to do something about the health of poor people) is the measurable goal of raising all nations to the recommended minimum WHO guideline of $34 per person per year. Countries first in line for the increased spending include Burundi, Mozambique, Zambia and Ethiopia. All engaged in the initiative agree that the major tests are of governance and systems, rather than specific health indicators. Its success will be followed closely. Activists couldn't help but notice that the launch in London of an eye-catching new initiative coincided with the quietly announced 50% reduction in the direct support of the British Government to the Global Fund 2008-2010.

3) On August 8, 2007, Nozizwe Madlala-Routledge, Deputy Minister for Health in South Africa, was sacked for criticising the conditions in an East London hospital, but it was generally understood that the action was taken for her travelling to- but not attending- an AIDS vaccines seminar organised by the International AIDS Vaccines Initiative in Madrid on June 13 2007. Immediate condemnation of the action was made by amongst others Treatment Action Campaign and The AIDS Law Project. Compounding the matter was the demand by the Government that Ms. Madlala-Routledge reimburse the state for the rent

for her ministerial home back-dated from 2001. This is seen to be the culmination of a political resurgence by Madlala-Routledge's former boss, Health Minister Manto Tshabalala-Msimang, who took medical leave for much of 2006, and who has been dubbed 'Dr. Beetroot' for her views on how to treat HIV infection. The two Ministers are known to have had diverging views on HIV/AIDS and public health for some years; and HIV is certainly not the only political difference between them, and between Madlala-Routledge and the ANC high-command. Now, the Treatment Action Campaign, The AIDS Law Project and other groups have pledged to establish a fighting fund to pay Madlala-Routledge's legal fees in defending herself against the Government's suit. Critics say that this is another example of a deeply-entrenching South African Government keen to pick a fight with the HIV/AIDS lobby, and be seen to win.

4) There is rumour and counter-rumour in and beyond South Africa regarding President Mbeki's position, and that of his Government, on HIV/AIDS. A brief catch-up is that Mbeki accepts that HIV is a sexually transmitted infection, and that AIDS is a real, debilitating illness, but that it is not established that HIV is only transmitted by contaminated bodily-fluid transfer, and that what is labelled as AIDS is often a misdiagnosis of other diseases. Importantly, Mbeki has equivocated on whether anti-retroviral therapy is an important enough intervention to expand universal free access. As pointed out in the GAIN Brief previously, the official (and often not so official) South African position on HIV/AIDS increasingly mirrors the intellectual desperation of the intelligent design movement, or the global warming sceptics: 'teach the debate'. The intellectual dishonesty exists in the tactic of insisting that a 'controversy' exists, thus according the same legitimacy to paranoid speculation as peer-reviewed medicine. Having lost the scientific debate, such arguments switch to the duplicitous tactic of claiming that lack of absolute evidence on the pathogenesis of HIV into AIDS reinforces opposite claims.

5) Contrary to the popular opinion that the South African Government takes the stand it does on HIV because of denial or ignorance, the mundane reality is that these policies are the result of political paranoia. The growth of the HIV epidemic is the second biggest news story in South Africa of the last twenty years, and the ANC knows that whatever their successes- and they have been many- the failure to prevent a 25% adult infection rate is an indictment of their time in power. Particularly so as those most affected by HIV/AIDS are the ANC's core vote: the poor, the rural, and above all, blacks. Spilt wine cannot be put back into battles, and the ANC is very sensitive to accusations that it has failed its own. Denial would be a hard enough battle to fight against in confronting a government. South Africans however have to live with a government that does all it can not to acknowledge the problem at all.

6) Global vaccine development was set back in September 2007, with the news of the failure of the phase two Merck V520 trial, which was seen as one of the brightest hopes among several global HIV Vaccine Initiatives, and was supported by the HIV Vaccine Trials Network and the US National Institutes of Health. The trial was based on genetically engineering an adenovirus, one of the causes of the common cold, as a virus 'template', similar to HIV, that would target those cells (CD8) related to immune-response that are targeted by HIV (CD4+), but instead of 'turning-off' their immune-response function, the adenovirus' genes would alter the CD8 cell to target and destroy HIV-infected CD4+ cells. First-stage trials in North and South America and Australia ran from 2004 to March 2007, but the second-stage trials were held in South Africa, and it is these that have failed. While a set-back, adenovirus mediated gene-therapy is still seen as a major hope for a breakthrough in HIV vaccine research.

