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War and HIV in Latin America
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Conflict has shaped the HIV pandemic from its inception, from the spread of HIV-1 in Central Africa, to the diffusion of HIV-2 from Portuguese Africa to the globe. At the same time, the relationship between HIV and conflict has been non-linear and poorly understood. Nancy Mock and her colleagues have been almost the only scholars to propose a model to understand this relationship. Their work suggests that several key variables (such as the time scale of the conflict, the characteristics of the parties involved, and the geographic scale of the fighting) explain wide variations in how warfare appears to have impacted the epidemic, sometimes in surprising ways. As a whole, their effort to create a “social ecology” of HIV and conflict holds great promise, and should be applied to regions beyond Africa, which was their focus.¹ This paper will build on their work by examining the HIV epidemic in Central America and the Northern Andes. In most cases, conflict seems to have limited the spread of HIV in Latin America during the twentieth century, but this now may be changing in Colombia. This experience has policy implications for how international aid organizations and other actors attempt to address HIV in conflict-affected regions.

Latin America in a Comparative Perspective

Latin America has a highly fractured epidemic of HIV/AIDS, with great differences in incidence, prevalence, and transmission from one region to another. Nonetheless, its experience of the epidemic as a whole has differed greatly from that of Africa or South East Asia. Even though on the surface it might appear to have many risk factors for HIV in common with areas with a high prevalence, the virus has not spread in a commensurate manner.² Why not? One possible explanation might be the impact of war. Most African states gained their independence during the period from the 1950s through 1970s. In many cases, independence came only as the result of prolonged conflict with colonial powers. Portuguese Africa was wracked by years of brutal warfare, in countries from Guinea-Bissau to Angola, as five centuries of colonial rule came to an end. In many cases in Africa, the fighting did not cease with independence, because new institutions lacked legitimacy, most nations contained multiple ethnic groups with weak allegiances to the state, colonial borders did not reflect African reality, some armed groups wanted to impose their political programs by violence, and the survival of white ruler regimes did not lay the groundwork for peace. Warfare has also plagued many Asian states now heavily impacted by HIV, such as Cambodia and Myanmar.³ Sadly, in the case of Cambodia it even seems that the epidemic may have been driven in part by the activities of U.N. peacekeepers.⁴ Warfare associated with the drug trade also seems to be contributing to the spread of the virus.⁵

In contrast, Latin America underwent independence in the early nineteenth century. Although extensive violence accompanied this experience (with some exceptions such as Brazil), the region has since come to be perceived as a “zone of peace” in International Relations scholarship. The linguistic, cultural, and religious unity of the region has tended to dampen conflict. Although there are notable exceptions (such as the Paraguayan War, 1865-1870), in general most conflicts within Latin America have occurred within states rather than between them. Most conflicts between states (such as Peru and Ecuador) have been over border issues that led more to skirmishes than sustained warfare. Epidemiologists have demonstrated that there

is a clear correlation between war and the spread of HIV in some African nations, such as Uganda during the overthrow of Idi Amin.⁶ From this perspective, it might seem that the absence of sustained warfare in much of Latin America during the latter half of the twentieth century might help to explain the region's relatively low level of HIV/AIDS. My paper will suggest, however, that this argument is problematic. In part, this is because the impact of war upon HIV is complex and contradictory, as Mott has suggested. Indeed, the experience of HIV and conflict in Latin America perhaps provides us with an opportunity to build upon existing literature on HIV and conflict in Latin America.

From its emergence, the spread of AIDS has been associated with military conflict, which has particularly impacted the HIV rate among women.⁷ Conflicts tend to spread HIV for a number of reasons.⁸ Wars may so weaken national governments that they cannot implement AIDS prevention programs. Rural areas or entire sections of the country may be cut-off from the government's health authorities. For governments struggling to survive HIV/AIDS may not be a priority, and warfare consumes resources that could otherwise be devoted to health education and programs. For people facing daily risks in a war zone, the long term dangers of HIV/AIDS may also not be their immediate concern. During warfare the social order tends to collapse, and many women are put in a position where it is difficult to deny men sex for protection or resources.

