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Linking HIV/AIDS, National Security and Conflict

A Colombian Case Study

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Abstract
An estimated 33 million people are today infected with HIV, many living in conflict or post conflict settings. The international community is increasingly recognising the effect HIV/AIDS can have on national security and conflict, both exacerbating conflict and being an obstacle to peace. The article argues for considering HIV/AIDS as a security issue and concludes four main theories on the links between HIV/AIDS, national security and conflict: 1. Uniformed personnel as a vector of HIV, 2. National security threatened by HIV/AIDS affected state institutions, 3. Increased vulnerability to HIV infection in conflict and post-conflict environments, and 4. HIV as an obstacle to peace building. These four theories are explored in the Colombian context. Of the four theories investigated it was found that 1 and 3 presented the strongest linkages between HIV/AIDS, national security and conflict. The theories 2 and 4 were less strong, mainly due to the relatively low HIV prevalence rate in Colombia.

Keywords
HIV/AIDS • Security • Conflict • Colombia

El vínculo entre el VIH/SIDA, la seguridad nacional y el conflicto
Un estudio de caso colombiano

Resumen
Hoy en día se estima que aproximadamente 33 millones de personas están infectadas con el virus VIH y muchas de ellas viven en países en conflicto o en postconflicto. Internacionalmente es cada vez más reconocido el efecto que tiene el VIH/SIDA sobre la seguridad nacional y sobre los conflictos, ya sea agravándolos o convirtiéndose en un obstáculo para los procesos de paz. El artículo argumenta a favor de considerar el VIH/SIDA como un tema de seguridad y en se postulan cuatro teorías principales sobre el vínculo entre el VIH/SIDA, la seguridad nacional y el conflicto: 1. el personal uniformado actua como un vector de VIH, 2. la seguridad nacional está amenazada por las instituciones estatales afectadas por el VIH/SIDA, 3. el aumento de vulnerabilidad a la infección del VIH en países en conflicto o en postconflicto, 4. el VIH como un obstáculo para los procesos de paz. Las cuatro teorías han sido estudiadas en el contexto colombiano. Se encontró que dos de ellas (1 y 3) presentaban una relación más estrecha entre el VIH/SIDA, la seguridad nacional y el conflicto. Las teorías 2 y 4 mostraron una relación menos estrecha, debido principalmente a la relativamente baja tasa de prevalencia de VIH en Colombia.

Palabras clave
VIH/SIDA • Seguridad • Conflicto • Colombia

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INTRODUCTION

Since first detected in 1981 HIV/AIDS has infected 65 million people worldwide and killed more than 25 million. Some 7,400 people are infected every day and in the decades ahead HIV/AIDS is expected to kill ten times more people than conflict (UNAIDS 2009). At the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001 HIV/AIDS was declared a development issue of the highest priority and considered as a threat to international security. In passing Resolution 1308 the Security Council recognised that the HIV/AIDS pandemic is exacerbated by conditions of violence and instability and stressed that, if unchecked, it may pose a risk to stability and security.

Research increasingly points to the link between HIV/AIDS, national security and conflict, demonstrating how conflict accelerates the spread of HIV and how HIV/AIDS in itself is a potential threat to national security. HIV/AIDS has arguably been securitized at the international level (De Waal 2005; Elbe 2006; Heinecken 2001; ICRG 2002; Roderick 2006; Schneider and Moodie 2002). This article looks at the value of considering HIV/AIDS a national security issue in Colombia, researching the inter-linkages between HIV/AIDS, national security and armed conflict in Colombia. Colombia is a relevant case due to its protracted conflict and comparatively low HIV prevalence rate. It is of particular value for two reasons. First, the majority of existing research is based on evidence from conflict-affected African countries, which suffer from much higher HIV prevalence rates. Secondly, Colombia is also an example of an internal conflict, which is the most common type of conflict. The findings are therefore relevant for other countries experiencing internal conflict and with low to medium high HIV/AIDS prevalence rates.

The article is based on the narrow definition of national security and does not therefore examine the links between the demographic and economic threats to national security caused by HIV/AIDS. Whilst these links are also likely to be important they have been excluded in order to permit more comprehensive and qualitative research on the theories which are of direct relevance to national

security based on the narrow definition. Likewise, there are many other factors that contribute to an increased HIV/AIDS epidemic independent of the existence of armed conflict. These factors are crucial for fully understanding the causes and effects of an HIV/AIDS epidemic in a country.

Existing evidence on the link between HIV/AIDS, national security and conflict has been analysed and grouped into four main theories. These theories were then explored in the Colombian context. The analysis is based on the interviews conducted in Colombia, supplemented by published materials. Interviews were conducted with the Cerac Foundation, La Fundación Seguridad y Democracia, the Government Collective Demobilization Programme, the Organization for International Migration, the MoD, the National Police, the Presidential High Commission for the Social and Economic Integration of ex-combatants, the Organization of American States, UNAIDS, UNFPA and the WHO.

HIV/AIDS AND SECURITY

The article, in exploring the link between HIV/AIDS, national security and conflict, approaches security from the narrow perspective, which limits security to that of military security and where military conflict is the key denominator to security (Walt 1991). In recognition of the shortcomings of the narrow definition, the theory developed by the Copenhagen School on Security Studies is applied, whose main authors are Barry Buzan, Jaap de Wilde and Ole Weaver. The cornerstone of the Copenhagen School security concept is the importance it places on the utilisation of the security label by governments and policy makers, and its discourse. The use of the security label does not only reflect whether the issue is a security threat, but whether it is also a political choice. An issue becomes securitized if it is presented as an existential threat requiring emergency measures and justifying actions outside the normal bounds of the political procedures. For an issue to become securitized it must be presented according to the particular logic of the security speech act, which has four components through which it must pass: i) *securitizing actors* (such as political leaders, intelligence experts, etc) declaring ii) *a referent object* (such as a state) to be iii) *existentially threatened* (e.g. by an imminent invasion), and who make a persuasive call for the adoption of iv) *emergency measures* to counteract this threat (e.g. declare war or impose a curfew) (Buzan, Weaver, Wilde 1998). The theory seeks to ask with some force the value in presenting an issue as a security issue, and to enable an analysis to determine whether the issue is better dealt with within normal politics.