7) The Health Economics and HIV/AIDS Research Division (HEARD) based at the University of KwaZulu-Natal in South Africa and the International Development Research Centre (IDRC) based in Canada have launched a scheme inviting letters of interest from teams from low and middle-income nations on research on the themes of economic growth and globalisation. Grants of up to C$100,000 for one and two year projects will be solicited before November 1, 2007, and the competition will consist of successful letters of intent being followed up by invitations to submit full submissions to successful candidates.

International Expert Meeting on HIV and the Police

8) Under the auspices of the international AIDS, Security and Conflict Initiative (ASCI), the Netherlands Institute of International Relations 'Clingendael' with UNAIDS and UNODC, convened an international expert seminar September 3 and 4, 2007, on the subject of HIV/AIDS and policing. Believed to be the first meeting of its kind, the seminar brought together professionals from police forces, justice, crime prevention and drug agencies, UN bodies and academia in order to discuss the specific issues relevant to police services by HIV/AIDS, and the role of police forces in nations of high HIV-prevalence.

9) The expert meeting heard evidence from the Pacific Islands, Nepal, South Africa, Sierra Leone, Botswana, Thailand and Kenya, among others. The meeting was held in response to specific concern in the ASCI process that police services were being left out of HIV and security analyses, or that when addressed by such work, were grouped demographically or socially into the same categories as military forces. Complicating the work even further is the focus in such analyses on policing services within international peacekeeping missions- because police services need to be separated from military personnel, and because international peacekeeping is often the first place that analyses of HIV and security is applied- and this only increases the temptation to assume that police and military personnel are similar enough not to be separated as discrete cohorts for analysis.

10) What are these specific issues? They can be grouped into a number of categories. First, data and its collection, which can be difficult within police services for social and professional reasons. In addition to this is a temptation in AIDS literature to take the more extensive evidence base on militaries, generalise this evidence for the entire security sector, and apply this uncritically to police services, which may vary wildly in terms of demographic, social and risk-exposure factors. Secondly, the different impact of concentrated (<5% in general population) and generalised (>5% in general population) epidemics on the functioning of police services. Specifically, a concentrated or low-level epidemic means that specific high-risk groups such as transactional sex-workers and intravenous-drug users will make up a significant proportion of the HIV-prevalent. A generalised epidemic means that such groups (even if absolutely high) are likely to be a minority of HIV-prevalent. This of course alters the policing dynamic, with the issue in a concentrated epidemic of those most vulnerable to HIV being among the 'high contact' groups for the police, and in a generalised epidemic the police themselves being the vulnerable group- in terms of maintaining force strength and basic operational readiness. Thirdly, the impacts of HIV on individual police officers, and police responses to HIV. This includes both police officers, support staff and families living with HIV, and promoting a policing strategy that accounts for the needs of a workforce with HIV-positive members, and includes issues of stigma and discrimination both within a police service and in its relationship to the community. Fourthly, police responses to HIV in the community, especially in terms of harm reduction. This will include interactions with high-risk groups such as transactional sex-workers and intravenous-drug users who are often wary of police action, criminalised or marginalised by the police, and who engage in practices that are illegal or display by choice behaviours that are beyond police sanction or protection. Fifthly, gender and sexual-based violence and exploitation, which again will bring individuals into greater contact with police, both as performers and receivers of such acts, as well as increasing risk-exposure to HIV. Sixthly, civilian police within international peacekeeping missions, who may be trained and deployed as police, but may be quartered and vulnerable to risk-exposure as soldiers to HIV. This is especially relevant with the security focus, following SC1308, deeming HIV as a principal security risk to peacekeepers and peacekeeping mandates. Finally, the specific issue of policies and programmes for HIV-positive officers and associated personnel need to be examined and thought-through.