Armies at war can also serve to introduce or accelerate the transmission of HIV. In many developing countries the HIV rate among soldiers is higher than in the general population, and may be over 50% in some armies in Southern Africa.⁹ One study that surveyed the region in 2005 suggests that the rates may be significantly higher than even this staggering figure:

Malawi, which has an adult infection rate of 15.96 percent, has an estimated 75 percent of its military personnel infected with HIV. Uganda, which is considered one of the world's success stories for its commitment to combating AIDS and its success in bringing its adult infection rate down to 8.3 percent, has a 66 percent infection rate in its military. This is nearly eight times the infection rate of the population as a whole. In Zimbabwe, estimates show that 80 percent of the military personnel are HIV-positive. Even more amazingly, the Zimbabwean government itself admitted in 1993 that up to 70 percent of its officer corps was HIV positive. Estimates for the South African Defense Forces peg the infection rate around 40 percent, double that of the adult population as a whole. However, there exists a wide degree of variation within that estimate. Some units, such as those in KwaZulu-Natal, have an estimated rate of infection of 90 percent.¹⁰

By the mid-1990s some army units in Thailand had a 10% HIV rate, while in Cambodia the rate reached 30%.¹¹ Historically, most soldiers are more likely to visit prostitutes and to have multiple partners.¹² The movement of soldiers thus presents opportunities for the transmission of the virus. The first appearance of AIDS in Uganda (the African state most impacted by AIDS early in the pandemic) was associated with the Tanzanian invasion that overthrew Idi Amin in 1978-1979. The virus initially infected people in those subcounties through which the victorious troops initially traveled.¹³ In civil wars from Colombia to Kosovo combatants also have used rape as an instrument of terror, which can leave women not only traumatized by also HIV positive.¹⁴

The displacement of large numbers of people also creates opportunities for HIV to spread to new groups. From Africa to South East Asia guerrilla groups have turned to trafficking women to support their activities. Soldiers stationed abroad for peacekeeping may have financial

resources denied to local communities, and have often fueled the sex trade, as has been the case in Kosovo. In Cambodia in the early 1990s UN peacekeepers seem to have contributed to the rapid spread of HIV, which particularly impacted women.¹⁵ High rates of HIV tend to weaken the state, which may lead to social unrest and exacerbate regional conflicts.¹⁶ People subject to violence may not believe that HIV represents their greatest danger, and so undertake risky sexual behavior that would not make sense in a more peaceful context. For all these reasons, it appears obvious that war should fuel an HIV epidemic.¹⁷

The experience of war, however, has not always led to higher rates of HIV. As Laurie Garrett has argued, it appears from a number of cases that war can sometimes have the paradoxical effect of impeding the spread of the virus:

One counter-intuitive effect of warfare, as the recent histories of Angola, Cambodia, Ethiopia, Namibia, Nigeria, South Africa, and Zimbabwe show, is that it can actually reduce the risk of HIV infection. During wartime, civilians either hunker down in their homes or flee war-torn regions and become refugees. Trade grinds to a halt, borders are locked tight, and social mobility is minimized. Consider Angola, for example. For 27 years, it was wracked by a civil war that left the now-peaceful nation in shambles. War, however, largely kept HIV outside Angola, since most forms of trade and travel, both within the country and across its borders, were essentially shut down for three decades. Since the end of the conflict in 2002, Angola's borders have reopened. Peace has brought greater trade— but also an increased HIV infection rate.¹⁸

One can see examples in Latin America of both of war's tendencies, which seem to suggest that warfare alone cannot account for Latin America's distinctiveness.