In the first two decades since the discovery of HIV/AIDS the disease has been conceptualised primarily as a public health and development issue. The major turning point was in the year 2000 when the issue was for the first time discussed at the UN Security Council, which declared HIV/AIDS in Africa a threat to

international peace and security. Further UN Security Council Resolutions have since been issued on HIV/AIDS and security, including S/Res/1325, A/Res/S-26/s and A/Res/60/262. HIV prevention has been integrated into UN peacekeeping missions. In 2004 a UN Inter-Agency Working Group was established to integrate HIV/AIDS policies in Demobilisation, Disarmament and Reintegration (DDR) programmes.

Applying the Copenhagen School securitization theory to the resolutions adopted by the UN Security Council it can be argued that HIV/AIDS has already been securitized, i.e. taken out of its non-politicised or politicised status and elevated to the security sphere by being presented according to the particular logic of the security speech act. As demonstrated by Elbe, arguments around HIV/AIDS "have shifted from humanitarian and public health ones to officials in international organisations, governments and NGOs (*securitizing actors*) increasingly arguing that beyond these humanitarian considerations, the survival of communities, states and militaries (*referring objects*) is now being undermined (*existentially threatened*), unless drastic measures (*emergency measures*) are undertaken by national and international actors to better address the global pandemic."(Elbe 2006).

However, as Elbe also points out, there are certain dangers in making HIV/AIDS a security issue. It could potentially push national and international responses away from civil society towards state institutions such as the military and the intelligence community, which have the power to override human rights and civil liberties. Of greater concern are the consequences of the "threat-defence" logic part of the security language. Viewing HIV/AIDS as a security threat would push the response to be based on narrower national interests rather than as a global multidimensional problem, thus risk adverting international efforts made in countering the HIV/AIDS pandemic. Portraying the disease as a security threat can also reverse the advances in normalising social perceptions regarding people living with HIV/AIDS (PLWHA). Finally, it allows states to prioritise AIDS funding for their armed forces and elite. On the other hand, securitizing HIV/AIDS brings with it a number of benefits, such as focus, attention and mobilisation of resources to fight the pandemic. In many heavily affected countries it is not excessive state mobilisation that poses the main problem, rather the utter absence of state response to the disease. The ability of states to override certain legal provisions is also an advantage in the struggle to weaken the grip of patents on life-saving medicines, as such patents could potentially be overridden in the light of national security considerations. In terms of normalising HIV/AIDS to reduce stigma and discrimination "there is a crucial difference between arguing that people with HIV/AIDS are a security threat and arguing that AIDS is a security threat."(Elbe 2006, 137).

LINKING HIV/AIDS, NATIONAL SECURITY AND CONFLICT

Evidence linking HIV/AIDS, national security and conflict can be grouped into four different categories: 1) uniformed personnel as a vector of HIV; 2) national security threatened by HIV/AIDS affected state institutions; 3) increased vulnerability to HIV infection in conflict and post-conflict environments; and 4) obstacles to peace building. The theories are strongly interlinked and will, as such, inevitably overlap.

Uniformed personnel as a vector of HIV

Uniformed services, as defined by the UN and the World Bank, include national militaries, police and international peacekeepers. Research show that this group displays HIV infection rates on average 2-3 times higher than the comparable civilian population (UNAIDS 2004). STI rates, which greatly increase the risk of HIV infection, are generally 2–5 times higher. In times of conflict the difference can be up to 50 times higher (UNAIDS 1998). Countries with large armies have higher HIV prevalence rates.(Fourie 2001) For the average developing country, reducing the size of the military from 30% to 12% of the urban population will reduce seroprevalence among urban adults by 4% (Fourie 2001).

Factors making uniformed services particularly vulnerable to HIV infection include:

- *Age*: most fall within the age group 15-24, which is the group at greatest risk for HIV infection.
- *Postings:* far from home communities and families have been identified as the most important factor leading to high HIV rates in the military. This practice encourages commercial sex as soldiers are removed from traditional social controls and partners as well as subjected to emotional stress (UNAIDS 1998).
- *Attitudes and behaviour*: part of military culture includes risk taking and aggressiveness. This has been found to lead to an increased willingness to engage in high-risk sexual practices, such as unprotected, purchased and/or coerced sex, and multiple partners. As soldiers have a steady income they are often considerably better off than civilians in surrounding communities, encouraging the growth of sex industries around military settings. Rape by soldiers is systematic in some conflict-affected countries. Sharing of skin piercing instruments used in tattooing is found to be comparably common within uniformed services (UNAIDS 1998).

National Security threatened by HIV/AIDS affected State Institutions

Reduced functioning of national militaries

HIV/AIDS seriously impedes the operational functioning of the military. Sick leave and leave to care for dependants have led to increased absenteeism, to the point that some high prevalence countries worry about being able to field a

full contingent for deployment on relatively short notice. Even if new recruits can be found, readiness, teamwork, discipline and command are compromised if absences are filled in by people who have not served together previously (UNAIDS 1998). Quality may be further reduced when younger and less experienced personnel are brought in to replace infected personnel. A weakened national military is per se a risk for increasing instability inside a nation and with its neighbours (UNAIDS 2006).

Reduced effectiveness of other key state institutions

AIDS poses a further threat to national security by reducing the state's ability to govern. AIDS is decimating civil services, police forces and national institutions, thus posing a fundamental threat to community and social cohesion. HIV/AIDS also has an adverse affect on a country's attempt to establish or maintain democracy as the next generation of political leaders is being wiped out (Fourie 2001).

At the most basic level HIV/AIDS has a profound impact on national policing. In Kenya AIDS accounted for 75% of all deaths in the force in year 2000 (ICG 2001). Teachers and health care workers are other heavily affected sectors. Africa is expected to have lost 10% of its teachers to AIDS by 2005, setting back education levels by 100 years. As education levels drop, the standard of living follows, leaving people with less of a stake in the system, ultimately increasing the risk of violence (ICG 2001). These dynamics can both singularly or in combination exacerbate and/or provoke social volatility and political polarisation.

The creation of a security vacuum

The impact of AIDS may as such intensify the struggle for political power as actors attempt to fill the vacuum left by the weakened state. Domestic and foreign sources of unrest (political, military or criminal) are likely to fill the vacuum left by weakened military and police forces. Even the perception of an AIDS epidemic amongst a national military may trigger wars or internal coups. In weak states opposition groups may exploit the situation by instigating civil unrest or toppling the ruling elite (ICG 2001).