11) Why is a focus on the police important at this time? There are several reasons for this. First of all, police are first responders. This role puts police officers at potentially greater risk of HIV-exposure due to the greater opportunities to come into contact with populations at risk of HIV, and the potential dangers of contaminated fluid contact, particularly needle-stick injuries. However, these risks are most probably offset by training in risk management, and very simple protective regimes such as including surgical gloves in basic first-aid equipment. Even still, the risks of contact with high-risk communities, greater exposure to personal violence, and the specific risks of needle-stick injuries, create a case for attention.

12) Secondly, police are a crucial demographic cohort. New recruits are likely to be of greatest age-risk of HIV exposure (15-39), and long periods of service enabled by a clear career and ranking structure that encourages the best officers to stay in service and become senior officers, mean that the senior officer cohort- whose use is predicated on their length of service and experience- are at just the age (30s and 40s) when HIV-infection is likely to produce most morbidity and mortality.

13) Thirdly, police are the public face of the state, the symbolic manifestation of public protection. Within wider debates on HIV/AIDS, good governance and democracy, the police play a crucial role in providing the most visible link between citizen and the state. If long-term effects of HIV/AIDS on political development are to be identified and understood, then the police offer both a good case study of what these may be, as well as a key role in mediating these long-term effects.

14) Fourthly, police are very often talked of as an after-thought of security, and this has been no different in the debates on security and HIV/AIDS. ASCI deliberately made police and other non-uniformed services a principle focus of their investigations- going so far as to devote one of four working-groups to the issue. As the original ASCI research plan stated: “The police, along with other uniformed services, such as paramilitary forces, customs and immigration, coastguard and prison warders, should not be treated simply as poor relations of the military.” This implies an examination not only of the specific effects on police forces, but the effects on the populations they serve too.

15) A principal analytical problem with the police exists in whether orthodox HIV-security analyses should be applied directly to the police (much of the literature, after all, provides caveats by referring to ‘uniformed services’ rather than just ‘militaries’). If ‘uniformed services’ is taken broadly, this will include both militaries and police together as a cohort for analysis. There are valid reasons to do this. If, on the other hand, there is a need to separate military from police personnel, so that these are discrete categories of analysis, researchers need to ensure that military personnel (principally, but not exclusively, soldiers) and police personnel (principally, but not exclusively, police officers), are separated and analysed. There are valid arguments this way too. Methodological debate over the use of military-focused security frameworks risks overshadowing the debate. It is, however, important to note that key differences exist between the police and military-centred security analyses, and that a key overarching issue to resolve is whether researchers take the security analysis, knowing its weaknesses, but also using the advantage it gives of an existing research-base and methodological experience, or whether researchers decide that new, non-military centred analyses are needed, and that these should be built as a first step on research on AIDS and the police.

16) A certain number of questions need to be asked by researchers undertaking studies of HIV/AIDS and policing. First, to what extent are police- as arbiters of conflict, guarantors of public order, and protectors of property and the basic personal liberties necessary for economic growth and development- contributors to societies that have high social resilience to HIV/AIDS and other emerging health threats? Police personnel can act as risk ‘condensers’, that is groups that act as effective transmitters of the virus, or reservoirs of infectivity that follow similar routines and patterns. This is obviously something we seek to discourage. Police can also act as risk ‘mediators’, that is groups that are not only at lower-risk of HIV contraction and transmission, but lead and contribute to the social strengthening of a community’s defence against HIV and AIDS, not just contributing to lower numbers of infections, but also to the resilience of a community to HIV/AIDS’ secondary, social, effects.

17) The second question is if crime deprives a society of the resources needed for development and economic growth, what effects will this have on a society’s resilience to the full effects of HIV/AIDS; and what can the police do about it? Charles Goredema, of the Institute of Security Studies in South Africa, reports that in Angola, scores of trans-national crime syndicates benefited from UNITA-backed trafficking of diamonds and other natural resources to fund their war against the government. Despite the war’s end in 2002, the crime syndicates have maintained, and in some cases strengthened their operations. “The loss of money through these crimes is a serious issue for the region because the money is lost by countries which can least afford to be without those kinds of resources”. Angola has an adult HIV prevalence rate of 3.7%, much lower than some of its neighbours, and this has been attributed by some to its history of conflict actually frustrating the normal sexual networks by which AIDS would spread. Angola is one nation whose development goals are frustrated by crime, a factor often overlooked in prescribing for development, but crime could potentially frustrate AIDS prevention efforts by resource loss, as well as resources that could otherwise be spent on healthcare, education and a myriad of other socially-protective programmes, being re-directed to combating crime. We are only just beginning to ask the questions necessary on HIV/AIDS and crime.