My paper will focus on the regions of Latin America most impacted by warfare in the late twentieth to early twenty-first century: Central America and the Andes. In the case of Central America, the two nations most impacted by warfare have been Nicaragua and Guatemala. Yet the most serious challenges with HIV in the region have been in Honduras and Panama. In South America the two nations most impacted by warfare have been Colombia and Peru. In the case of the former, the fighting stretches back to "La Violencia" during the 1950s, and seems likely to continue, despite the national government's recent successes against the main guerrilla group, the Revolutionary Armed Forces of Colombia (FARC). In the case of Peru the nation underwent a savage guerrilla conflict in the 1980s, that was ultimately ended by President Fujimori, though at the cost of serious human rights violations. Sadly, the fighting seems to once again be escalating. In both countries the violence has hampered efforts to gather information on the epidemic. Despite our imperfect knowledge, however, the contrasting experience of these four nations suggests new ways of thinking about the relationship between war and HIV.

Conflict in Central America

Central America consists of seven nations, Guatemala, Belize, Honduras, El Salvador, Nicaragua, Costa Rica and Panama. Throughout the Cold War the United States supported the social status-quo in the region as part of an alliance with local elites, in the conviction that all reform movements were associated with Communism. With the large and dissatisfied indigenous population the Guatemala, the extreme social inequality of El Salvador, and the unpopular dictatorship of Nicaragua, this policy contributed to the revolutionary movements and civil wars that wracked the region beginning in the 1970s.¹⁹

By 1979 guerrilla groups were fighting throughout the Guatemalan countryside, while the

military had begun a brutal counterinsurgency campaign that with time evolved into something approaching a race war. In El Salvador the military had long had a key role in the political system. As early as 1970 guerrilla activity had broken out in rural areas, and by the end of the decade the country was in the midst of a true civil war. The government responded with brutal repression that only fueled the insurgency. In Nicaragua a guerrilla movement (FSLN- National Sandinista Liberation Front) had been founded in 1967. In 1972 an earthquake devastated the country's capital, Managua. In the wake of this disaster, most Nicaraguans believed not only that the government had proved ineffectual, but also that President Anastasio Somoza Debayle had stolen much of the funds and supplies donated from abroad for reconstruction. This anger helps to impel a national insurgency that toppled Somoza's government in 1979. The party that emerged in the nation's leadership was Marxist though democratic, and committed to a widespread program of social reforms. President Ronald Reagan of the United States responded by launching a campaign to overthrow the government through the CIA. As part of this program the United States funneled money to a guerrilla army of dissidents -many of whom at first were former Somocistas- organized by the CIA on Nicaragua's northern border in Honduras. At its peak in the mid-1980s this army may have had 15,000 men. In return for hosting the "contras" and U.S. troops Honduras received military aid and training, and Washington's economic support.²⁰

Some Central American countries escaped the violence. Costa Rica had abolished its army in 1949, and gradually adopted social welfare policies that reduced social inequality, provided good quality healthcare, and reduced political conflict. During the civil wars of the 1980s Costa Rica defied Washington, and supported the Nicaraguan government. Belize is an English speaking state that received its independence from Britain in 1981. Even during the 1980s it remained relatively isolated from the political turmoil of its neighbors. Panama's strong man Noriega would ultimately become engaged in a confrontation with the United States that would see President George Bush send the U.S. army to invade the country to capture him, after which U.S. soldiers brought him back to Florida to face drug charges. He was convicted. But the country did not experience a civil war during this period. Nonetheless, the entire region suffered in the warfare and unrest of the 1980s, which generated large numbers of refugees, devastated the economy, and absorbed all the political energies of Central America's leadership.

In the end the violence was brought to an end because of a peace plan generated within the region itself. Costa Rican president Oscar Arias proposed an agreement that all countries involved in the conflict accepted in August 1987. This pact which entailed "a cease-fire, national reconciliation, amnesty, democratization, termination of external aid to insurgent movements, and free elections."²¹ Nicaragua, El Salvador and Guatemala each reached an agreement between the government and the rebels that brought the fighting to an end by 1996, when Guatemala's guerrilla groups laid down their arms. The Sandinistas in Nicaragua lost a free election in 1990 that brought a moderate conservative government into power, which dismantled many of the social programs the Sandinistas had implemented. In El Salvador the dominant right-wing party won election in 1994, which nonetheless saw the party headed by the former guerrillas become a meaningful political party. The transformation within the region is striking, despite the organized crime and drug trafficking that continues to bring violence to Central America.