Increased vulnerability to HIV infection in conflict and post-conflict environments

Conflict zones provide ideal conditions for the accelerated spread of HIV/AIDS, as most risk indicators for HIV vulnerability sharply rise. The nature of a conflict will significantly influence the likelihood of an epidemic. Short wars that depend on "distance" tactics such as aerial bombardment are less likely to spread HIV/AIDS than conflicts that lead to long-term fighting on the ground and mass movements of soldiers and civilians (Human Security Centre 2005). Conflict also

increases the number and power of two groups at the highest risk of contracting HIV/AIDS: soldiers and sex workers.

Damage to the health infrastructure
Healthcare infrastructure is repeatedly attacked in conflict zones, which is also one of the main systems to respond to an HIV epidemic. This creates three significant problems: 1) increased demand for healthcare services as war-casualties and infectious diseases increase; 2) supply of healthcare services rapidly contracts as services are redirected to battlefield surgery and emergency medicine. Conflict-affected populations often lack access to reproductive health services, denying the most basic protection against HIV. There is often an acute lack of ARV provision and treatment for opportunistic infections. During conflict there is an increased need for blood transfusions though there is often a shortage of resources to screen blood; 3) breakdown in monitoring and surveillance systems, preventing accurate estimates of HIV prevalence and thus preventing targeted high-impact interventions (Roderick 2006).

Changed behaviour of conflict affected populations
Conflict and militarization tend to exacerbate gender inequality, which is shown to reduce the ability of women to protect themselves against HIV: either through the fidelity of their partners or through condom use. As reported by UNAIDS women often become reliant on transactional sex as their lives are disrupted and impoverished. Conflicts are also associated with increases in rapes, which on some occasions have been used as a weapon of war such as in Rwanda and Bosnia. Medical conditions arising from rape make women further vulnerable to HIV infection. There is often an acute lack of HIV/AIDS knowledge in conflict situations, caused by the undermining of awareness raising and prevention efforts. Moreover, even where awareness is high the daily realities of life under conflict can diminish the perceived risk of HIV infection. Lastly, alcohol and drug use often increase as a reaction to trauma, and with it lower perceptions of HIV infection risk and behaviours change.

Refugees and IDPs
Refugees and internally displaced persons (IDPs) have been identified as a group highly vulnerable to HIV/AIDS. Migration from high prevalence areas to low, or vice versa, has been found to accelerate increases in HIV rates, as refugees/IDPs interact with the host populations (in many instances as a mean of survival) or with their home communities on their return. Factors contributing to their vulnerability include: uprooting and movement, sexual violence and exploitation, poverty and lack of medical services or the inability of existing services to cope

with the additional increase in demand. Adequately monitoring and surveying the health situation amongst displaced populations is extremely difficult due to relocation, loss of medical records and the difficulty in accessing these populations (Roderick 2006).

Wartime policies and priorities

States in conflict are making slow progress in implementing plans to fight HIV/AIDS. Given the long incubation period of HIV, monitoring its spread has not been a priority under emergency conditions. International financing to fight HIV/AIDS is almost entirely absent in conflict countries.

The post-conflict environment

The post conflict period is a time of high societal vulnerability to HIV. The ending of conflict often leads to substantial population movements, opening of roads, increased flow of commerce, demobilisation of combatants and deployment of peacekeepers and aid workers. This environment could provoke an explosive spread of HIV (de Waal 2005).

Obstacle to Peace building

HIV/AIDS as a disincentive to end conflict

HIV/AIDS can result in disincentives to end conflict. Where soldiers come from low prevalence countries they have often facilitated the spread of HIV in their home communities once they return. Some analysts have reported that one of the reasons for why the Rwandan Government has been slow to end its involvement in the Democratic Republic of Congo (DRC) is that it fears the return of potentially highly infected troops will increase HIV/AIDS prevalence rate in Rwanda. On the other hand military officials in the DRC have confirmed that high rates of HIV/AIDS encourage risk taking among soldiers who believe they have already received a death sentence. Soldiers infected have their time horizons shortened dramatically and in DRC it has been shown that they will choose continued fighting, plunder and short-term enrichment over the prospect of peace (Schneider and Moodie 2002).

Reduced willingness by states to provide or receive peacekeepers

HIV/AIDS affects peacekeeping operations both in terms of a country's willingness to contribute troops and its willingness to receive international peacekeepers. In 2000 the then US Ambassador to the UN stated that the USA will no longer vote for peacekeeping resolutions that do not include HIV/AIDS prevention targeting peacekeepers (Fourie 2001). India, Pakistan and Bangladesh, which are

major troop contributing countries and with low HIV prevalence, have expressed concern over the risk their troops face of contracting HIV while deployed abroad (UNAIDS 2006). Peacekeepers have also been found to spread HIV, particularly so in Cambodia, Liberia and Sierra Leone, with the result that countries are becoming increasingly unwilling to accept peacekeepers from high-prevalence countries. Unless the spread of HIV among African armies is stopped soon, it is possible that many countries will be unable to participate in peacekeeping operations (Pharaoh and Schonteich 2003). This would have serious consequences for peacekeeping operations as soldiers from countries with high HIV/AIDS prevalence yield 11% of the UN force, whilst countries nearing such high prevalence make up 37% (UNAIDS 2003).

Obstacle to reconstruction and recovery of national security

The burden HIV/AIDS places on human and financial resources puts government institutions under threat just as they are needed the most. Demobilising and reintegrating combatants may be threatened by combatants returning to villages and families heavily affected by the HIV, and by breakdown of government, police and civil society and by overall AIDS-related economic decline (ICG 2001). Failure to rebuild and reintegrate post-conflict countries is identified as one of the main causes for a relapse of conflict.

HIV/AIDS AND SECURITY IN COLOMBIA

The Colombian conflict, lasting for nearly 50 years, has seen many changes in actors, behaviour and incompatibilities. Issues pertaining to social justice were of main concern when FARC and ELN were formed, though the quest for economic and political power, as well as control over the lucrative drugs trade, have come to dominate the motivations of the guerrilla groups. The paramilitaries were formed to fight back against the guerrillas and to protect landowners, although they too became increasingly associated with the narcotics industry. Successive governments have attempted DDR processes with the rebel groups. Between 2002 and May 2008, 16,565 guerrilla soldiers[1] demobilised (MoD 2008). Of these 12,005 pertained to the FARC (72%) and 2,363 the ELN (14%) (FIP 2009). During the same period, 31,526 guerrilla soldiers were captured and 12,324 killed (MoD 2008). By the end of 2006, some 32,000 paramilitaries had demobilised (MoD 2008; FIP 2009).