18) Thirdly, and logically following on from this, do we know that HIV/AIDS is a problem for public order? It is understand, loosely, that HIV/AIDS contributes to several social problems. It is also known that social problems, particularly socio-economic problems, contribute to high rates of crime. But this is not the same as saying that HIV/AIDS creates public disorder. At best, we know that a complexly inter-related set of social issues are influenced by rates of HIV infection, morbidity, and AIDS deaths; and that a similarly complexly inter-related set of social issues are influenced by, and influence, crime.

19) Why do these issues need stating, and need stating now? Principally, it is difficult to talk about HIV and policing, and so the sector has been passed over for a number of years. Police services are both visible representives of the authority of the state, and the major internal defence against threats directed

at it. Police services, understandably, are cautious in admitting any weakness or threat to their authority- real or perceived. In addition to this, the methodological necessity of talking about a 'security sector'- so that different groups charged with security are included together with militaries in analysis- means that precision is lost in talking about the various groups included under the security umbrella and, ironically, 'security sector' itself becomes a lazy synonym for 'military.' In addition to this is a feeling that police officers are not a priority for HIV-reduction. Human rights approaches to HIV/AIDS have characterised the early struggle against the epidemic; first as protection of the minority rights of groups particularly affected by HIV/AIDS, but in recent years as establishing a moral case for intervention against HIV/AIDS- particularly from external sources- in nations overwhelmed by, and ill-equipped to deal with the epidemic, because those affected by HIV/AIDS were disproportionately poor, or young, or female, or members of other vulnerable groups. An implicit chauvinism against police services may exist, therefore, as a group low down the priority list, particularly in circumstances where the police have been seen as human rights abusers, rather than human rights defenders.

Justice Africa Research on HIV/AIDS and Policing

20) Justice Africa has been at the forefront of promoting efforts to increase the evidence-base on HIV/AIDS and policing. Having pioneered a model of identifying individual, well-placed, African-based researchers, and contracting them to undertake small-scale, academic-quality, case-study research, Justice Africa has produced new research on HIV/AIDS and policing in South Africa, Sierra Leone and Benin, which will be published in Winter 2008.

21) In South Africa, researcher Themba Masuku of the Centre for the Study of Violence and Reconciliation addressed HIV/AIDS within the South African Police Service (SAPS), specifically posing the question of whether HIV/AIDS' impact on the SAPS represents a threat to the South African state. Masuku has undertaken an extensive evidence-review of data collected in South Africa, generally concluding that police officers face a low risk of contracting HIV solely through their actions as police officers; with any increased exposure to at-risk populations being off-set by risk-management training and awareness. However, this is not the question that interests Masuku. Rather, Masuku asks whether HIV/AIDS- affecting one in every five adult South Africans, and a higher percentage of young adults- will undermine the capacity of the SAPS to deliver order, stability and protection.

22) HIV/AIDS and public order is a sensitive subject in South Africa; where the murder rate is 48/100,000 (this compared to a rate of 1.52/100,000 in England and Wales.) Any suggestion that HIV/AIDS is eroding the capacity of the police service to do its job is understandably politically charged, and a lot of bad evidence has been produced on circumstantial and speculative evidence suggesting that above a certain adult prevalence level (and certainly in Southern Africa where adult infection rates peak at above 20%) institutional capacity to deal with both the human resource loss in national security agencies, and to effectively meet any increased social dislocation caused by such high mortality and its attendant phenomena of declining productivity, economic recidivism, and high health costs, will be dramatically curtailed. Masuku's research shows that this is manifestly not (yet) the case in South Africa, where if these phenomena were to be experienced, they would be felt first.