With its lack of natural resources, relative poverty, extreme inequality, over-reliance on export crops such as coffee and bananas, weak democratic institutions, and frequent outside interventions, Central America has long faced serious challenges. The wars and political unrest

of the 1980s left the region exhausted, with hundreds of thousands of refugees in Mexico and the United States, and serious economic challenges. It was in this context that AIDS arrived in Central America. In 2004 the statistics showed that the incidence was “highest in Belize (2 percent adult prevalence), Panama (1.5 percent adult prevalence), Guatemala (1.0 percent adult prevalence), and El Salvador and Costa Rica (0.6 percent adult prevalence), and Nicaragua (0.2 percent adult prevalence).”²² The history of this disease in this region cannot be understood apart from this history of war, which created migration outside the region, sealed borders and exhausted governments.

One of the most important aspects of warfare is that it seals borders, which in most cases appears to have accelerated the spread of HIV/AIDS. Warfare impedes the ability of UNAIDS and other organizations to acquire accurate information about HIV rates and epidemiology. Danger and chaos also restrict the ability of nongovernmental organizations to educate and pressure governments to act, which has been the case in Burma and the DRC. For this reason in many developing nations at war it is difficult to obtain good information about HIV rates, although it is clear that they are escalating. But in a few rare cases war seems to have had a paradoxical effect, in that it may have isolated some nations from the spread of HIV/AIDS. This appears to have been the case in Nicaragua in the 1980s, during which the Nicaraguan contras conducted warfare along the nation’s border, without penetrating deep into the country, or challenging the local authority of the state. Instead Honduras bore the brunt of the early AIDS epidemic in Central America, which raised the question of how the conflict influenced the epidemic in this country, when the disease took a different path in Honduras’s neighbors.

Honduras and Nicaragua

The AIDS epidemic truly began in Honduras, and it still has the highest rate for Central America. Honduras is also the poorest country in Central America, if not in all of mainland Latin America.²³ It very quickly became the epicenter for the disease. In the last 1990s the country had “only 20% of the population of Central America, but 60% of all the AIDS cases, according to UN officials.”²⁴ Indeed, the sharply higher rates of HIV in Honduras early in the epidemic caused some researchers to worry that there might be something distinctive about the variant of HIV found in the country. Epidemiological research, however, failed to find that an unusually aggressive sub-type of HIV.²⁵ But the statistics remained too striking to ignore. In 1995 Honduras had 4,619 reported cases of AIDS, more than the total of all other Central American nations combined. El Salvador, in second place, had 1,248.²⁶ Terrifying predictions circulated in 1994 that by 2010 one Guatemalan in five might be infected with the virus.²⁷ In some communities, such as the Garifuna people of the northern coast, the rate of HIV was particularly elevated at perhaps one person in fifty.²⁸ This holds with a pattern that has found that in the Caribbean coast region of Honduras and Belize “the epidemic is generalized and affects both urban and rural populations. The Garifuna Afrocentroamerican ethnic group that inhabits this area has been particularly affected.”²⁹ Elsewhere, sex workers in San Pedro Sula were seropositive in 14-21 percent of cases.³⁰ Given that the country had a common language, history, culture and geography with its neighbors, what could account for these rates, if the figures were accurate?