How a conflict is defined is crucial to the response from both a humanitarian and political perspective, and it will determine whether international humanitarian law becomes applicable. In a clear break from his predecessors, Uribe takes the

1 The figure includes soldiers from FARC, ELN, EPL, ERG, ERP, JBC.

view that there does not exist armed conflict or civil war in Colombia. Instead the government interprets the conflict as a fight between the legitimate state and terrorist groups. The policies adopted by Uribe- emphasising military defeat over the guerrilla, recuperation of state authority and monopoly of coercive force- have led to increased fighting and destruction on the ground. During the Uribe government the status of the Colombian conflict has been elevated to the level of civil war three times (as defined by the Uppsala University Peace and Conflict Resolution Institute, 2007); in 2002, 2004 and 2005. This impacts on the HIV/AIDS epidemic, as it produces more battle related injuries which treatment requires the strict adoption of universal precautions[2] in order to prevent HIV transmission. The increase in violence has also prevented the repatriation of IDPs as well as led to new displacements. By the end of 2008, the government registered 2.8 million IDP, however many NGOs, such as COHDES, believe the real number surpasses 4 million, of which an estimated half is under the age of 18.

In 2007, the HIV prevalence rate in Colombia was 0.7% (MPS 2008) and it is estimated to reach 1.5% by 2015 (ONUSIDA 2006). Underreporting is of serious concern: between 1983 and 2007, 57 489 cases had been reported, although it is estimated that the real number of cases amongst the age group 15 – 45 is 171,500 (MPS 2008). The gap between reported and estimated cases is mainly attributed to infected people not accessing testing services and the limited coverage and quality of data of the national notification system. Of the reported cases between the years 1983 – 2007, 25% were in Bogota, 19% in Valle, followed by 14% in Antioquia. These are also the departments that first had a system of registration (MPS 2008).

Uniformed personnel as a vector of HIV

This section includes also the main illegal armed groups, the guerrilla group FARC and the paramilitary umbrella group AUC (Autodefensas Unidadas de Colombia), due to the important role they play in the conflict, their considerable size and because they are structured and function in similar manners as a conventional army. It is therefore important to analyse their potential role as a vector of HIV infection. Analysis on the paramilitaries is based on the force as it was up until the demobilisation process came to an end in late 2006.

The National Public Forces (La fuerza pública)

The Public Forces include the army, air force, navy and the police, which in 2009 numbered 419,828. Since 1997 there have been 357 reported cases of HIV within

2 Universal precautions are infection control measures that reduce the risk of transmission of blood borne pathogens through exposure to blood or body fluids among patients and healthcare workers.

the police. In 2007 (up until August) 57 new cases were reported. The majority of these cases are amongst 18-24 year olds pertaining to the lower ranks. These soldiers are believed to adopt more high-risk behaviours such as promiscuity, in addition to having lower levels of education. The army reported 411 accumulated cases of HIV/AIDS in 2003.

Age • The main age group within the police is 20–24 years old, followed by 25–29 years, of which the majority pertain to the lower to middle ranks. The main age group within the military is 19–24 year old.

Postings • Professional soldiers and police recruits are posted throughout the country without consideration to their home communities for a minimum of two years. Soldiers are often not able to bring their families, though the police often can. Conscript soldiers are whenever possible posted within their home communities. Postings can therefore potentially increase vulnerability to HIV/AIDS as it leads to geographical relocations and results in soldiers spending prolonged periods away from their families.

Attitudes and behaviour • Personnel are relatively well paid, with the lowest paid ranks receiving well above the minimum pay. As such, members of the Public Forces who serve in rural conflict affected areas are financially considerably better off than the surrounding population. It was recognised by the MoD that such advantageous position facilitates coerced and/or purchased sex or sexual relations in exchange for commodities.

The Public Forces have been repeatedly criticised for human rights violations. The UN World Committee Against Torture reports that the human rights situation and compliance with humanitarian law in Colombia have deteriorated dramatically since 1996. Even the USA has raised concerns over human rights violations in its negotiations over Plan Colombia. Violations include rape, torture and disappearances of socially marginalised persons. Cerac reported concerns over blockades on commodities such as drugs, condoms and contraceptives into rural areas. The MoD confirms such restrictions, but state they only apply to large quantities of chemicals and drugs used for processing cocaine, although to some extent they also apply to condoms. Other organisations claim there is a deliberate tactic by the Public Forces to prevent condoms and contraceptives reaching the guerrillas.

HIV prevention is being increasingly recognised by the Public Forces as a more cost effective strategy than treatment and prevention campaigns which are being implemented in collaboration with the UN. This is a recent development, as only five years ago HIV prevention was not even considered an issue. Nevertheless, according to the National Police knowledge of HIV/AIDS remains very low within

the Public Forces and there is a lot of discrimination towards PLWHA. HIV tests are provided, but there is much ignorance surrounding the tests and many do not want to test as they fear the results. HIV/AIDS treatment is available within the Public Forces but is mainly concentrated in the major towns. Healthcare provision for Public Forces personnel is generally poor in the rural areas and HIV/AIDS service provision becomes all but impossible in rural and conflict affected zones. HIV/AIDS is not considered a main preoccupation and resultantly few resources are diverted to the issue.

Illegal Armed Groups

It is almost impossible to measure HIV prevalence amongst these groups, for reasons such as their clandestine nature and the prohibition placed on humanitarian organisations accessing these groups. However, there are reasons to believe that members of these groups have a heightened vulnerability to HIV and could play an important role in its transmission to the general population. The findings suggest some differences between the paramilitaries and the guerrilla.

Age and level of education • Statistics collected during the DDR processes show that the majority falls within the age group most vulnerable to HIV/AIDS infection. 25-34 is the age group reporting the majority of new infections in Colombia and within this age group most demobilised paramilitaries are found. More than half of all new infections worldwide take place within the age group 15-24, which is the age group where the majority of demobilised guerrillas were found. Low levels of education further increase vulnerability to HIV infection: within the paramilitary group only 39% had secondary education and within the guerrillas a mere 24%. Amongst both groups 8% were illiterate (Alta Consejería para la Integración Social y Económica 2006).