23) A review of the evidence Masuku presents convinces us of a few things. Firstly, if HIV/AIDS was having adverse impacts on the South African Police, we would expect to see massive and rapid change in the institutional productivity of the police service: that is in the maintenance of law and order. South Africa, as Masuku notes, has crime rates typical of a middle-income nation with large (particularly urban) inequality; and violent crime rates which are amongst the highest in the world. But there is nothing in the larger social and demographic data to suggest that these rates would be lower without the presence of HIV/AIDS. Using examples from across the Southern African region, Masuku notes that in countries such as Malawi and Mozambique, similar resource issues for policing are raised by HIV/AIDS, but it is Zimbabwe with the greatest experience of social chaos- displacement, economic collapse, infrastructural breakdown- and this is primarily due to short-term political disorder, rather than the long-term (albeit high) HIV rate.

24) Secondly, Masuku shows that data can be collected relatively well for police services, and for this the South African Police should be congratulated. One major error, however, is the failure to test new police officers on recruitment. The importance of testing recruits is that being typically young, they will have had less time to be exposed to HIV, and so you will know both how many recruits are joining the force infected, and whether or not this cohort of individuals differ in their behaviour from the general population.

This will tell you both direct risk exposure through the job of police officer, and the indirect risk exposure through the social status and position of being a police officer.

25) Thirdly, the South African police show an infection pattern generally similar to the rest of the South African population. Although through general risk factors the police fatality rate will be higher than for a sample of the population of the same age and demographic profile- because of violent crime, which unfortunately is an issue in South Africa- the general death rate in the SAPS has increased in recent years at the same pace as the general public (now at 0.9% pa)- and this rise is largely attributable to AIDS. Therefore, the specific risks to the police from HIV/AIDS seem not to have changed, but the general risks to the South Africa police (from being members of a society with high rates of HIV/AIDS) have changed. More data is needed here, but a working assumption is that a specialised population cohort, with highly technical skills and lengthy training needs, will experience greater internal stress than the general population would experiencing a similar relative decline in human resources, as the general population will have greater institutional and adaptive capacity than a specialised population with highly technical needs.

26) This research collected data on knowledge of HIV transmission and risk exposure among police officers in a major urban centre in South Africa. A condition of the data collection set by the South African Police Service on Masuku was that all data was to be approved for publication by the Service. Despite permission being sought at all levels up to the office of the South African Minister for Public Safety, none was forthcoming, and The Centre for the Study of Violence and Reconciliation and Justice Africa are unable to publish this data. This is a shame. The data actually provides some temperate and honest appraisal of the situation. Because its objectives and ambition were rigorously and academically focused, the SAPS have missed out on an opportunity to make publicly available evidence that confirms what reasonable voices expected anyway: that HIV rates are no worse within the SAPS personnel sampled than within any other similarly-profiled group, but that you can only take the experience of one sampled group as indicative rather absolute proof. The South African Police Service, rightfully, are worried that inflammatory and biased data would unfairly impugn their officers and undermine public order. But the suppression of data that is largely benign, that will demonstrate that well-presented data and conceived methodologies can allow an honest appraisal of facts, and critical evaluation of performance, only dilutes the pool of information available; and allows the inflammatory to remain mainstream. Masuku's evidence shows that HIV infection in the SAPS, and the effects of such infection, may be no worse that in the general population, in which case it is difficult to put together a case that the police are an urgent priority in the competition for resources. But the point is the evidence shows that infection rates are no better either. It is this banal, mediocre, reality, rather than any egregious moral failure, that is most troublesome about the approach to HIV/AIDS from a democratic South Africa.

27) In Benin, researcher Darcel Gabriel-Nelson undertook a study of paramilitary officers using voluntary questionnaire surveying in April, May and June 2007, in four urban centres and border districts- Cotonou, Porto Novo, Kraké Plage and Hilla-Condji. Two factors make this study interesting. First, it was produced in a nation that is less-known in terms of HIV/AIDS, due to a lower, un-generalised, infection-rate (1.8%; a fall from 4% in 2001), and a relative imbalance in the literature published in English on HIV/AIDS away from West Africa, and in particular Francophone West Africa. Secondly, as in many nations, 'police officers' in Benin are not as definable a category of individuals as they are in other some nations. In Benin, the category of individuals covered by the survey include gendarmerie, national police, customs agents and forestry rangers; and report to a variety of Ministries, including the Ministries of the Interior, Finance and Economy, Environment and Defence. In addition to this, the national police has its own self-contained health service, insurance system, and hospital; a situation which is statistically complicated as it admits the general public able to pay for its services too.