One common argument was that the virus had been introduced either by U.S. troops, or by the large numbers of contra fighters. Some local academic leaders pointed to the fact that the presence of U.S. troops had created a huge industry in the sex trade:

According to Juan Almeyda, a US-trained Honduran doctor and former Rector

of Honduras National Autonomous University, the presence of foreign troops in Honduras has created or exacerbated some serious health problems. To escape from poverty, thousands of Honduran girls have become prostitutes. In the city of Comayagua (near the US military base of Palmerola) there are an estimated 3000 prostitutes, about 60% of the total number of prostitutes in the whole country. This high level of prostitution has contributed to a pronounced increase in sexually transmitted diseases, including penicillin resistant gonorrhoea. Teachers in Comayagua have noted venereal sores even in primary school children.

Honduras also has the highest number of people with AIDS in Central America.³¹

This was more than the opinion of a single academic. One study identified “a special group of women that don’t consider themselves sex workers, but who attended to the soldiers at the Palmerola base in the city of Comayagua. The majority of them are very young, many of them students that live in Comayagua or that come to this city on the weekends and meet with the North-Americans in discotecas and restaurants that have restricted access.”³² Another study argued that U.S. soldiers had been “of the ports of entry of the infection (AIDS) through the troops of the United States stationed at the military base of Palmerola. . .” and surveyed sex workers in the city of Comayagua. Of 65 prostitutes, ten proved to be HIV positive in 1990.³³

Based on this evidence, the rapid spread of the disease could have been caused by Honduras’ unique position as a station point for U.S. troops and CIA forces during the civil war. This might explain the rapid spread of the virus, and the fact that the disease so quickly became dominated by heterosexual transmission. The first reported AIDS case in Honduras in 1985 was a man of “bisexual conduct who had lived in San Francisco, California.”³⁴ Yet he was exceptional because from the very start the Honduran epidemic was dominated by heterosexuals. Indeed, what has always been striking about the Honduran epidemic is that the percentage of cases made of gay men always been so low. As early as 1993 gay men accounted for no more than 7.1% of all cases among men in the country, while heterosexual men accounted for 71.2%.³⁵ It was not that the infection rate among gay men was unusually low. One study reported in 2003 that 13% of all men having sex with men were HIV positive in Honduras. For transvestites the figure was 23.5%³⁶ But they were not the majority of people infected. Sex workers seem to have been more important in the spread of the virus. In 2003 over 10% of all sex workers were infected with HIV.³⁷ Half of all men who were infected in the early 1990s reported having used the services of prostitutes.³⁸ If this was the case, was it possible that U.S. policy contributed to the AIDS epidemic not only in Honduras, but also elsewhere in Central America? One author, D. Summerfield, presented this argument in the *Lancet* in 1991:

There are striking variations in AIDS case detection rates between the countries of the Central American isthmus, and the politics of this troubled region seem to have been playing a part. By the end of August, 1990, Honduras had reported 626 cases to the World Health Organization (WHO), El Salvador had reported 192, Panama 180, Costa Rica 169, Guatemala 80, and Nicaragua only 8. Analysis of World Bank and other data suggests a correlation between the number of known cases in each country and the extent of military and economic aid delivered by the US during the 1980s, measured in terms of dollars and by the numbers of US military and other personnel stationed there.³⁹

Many questions, however, remain with this argument, as the Honduran case makes clear.

The geography of the virus does not seem to match clearly with the hypothesis that the

epidemic emerged around U.S. military bases and the contra staging points. From the start the disease focused on the two main cities of San Pedro Sula and Tegucigalpa, which between them accounted for more than half of all reported AIDS cases. During the period from 1985 to 1993 San Pedro Sula reported 1004 cases of AIDS, while Tegucigalpa reported 371 cases out of the 2,510 identified in the country. Comoyagua, the fourth largest city in the country, reported 58 cases.⁴⁰ It hardly seemed an epicenter for the disease. Some specialists argued AIDS was introduced into San Pedro Sula “by Caribbean sailors long before there were military maneuvers on U.S. bases in the west of the country.”⁴¹