Structure • As the AUC, the paramilitaries significantly strengthened their coercive force, and, as such, power over local government and communities in many regions in Colombia. Massacres were often committed by a vanguard group which would then recruit local people to maintain control. The vanguard group would move on to the next village to continue to expand their control. OAS-MAPP voiced two significant HIV/AIDS implications: massacres often involved rapes, making the vanguard group a direct transmitter of HIV, secondly PLWHA were singled out and assassinated. Whilst this could very crudely be argued to reduce transmission, it fuels discrimination and stigma towards PLWHA, which is a main factor for increasing prevalence rates.

The structure of FARC is somewhat different. In order to confront the government, their army must be more cohesive, disciplined and formidable in combat

than the paramilitaries. Guerrilla tactics result in more injuries than those of the paramilitaries, a factor increasing HIV transmission. Conflict dynamics such as cultivation of illegal crops and the appropriation of land by the paramilitaries have generated a large population displacement towards remote regions, which has become the social support base of the guerrilla (Duncan 2006).

Behaviour • Lifestyles differ substantially between the paramilitaries and the guerrilla, with the lifestyle adopted by the paramilitaries being more prone to HIV infection and transmission. FARC adopts strict living rules interfering very much with the private lives of their combatants, including regulating sexual activity, which could be seen as a factor lowering vulnerability. Based mainly in the mountains, healthcare is poor and living conditions are much more difficult than those of the paramilitaries. Although poor health is linked to an increased vulnerability to HIV infection, isolation from the general population is a potential reducing factor. The paramilitaries impose very few living rules and pay salaries to their recruits. Their combatants are also based in urban areas and have greater access to women– factors identified as increasing HIV vulnerability. Many soldiers pertaining to the guerrilla have switched sides and joined the paramilitaries. OAS-MAPP reported that, of the demobilised paramilitaries, 20% had been in the guerrilla but converted to the paramilitaries due to the difficult living conditions. These kinds of movements are also a potential factor increasing HIV vulnerability and transmission. In response to such deterioration, the guerrilla is becoming more paramilitarised, adopting their methods and even entering into business with them (and later their successors) over drug trafficking. This has resulted in a loosening of the rigid living rules, which could potentially increase vulnerability to HIV infection and transmission (OAS-MAPP).

Within the illegal groups, recruits are often subject to mandatory HIV testing and those who test positive are killed. During the demobilisation interviews it was claimed, by both groups, that there is a tactic by the enemy group to infiltrate HIV positive women into their counterpart forces as a strategy to infect their enemy. Whilst such claims are almost impossible to verify, it points towards viewing purposeful HIV infection as a weapon of war.

Attitudes • The level of intolerance towards HIV/AIDS and homosexuality is high. Both groups have adopted a strategy of social cleansing of PLWHA, which is rooted in stigma and a belief that only prostitutes and homosexuals have HIV. UNHCR reported that in field visits it was commonly found that HIV positive persons, prostitutes and homosexuals, were raped and/or killed. The paramilitaries often either forced staff in health centres to divulge HIV-test

results or placed informants within clinics in order to identify HIV positive persons. In other instances individuals were subjected to mandatory testing. Based on such stigma and discrimination, the armed groups are spreading false information on HIV/AIDS and fuelling discrimination. Organisations such as OIM have reported that in such environments it is difficult to encourage people to be tested.

National Security Threatened by HIV/AIDS Affected State Institutions

While it cannot be said that the HIV/AIDS epidemic in Colombia has reached the point where the epidemic threatens the effective functioning of the state, what could be argued is the situation in reverse: the territorial weakness of the state (caused by non-HIV/AIDS related factors) is increasing the risk of an accelerated HIV/AIDS epidemic. It highlights the importance of prevention in order to avoid reaching the stage where HIV/AIDS starts to create a security vacuum and becomes an additional destabilising factor to national security.

Territorial weakness

Colombia is a country with comparatively strong institutions at the central level. The weakness lies in the territorial reach of the government, where in parts of the country the state is either extremely weak or completely absent. In these areas the illegal armed groups are disputing the state monopoly. According to the MoD, the Public Forces are present throughout the country, although in the southern and western part of the country and parts of the eastern coast their presence is mainly limited to the departmental capitals. However, their presence is increasing year on year. Sources investigated outside the MoD all claim that there is a total lack of state presence in large parts of the country, in particular in the rural conflict affected zones. Additionally, the ICG reports that in most regions it visited there were reports of security forces either tolerating the new armed groups and criminal gangs that have emerged after the demobilisation of the AUC or even actively working with them. The territorial weakness of the state in these areas prevents it from fulfilling its fundamental obligations to its citizens, such as healthcare provision and the upholding of civil and human rights. It enables the illegal armed groups to infiltrate the national healthcare infrastructure and, being the authority administering justice, the rights of PLWHA and other minority groups become seriously threatened (ICG 2007). The power of the illegal armed groups enables the enforcement of their attitudes and beliefs on HIV/AIDS and, acting as the state, they have the power to prioritise issues and resource distribution, which would arguably disfavour HIV/AIDS prevention and treatment. Access by humanitarian organisations and other healthcare providers to the populations in these communities becomes increasingly difficult.

Narco-conflict

Cultivation of illegal crops takes place in isolated areas with limited or no state presence and thus resultantly limited channels for the population to participate in legal economic activities. Cerac reported that cultivation and processing of coca significantly increases the income amongst the population and the dynamics of the industry has been found to produce situations where a significant number of young men with a comparably substantial amount of money have little other stimulation than consumption of drugs and sexual relations with women or prostitutes. An increase in prostitution has occurred, and a resultantly higher incidence of HIV/AIDS. With no state provided social services, there is an absence of healthcare services and risk reducing programmes.

Increased vulnerability to HIV infection in conflict and post-conflict environments

The conflict is characterised by prolonged fighting on the ground, involving more soldiers and movement than short wars that depend on distance tactics. Casualty rates from land mines are amongst the highest in the world, as are the number of IDPs. 45% of the Colombian population live below the national poverty line (UNDP 2007) and the coping strategies of the conflict affected population often lead to high-risk behaviour in terms of HIV infection and transmission.