28) The study was self-reporting. This means that the overwhelming proportion of respondents were men; although this is not necessarily unrepresentative of the population structure of the force. The data show an infection rate of 1.25%, roughly 70% of the national average- although it must be stressed that this is based on voluntary disclosure of known status rather than anonymous and aggregated blood-testing. If we take into account any likely misreporting inherent in a study of this size, it doesn't do anything to dispel the notion that HIV/AIDS affects the police in much the same way as it does the general population. What seems interesting here is that national structures and legislation in Benin to prevent HIV/AIDS and protect the rights of those living with HIV are fairly good- Benin is doing fairly well according to 'Three Ones' principles (one country coordinating mechanism, one monitoring system, one national plan), and ARVs are made (in principle) free to all in need- but education on the effects of

HIV/AIDS, and how one is at risk from HIV, seems fairly poor. A quarter of respondents admit to sexually-risky behaviour, only 19% reported that they used condoms during all sexual experiences, and 50% of respondents believing that other factors- such as kissing or sharing cutlery- were responsible for HIV transmission in addition to the three accepted modes (sexual intercourse, needle-stick injury, and mother-to-child transmission.)

29) In addition to this, two particular factors mark Beninese paramilitary officers as at-risk from HIV exposure. First, respondents reported unusually high levels of exposure to bodily fluid exchange, and low levels of training for these contingencies. Particularly, a combination of a lack of basic protection (such as latex glove), and violence directed by and to the police, heighten vulnerability for the police (although other research fails to establish what the statistical risk increase would be for police officers from these two factors; rape and sexual violence apart, the risks would be quite low). Second, corruption appears rife throughout Beninese paramilitary forces, with 47% of officers reporting accepting bribes, and 14% of these admitting to soliciting sexual favours. The self-reporting figures here are interesting, and can only lead to questions as to real levels, given an understandable unwillingness of many to disclose- although as Gabriel-Nelson points out, the respondents were largely from senior ranks.

30) This study is an important first step in the understanding of HIV/AIDS and police services in Benin and West Africa. It has the benefits of a methodology that was tested out with little compromise due to the cooperation and assistance shown by the Beninese police; good access to officers in the Beninese police; surveillance of officers in different environments (urban/rural) and social groups; a high response rate from contacted individuals; and an ability to put questions of a personal nature to respondents. Benin shows that a nation with a low HIV rate, and a general willingness to do those things necessary to keep the rate low, can achieve successes against HIV while being open to external surveillance. However, Benin also shows that levels of HIV awareness may be low, or stagnate, in areas where HIV is low- and this creates potential for the spread of HIV into immuno-naïve populations. Benin also shows that whilst HIV does not need to be a professional risk-factor for police officers, ignorance, human-rights abuse, and sexual-corruption may provide future risk factors for officers.

31) In Sierra Leone, researcher Alison Thompson conducted a survey of post-conflict security-sector reform and HIV control. Sierra Leone is among the nations with the lowest human development; with indicators on maternal health, childhood poverty, primary education and life expectancy, right at the very bottom of international league tables. Since the end of the civil war in 2002, Sierra Leone has undergone a massive programme of reform among all branches of civil government, including the police service, substantially aided by foreign assistance. Thompson's study differs therefore from the Benin and South African studies in surveying a nation that has undertaken, and is undertaking, a root-and-branch over-haul of its security apparatus to institute a force that is plural and representative, at the same time as addressing threats such as HIV/AIDS.

32) HIV/AIDS awareness and protection in the Sierra Leone Police Service has been extensive and well-planned for a number of years, reflective of a donor-driven agenda of reconstruction and development that the Government of Sierra Leone has nurtured and encouraged. The ending of a twelve-year civil war in 2002 has left Sierra Leone with very deep and lasting scars that will take years of engagement to heal. The HIV/AIDS situation in Sierra Leone is a complicated one with complete break-down of surveillance systems during conflict, and the slow re-establishment of such mechanisms since. Proper epidemiological surveying is still inadequate outside of Freetown and some other population centres, with a UNAIDS estimate of 1.6% on a range of 1-4%. Evidence presented both anecdotally and officially, and backed up by Thompson's survey, suggests that while a 1-4% prevalence range does not suggest a generalised epidemic, levels of HIV/AIDS among at-risk groups- particularly transactional sex workers- together with high levels of reported sexual violence and corruption, point to a growing and only partially controlled HIV epidemic in this nation.