The idea that the contra army might have been an instrument spreading the virus in Honduras has also been undercut by the Nicaraguan experience. With the end of the war the contras were repatriated and reincorporated into Nicaraguan society. But this failed to bring with it a sharp rise in the incidence of HIV/AIDS, in part because careful study proved that few contras were infected:

It has been feared that the return of large numbers of Nicaraguans from countries where HIV and AIDS are more prevalent than in Nicaragua could have a significant impact on the development of the AIDS epidemic. Sera collected from Nicaraguan refugee camps in San Salvador during 1984 revealed no cases of anti-HIV seropositivity in 182 samples. In Nicaragua, testing for antibody to HIV was performed during the process of demobilization and repatriation, but coverage was not complete because of the voluntary nature of testing and intermittent lack of testing kits. Of the 6002 Contras screened, only one had confirmed HIV infection. Around 13,000 people have been officially repatriated from Honduras, half of whom are less than 15 years of age. Four adults, two men and two women, who reported themselves as heterosexual have been found to be seropositive.⁴²

The geography of the contra camps also did not match the areas with high incidence of HIV. As Nicola Low and her colleagues noted about “60% of the people with AIDS in Honduras are from the seven largest cities and towns in central and north western Honduras. Contras and their families lived in rural towns and military camps on the southern border with Nicaragua, where the impact of AIDS has been less.”⁴³ The Honduran AIDS epidemic began in the north, while the Contra camps lay in the south.⁴⁴ The return of the Contras proved not to bring a major AIDS epidemic to Nicaragua.

Indeed, Nicaragua’s HIV rate remains the lowest in Central America, despite the rapid privatization of the health care system after the Sandinistas lost an election in February 1990. In less than three years after the Sandinistas left power the funds for public health “declined by 40 percent, in line with a Structural Adjustment Plan imposed by the International Monetary Fund.”⁴⁵ In 1995 Nicaragua was “the poorest country in Central America and its economy was continuing to deteriorate.”⁴⁶ The general level of AIDS education and awareness in Nicaragua in the early 1990s was not high, as “over 40 percent of adults in Managua think that HIV can be spread through public toilets, by sharing drinking vessels, or by mosquitos.”⁴⁷ There have been concerns that the confidentiality of test results in Nicaragua was not maintained. The Ministry of Education opposed handing out condoms in schools because it might lead to promiscuity. The Catholic Church in Nicaragua also fought hard against condom use. Government officials criticized homosexuals, while the “Minister of Health himself recently claimed that AIDS was not an issue for Nicaraguans, only for foreigners.”⁴⁸ For all these reasons, Nicaragua would have appeared to be a country terribly vulnerable to HIV/AIDS.⁴⁹

Despite these facts, the first case of AIDS did not appear in Nicaragua until 1987 and in 1994 “Nicaragua had the lowest number of cases of HIV/AIDS in Central America and the lowest prevalence and incidence of HIV/AIDS in Latin America.”⁵⁰ In 1995 the nation had reported 117 cases of AIDS.⁵¹ The disease largely remained confined to the capital of Managua, which had 57% of the total cases.⁵² In 2003 UNAIDS reported that the HIV seroprevalence rate among adults was 0.2%.⁵³ One study in 2003 has found that the HIV rate among commercial sex workers was only 0.3%, and in the capital the rate was 0%.⁵⁴ Given the similarities between Nicaragua and its northern neighbor Honduras, this continuing low level of HIV infection appears mysterious. One argument has been that isolation imposed by the war may explain the Nicaragua’s low rate of HIV/AIDS:

The relationship between rates of AIDS cases and U.S. involvement in the countries of Central America suggests that the ten years of low-intensity warfare raged by the United States against Nicaragua delayed the arrival of HIV. This effect is in direct contrast to observations of the spread of the virus in Central and Southern Africa. In Uganda, which has the highest number of AIDS cases in Africa, recruitment practices and subsequent troop movements explain much of the variation in AIDS case rates among districts. Social disruption and the growth of prostitution around military camps are proposed as factors that will propagate HIV infection in countries such as Mozambique and Angola with have had low intensity wars. Nevertheless, the incidence of AIDS in these two countries is currently much lower than in central Africa and it could therefore be argued that, as in Nicaragua, the entry of HIV has been delayed by the isolation experienced by these countries.⁵⁵