Damage to the healthcare system and infiltration by the illegal armed groups into local government and the healthcare infrastructure

The main damage to the national healthcare infrastructure caused by the conflict is the dysfunction of the healthcare system, which has led to a worsened health status of the Colombian population. The WHO reported that municipal mayors and the local ministries of health are the institutions which have been particularly infiltrated in ways such as asking for quotas and influencing contracting procedures. One way the infiltration manifested itself is that many of the administrative bodies of the subsidised healthcare regime became either owned or controlled by the paramilitaries. With the decentralisation of healthcare provision, the local townships obtained considerable power over budgetary allocations and thus priority setting, which in many regions in Colombia has therefore become determined or influenced by the illegal groups. These groups have also used the healthcare infrastructure to serve as their own networks. Healthcare providers are co-opted through threats or bribes to provide healthcare to the guerrillas or paramilitaries, which has resulted in the displacement of supplies from the civilian population. In the Atlántico department alone, $100 million was taken from the health system by the paramilitaries (ICG 2007). Apart from the financial benefits, controlling the healthcare system is also highly useful for maintaining the fighting force.

While the general population can theoretically access testing services under the government insurance scheme, the main issue with VCT services is the inability to ensure confidentiality and protection. UNHCR has reported that in nearly every field visit conducted PLWHA had been discovered, through informants or by other means, and assassinated. Forced testing and forced disclosure of the results was also frequently cited.

Barriers to access

Consequently, State inability to deliver universal healthcare services leaves many people without access. The armed groups controlling these areas decide who can access what kind of services. The UN and other organisations have encountered serious difficulties in accessing areas targeted for healthcare provision. Access to IDP communities is often denied or limited due to the high risk of violence for both healthcare personnel and clients. FARC has let it be known that international organisations are not welcome in the territories they control in north-eastern Colombia (Minear 2006). Projects implemented by national and international organisations are frequently subject to threats from illegal armed groups. One such example is Proyecto Colombia, one of the largest HIV/AIDS projects in Colombia. The majority of threats related to providing information on HIV-tests results in and have resulted in the displacement and exile of project staff and beneficiaries. This has had the adverse effect of transforming initiatives to promote VCT, and thus improving public health, into risk factors (OIM).

Resultantly access to HIV/AIDS services in Colombia is limited. For example, there is an acute lack of test kits and adherence to ARV has become a serious problem, with people not following the regime strictly and thus threatening resistance to ARVs (WHO). In addition, as many people fear the discovery of their status they may not access care and support services even when available. One response to the problem would be to target the illegal armed groups with information on HIV. However, the UN and other organisations (apart from the ICRC) are prohibited from accessing these groups. Although working with the illegal armed groups on HIV/AIDS education and prevention and other human rights issues could be an effective way to counteract the aforementioned problems, it could also risk providing certain legitimacy to these groups.

Dysfunction of monitoring and surveillance systems

In many parts of the country there is a complete lack of surveillance and monitoring of HIV/AIDS, and reporting is a serious problem in conflict affected zones. As such, WHO reported concern that the statistics that indicate that HIV/AIDS is mainly a problem in urban areas may be skewed as the conflict is taking place mainly in rural areas. As most existing VCT and treatment services are found

in the larger cities, which also have better reporting mechanisms, the reported HIV/AIDS situation in Colombia might be distorted. There is also the risk that AIDS deaths are recorded by the opportunistic infection rather than the presence of the virus.

Changed behaviour of conflict affected people

Loyalty towards a paramilitary or guerrilla leader is often demanded in the areas they control. Access to healthcare services becomes conditional upon cooperation with the illegal groups, which through this system are also supplied with informants on PLWHA. These conditions have generated a level of tolerance within the community towards crimes committed against PLWHA and other minorities. Another coping strategy reported by UNAIDS to be of increasing concern is the rise in sex in exchange for money or food or for access to social benefits. UNCHR has reported that young girls, in order to ensure their survival and wellbeing and that of their family, purposely become pregnant by paramilitary leaders. Relationships between young girls and older and powerful paramilitaries are common and is a factor making young women particularly vulnerable to HIV.

Promiscuity and prostitution is widespread in Colombia and is particularly rampant in rural areas. While this can partly be explained by the social structure of the Colombian society, it is also a result of the lack of opportunities and the short-term life perspective felt by many as a result of the conflict. This is believed to lead to increases in sexual activity, often with prostitutes, and a rise in women turning to transactional sex for survival (OAS-MAPP). UNHCR has reported high rates of trafficking of young women for the sex industry. The Health Secretariat reported that many return HIV positive and continue to sell sex on their return. It was also reported that families highly value the money their daughters can earn abroad and many saw this as an only option for the young women to get out of poverty.

Knowledge of HIV/AIDS is high in Colombia. What is less known is the right to VCT services as part of the national health insurance. Condom use continues to be insufficient and is particularly low amongst sex workers. In a study amongst sex workers and their customers carried out in Bogotá in 2001 and reported by the UNHCR, 41% of the women reported that they rarely used condoms, 61% of the customers reported that they never used condoms; 75% responded that they sometimes paid to have sexual relationships without condom; and 69% did not use condoms when under the influence of psychoactive substances.

Sexual violence is common in Colombia. Rapes are rarely reported, confirmed both by human rights organisations and the police. The crime is perpetrated by the illegal armed groups and the Public Forces alike. While post-exposure prophylaxis is available in some instances, women often do not attend clinics

post-rape due to stigma and shame and therefore do not access prophylaxis services. It was found that in some areas many young women after being raped preferred to access emergency contraceptives at a pharmacy as this was seen as more confidential than reporting the rape and receiving counselling at a government hospital.

Refugees and IDPs

The difference between the registered number of IDPs and UN/NGO estimates suggest the possibility that more than 1.2 million IDPs are without any access to healthcare services. In an investigation made by WHO in 6 of the largest municipalities it was found that approximately 20% of IDPs and 30% of host populations did not possess any kind of document to access healthcare services. 10% of IDPs who sought medical assistance were denied, in comparison to 2% amongst the host populations. HIV amongst IDP populations is not a priority issue and there exist very limited data on HIV/AIDS for this group (WHO; Universidad de Antioquia 2005).