33) The police have been identified as a priority group for reform in Sierra Leone in order to promote stability and national reconciliation. This has largely been a successful affair, particularly since the removal of Charles Taylor in neighbouring Liberia in 2005. This has been mirrored by reform in the military too, Thompson reports that direct aid from Britain to Sierra Leone in the last fiscal year was £50m, of which £12m was for support of the security sector- both military and police- and only £15m for direct budget support to the Government of Sierra Leone. In comparison, only £5m has been made available for the courts and the prisons, meaning that a long-term strategy has been put in place that prioritises order above justice in Sierra Leone. This has impacts on policing and HIV/AIDS by reducing

the amount of money available for human rights protection, prison and penal reform, and the targeting of sexual violence (which, by definition, is more private than non-sexual violence.)

34) Thompson describes HIV/AIDS control in Sierra Leone as characterised by 'competing demands'. She makes the point that "[g]iven the extent of the displacement of the population of Sierra Leone throughout the conflict, the high degree of militarisation of society as well as the widespread and systematic use of rape and sexual slavery as a weapon of war by fighting forces on all sides (including the very peacekeepers sent to protect such civilians), the civilian population was exposed to extreme levels of vulnerability with respect to HIV/AIDS throughout the conflict." As Thompson shows, the long-term serological effects of the conflict are unknown, but the actions of the war, and their effect on the people of Sierra Leone, are well documented: including rape and sexual violence used as a weapon of war, and the growth in 'survival sex' as women, particularly displaced women, would engage in informal or formal transactional sex work- something which was aided by the presence in the country of peacekeepers from across Africa.

35) It is this last point that remains significant for those engaged in the control and management of future spread of HIV/AIDS. Thompson notes that risk profiles in both the army and police during the civil war increased significantly; with a typical two to five times greater probability of HIV infection measured across studies relative to the background environment. Critically, a WHO survey of 158 soldiers in 2000 discovered a 42% prevalence rate among this very small pool. It is very important to note that these are limited studies, and the circumstances in Sierra Leone were unique to this country; what Thompson shows is that a range of factors in the 'complex emergencies' that characterise modern warfare and post-conflict reconstruction in Africa, including basic medical infrastructural and surveillance breakdown, high levels of personal violence, particularly sexual-violence, chronic structural poverty, financial corruption and graft, and poor governance of reconstruction efforts, can facilitate the environmental and human conditions necessary for the spread of HIV.

36) Three important and unique factors about HIV/AIDS in Sierra Leone are highlighted in Thompson's study. First, the efforts to control HIV/AIDS in Sierra Leone have improved considerably in recent years; and both in terms of its geographical location in West Africa, and its relatively low official prevalence rate, Sierra Leone seems to be making reasonably good efforts relative to those of its peers. However, we must question the extent to which this is a donor-driven priority- especially given the level of funds made available for the support of the Sierra Leone Police and Army. This is not to suggest that HIV/AIDS is not a priority, and is not taken seriously. Rather, it is necessary to question how far the priorities of the government of Sierra Leone would differ from those of its political critics. Second, Thompson points out that corruption is rife throughout Sierra Leone's police and military, and this affects the effort to fight HIV/AIDS. Both the contribution to sexual corruption, and the misdirection of apportioned funds for HIV/AIDS, mean that whilst attempting to contribute to HIV reduction in Sierra Leone, the security sector also acts as a potential, and largely unmeasured, net contributor to HIV/AIDS too. Thirdly, reducing the security sector's net contributions to HIV/AIDS means that greater funding need to be allocated to HIV programming within the penal and criminal justice sectors. Thompson's findings among prisoners indicate that very low priority is given to this group.

37) The preliminary findings of Thompson, Masuku and Gabriel-Nelson are attached to this briefing. These papers are unpublished draft manuscripts.