Repatriation of IDPs has been prevented by the continued violence. It is also limited due to the long time that many of the victims have been displaced, often between 10-15 years. Many have formed new lives and no longer consider themselves as displaced (Fundación Seguridad y Democracia). This would potentially reduce the likelihood of the spread of HIV caused by population movements. On the other hand, being non-camp based is a factor potentially increasing vulnerability. IDP camps reduce privacy and thus sexual activity, and facilitate access by humanitarian organisations.

Wartime policies and priorities

There has been a rather stable financial investment in the national health system, although more resources are needed to implement the National Health Plan and state health insurance scheme. Regarding HIV/AIDS the government is focusing on improving information and quality of services, with some important investments made. Nevertheless, as identified by WHO, insufficient allocation of human and financial resources continues to be the main barrier to implementations of HIV/AIDS policies and strategies, rooted in the low prioritisation of HIV.

As state provided HIV/AIDS prevention and treatment services in the conflict affected areas are severely limited, humanitarian organisations and NGOs play an important role in providing such services. By interpreting the conflict as a fight against terrorism, the Colombian government is circumscribing the functioning of international humanitarian and human rights organisations by preventing the application of international humanitarian law. It also prevents non-state organisations from approaching the illegal armed groups in the fight against

HIV/AIDS. Overriding human rights and civil liberties also denies the human rights of PLWHA and other minority groups and prevents proper investigations into the crimes perpetrated against these groups, including the assassination of PLWHA. Interviews with the national police confirmed that such investigations were not a priority, and that in any case there does not exist a system to establish the proportion of reported crimes which relates to breaches of human rights of PLWHA and other minority groups. The policy causes further obstacles to the displaced population, as in many cases they are unable to register as IDPs because the government does not officially recognise displacement when caused by the narco-conflict.

Although international presence relating to the peace negotiations in Colombia is fairly recent, it is significant. In the peace negations held with FARC in 1998 some 20 countries were present in addition to the UN. In the AUC demobilisation process the OAS-MAPP held an important position and has enabled the involvement of further international actors. The peace negotiations with ELN held in Cuba included the 'group of friendly countries' consisting of 7 different countries. The recent negotiations conducted with FARC on a humanitarian agreement were led by France, Spain and Switzerland, and they included the participation of Venezuela. The UN has significant presence in Colombia, with a considerable number of international staff contracted. The research conducted found no indications that this is threatening an increase in HIV.

During the talks leading up to the peace agreement with the AUC in Santa Fe Ralito there was a concentration of military personnel, AUC combatants and government officials, and, significantly, an influx of money. As a result, both demand for and supply of prostitutes increased, with sex workers arriving from many different parts of the country. As part of the conditions for the peace talks, the paramilitaries were enclosed in large ranches protected by the police in order to negotiate with the government without being attacked by the guerrilla. However, according to OAS-MAPP police protection was rather porous in the sense that it permitted prostitutes to enter the premises and the establishment of brothels surrounding the ranches. There was also a demand by the paramilitaries for virgin girls to be supplied. The WHO reported an increase in STI and HIV rates in the region following the Santa Fe Ralito Accords.

Healthcare is part of the demobilisation programme through which VCT services are provided. Nevertheless shortcomings in the programme include insufficient resources (e.g. only 1 healthcare professional per 5,000 demobilised combatants, and 1 psychologist per 120. The WHO recommends a minimum of 2.5 healthcare workers per 1000 people under normal circumstances). It was also found that sexual violence increased during this period. In addition there have been few efforts to sensitise civil society on what is meant by the DDR process, which has

resulted in high levels of discrimination against returning ex-combatants (OAS-MAPP; Fundación Seguridad y Democracia). The failure to properly reintegrate the demobilised combatants into society, in addition to the shortcomings in sustainable behaviour change activities, could risk that they continue to harbour the attitudes and behaviours found to increase the risk of HIV infection and transmission. A significant proportion of demobilised combatants have joined the newly formed illegal armed groups- the MoD reports that 10-15% of members captured from the newly formed illegal groups were former paramilitaries. The DDR processes have not, however, lead to large-scale population movements.

Obstacles to peace building

There appears to be little evidence pointing towards HIV/AIDS being an obstacle to peace building, in the sense that it becomes a disincentive to end conflict or an obstacle to the reconstruction of national security. However, the increasing HIV prevalence rate merits a discussion on the issue. Prevalence is increasing most rapidly amongst vulnerable groups, to which the uniformed personnel and the illegal armed groups pertain. The risk exists that HIV rates will increase dramatically within these groups and could, as such, become a potential obstacle to peace building, which has been found to have happened in other high-prevalence conflict affected countries. The same could be argued for the theory of HIV/AIDS as an obstacle to the reconstruction of national security. The state institutions in charge of maintaining national security do not appear to be threatened by the impact of HIV/AIDS, although factors accelerating the HIV/AIDS epidemic are present. In addition, the Santa Fe Ralito process has demonstrated how peace negotiations and initiatives can increase HIV transmission. This points to the importance of early prevention to avoid creating additional obstacles to achieving peace in Colombia.

Research did not indicate the deployment of peacekeepers in the near future. However, if a future agreement were to be reached which would include UN or regional peacekeepers, the issue of HIV/AIDS should not be ignored, given the fact that Latin America and the Caribbean is the second most affected region by HIV/AIDS.

CONCLUSION

Based on the evidence found in Colombia and on previous research, HIV/AIDS is clearly a security issue. The four theories linking HIV/AIDS, conflict and national security appear to hold true even in countries with comparably low prevalence rates. In Colombia evidence was found to support all four theories, though their strength varied. The theories *uniformed personnel as a vector of hiv, and increased vulnerability to HIV/AIDS in conflict environments* demonstrated the strongest

linkages between HIV/AIDS, national security and conflict. The relatively low HIV prevalence rate made the theories *national security threatened by hiv/aids affected state institutions*, and *hiv/aids as an obstacle to peace building*, less of an issue. However both theories were demonstrated in reverse, i.e. that a weakened state and peace building initiatives could contribute to the spread of HIV/AIDS. What was clear in the Colombian case was the role played by the illegal armed groups in the spread of the HIV/AIDS epidemic, and that the conflict environment is contributing to the increased spread of HIV.

If HIV/AIDS was securitized by the Uribe government, i.e. declared an existential threat requiring emergency measures and justifying actions outside the normal bounds of political procedures, the response would risk being shifted to state institutions which have proven to be highly undemocratic and non-transparent, whilst repeatedly condemned for human rights violations. It would bring HIV/AIDS into the framework of the democratic and security policy, under which Uribe has already claimed that human and civil rights are obstacles to defeating the illegal armed groups. It would risk the misuse of resources earmarked for HIV/AIDS, or their diversion to the security and state elite, at the expense of the civil population. Also it would be highly unlikely that the illegal armed groups would be included in the response. However, to prevent the HIV/AIDS further negatively affecting the Colombian conflict, as well as preventing the conflict further exacerbating the HIV/AIDS epidemic, any response must target the illegal armed groups.

What is needed is an attitude and behaviour change around HIV/AIDS, access to prevention and treatment services, the guaranteeing of the rights pertaining PLWHA and functioning and reliable monitoring and surveillance mechanisms. If the conflict is not resolved, and thus local state institutions continue being infiltrated by the illegal armed groups and the central state is unable to regain full territorial control, securitizing HIV/AIDS could permit the UN and humanitarian organisations to provide these essential life saving services to the conflict affected populations. It would also give the government an opportunity to seek the assistance of the international community without declaring a civil war or changing its war policies. However, conferring the response to the non-state sector and international agencies and organisations would relieve the government from its responsibility to provide basic services to its populations, and this makes the response to HIV/AIDS subject to the goodwill of such agencies.

Whether the government were to securitize HIV/AIDS or not, there is a strong need to view HIV/AIDS as a wider security issue and not just a public health issue in Colombia. HIV/AIDS impacts negatively on the conflict, and the conflict has a negative impact on the HIV epidemic, thus prevention is urgently required to avoid this situation being exacerbated.

HIV/AIDS does not on its own cause wars, neither does armed conflict directly generate HIV/AIDS. However, the structural damage HIV/AIDS is able to inflict can have a profound effect on national security and the presence of armed conflict can exacerbate in vulnerable societies those factors that could lead to greater incidence of HIV transmission. Efforts to fight the pandemic are unlikely to succeed if they do not involve the security sector. However, HIV/AIDS should be presented as a security issue in addition to also being a health, development, economic, social, political, and gender issue. It should be framed as an issue with important security dimensions rather than as a dangerous and overwhelming security threat (Elbe 2006). Such issues are included in the broader framework of human security.

References

Buzan, Barry, Ole Wæver, and Japp de Wilde. 1998. *Security: A new framework for analysis*. Boulder: Lynne Rienner.

De Waal, A. 2005. HIV/AIDS and the military: AIDS, security and democracy. http://asci.ssrc.org/doclibrary/issue_paper1.pdf.

Duncan, Gustavo. 2006. *Los señores de la guerra*. Bogota: Planeta.

Elbe, Stephan. 2006. Should HIV/AIDS be securitized? The ethical dilemma of linking HIV/AIDS and security. *International Studies Quarterly* 50 (1): 119–144.

Fourie, P. 2001. Africa's new security threat, HIV/AIDS and human security in Southern Africa. *African Security Review* 10 (4).

Fundación Ideas para la Paz. 2008. Estadísticas sobre reinserción en Colombia. http://www.ideaspaz.org/secciones/publicaciones/download_documentos/estadisticas_reinsercion_colombia%20(31%20enero%202008).pdf

Heinecken, Lyndy. 2001. Strategic implications of HIV/AIDS in South Africa. *Conflict, Security & Development* 1 (1): 109–115.

Human Security Centre. 2005. The human security report 2005: War and peace in the 21st century. New York: Oxford University Press.

International Crisis Group. 2001. HIV/AIDS as a Security Issue. Issues Report 1. http://www.crisisgroup.org/home/index.cfm?id=1831&l=1.

———. 2007. Colombia's New Armed Groups. Latin American Report 20. http://www.crisisgroup.org/home/index.cfm?id=4824.

Minear, Larry. 2006. Humanitarian agenda 2015: Colombia country study. Briefing Paper Tufts University. http://wikis.uit.tufts.edu/confluence/download/attachments/14553474/Minear--Humanitarian+Agenda+2015--Colombia+Country+Study.pdf?version=1.

Ministerio de Defensa. 2008. Logros de la Política de Consolidación de la Seguridad Democrática. http://www.mindefensa.gov.co/descargas/Sobre_el_Ministerio/

Planeacion/ResultadosOperacionales/Resultados%20Operacionales%20Ene%20-%20May%202008.pdf.
Ministero de Protección Social. 2008. Plan Nacional de Respuesta ante el VIH/SIDA Colombia 2008-2011. Bogotá: Ministerio de Protección Social.
Universidad de Antioquia. 2005. *Salud y desplazamiento en Colombia*. 13 vols. Nuevas Ediciones.
Pharaoh, Robyn and Martin Schönteich. 2003. AIDS, security and governance in Southern Africa: Exploring the impact. ISS Paper 65.
Roderick, A. 2006. HIV/AIDS and Governance along the corridors of conflict in West Africa. *Conflict, Security and Development* 6 (1): 51–73.
Schneider, M. and Moodie, M. 2002. The destabilising impacts of HIV/AIDS. Washington: Center for Strategic and International Studies. http://www.kaisernetwork.org/health_cast/uploaded_files/Destabilizing_impacts_of_aids.pdf.
The International Conflict Research Group (ICRG). 2002. HIV/AIDS as a threat to global security. Conference. November 8–9, at Yale University. New Haven, United States.
UNAIDS. 1998. AIDS and the military. http://data.unaids.org/Publications/IRC-pub05/militarypv_en.pdf.
UNAIDS. 2003. On the frontline: A review of policies and programmes to address HIV/AIDS among peacekeepers and uniformed services. http://data.unaids.org/Publications/IRC-pub05/JC950-FrontLine_en.pdf.
UNAIDS. 2006. PCB Archive. Joint United Nations Programme on HIV/AIDS. http://www.unaids.org/en/Aboutunaids/Governance/200609-19PCB.asp.
UNDP. 2007. Informe del Coordinador Residente ONU Colombia 2007. http://www.pnud.org.co/img_upload/8a78f0253b88804293c37ee3c3e85737/Informe%20del%20coordinador%20residente%20onu%20Colombia%202007.pdf.
Uppsala University. Conflict Database. 2007. http://www.pcr.uu.se/database/project.php.
Walt, Stephen. 1991. The renaissance of security studies. *International Studies Quarterly* 35 (2): 211–239.

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