The civil wars of Central America in the 1980s do seem to have shaped the epidemic, but not in the manner that might have been expected. The two countries in the region that currently have the highest rate incidence of HIV are Panama and Belize, neither of which experienced the years of warfare that their neighbors endured in El Salvador, Nicaragua and Guatemala.⁵⁶

The connection between warfare and AIDS in Central America remains complex. It is unclear if U.S. soldiers helped to introduce the virus to Honduras, although if that was the case there should have been more infections in the areas where the troops were stationed. The U.S. military also monitors HIV rates among servicemen and women and there have been no studies indicated a high incidence of seropositivity among troops stationed in Central America. One of the most mysterious aspects of AIDS is its ability to devastate one country such as Honduras, while a statistically and culturally similar neighbors escapes its wrath. There is no clear explanation for why the HIV/AIDS epidemic in Honduras emerged so early, or cut such an aggressive path through the population of young heterosexuals.⁵⁷ It seems likely, however, that war not only isolated Nicaragua from the virus for a decade (it still has the lowest rate in Central America) but also may have slowed the virus’s spread elsewhere in the region. Other nations heavily affected by the fighting, such as El Salvador and Guatemala, were less impacted by HIV than nations at peace, such as Panama and Belize. It is unclear how long this influence will continue to last as new forces, such as migration to the United States and Mexico, shape the current course of the epidemic.

The Andes

While Central America underwent serious conflict in the 1980s, similar struggles became particularly bitter in the Andes during the same period, and stretched into the following decade.

Much like the civil wars in Central America and Southern Africa during the 1980s, this instability and violence in the Andes may have initially served to isolate these countries and delay the initial spread of HIV, although the Colombian experience suggests that this may not hold true for the future.

Colombia likely has the bloodiest history in twentieth century South America. At the end of the War of a Thousand Days (1899-1903) the country had lost over a 100,000 lives, and was too exhausted to withstand U.S. expansionism. President Theodore Roosevelt supported a political revolution in Panama in 1904 that created a new nation, so that the U.S. could build a canal across the isthmus. While the bitterness over this loss fed nationalist sentiments in Colombia, the nation remained polarized between the liberal and conservative parties. When the head of the liberal party, Jorge Eliecer Gaitán, was murdered in Bogotá on April 9, 1948 it sparked massive riots, and widespread violence in the countryside killed perhaps 300,000 people before 1957. In some sense, the violence never truly ended. President Alvaro Uribe came to power in May 2002 and implemented an aggressive military policy to defeat the guerrilla insurgency, with support from international donors of which the United States is the most important. Not only has the government had to fight powerful guerrilla organizations such as the FARC, which date back to the 1960s, but also right wing para-military organizations, founded in the 1980s. The ensuing conflict has created a society that suffers from random violence, widespread kidnappings, internal refugees, and political terror.⁵⁸

All of these problems have been exacerbated by the drug trade. Colombia has a tradition as a smuggling center that dates back to the colonial period, when it was a source for black market emeralds. With the rise of cocaine during the 1970s, Colombians moved to dominate the distribution of this product. According to the U.S. government Colombian “traffickers still provide 90 percent of the cocaine used in the United States and 50 percent of the heroin. . .” although much of the raw product may be created in Peru or Bolivia.⁵⁹ During the early 1990s, the Colombian state first fought and won war with drug lord Pablo Escobar, then managed to cripple the Cali cartel. This was a terrifying period in Colombian history, when Escobar exploded car bombs outside government buildings in Bogotá in order to break the will of the state. Pablo Escobar’s death in 1993 was a victory for the government, but it failed to end Colombia’s civil war. New drug lords not only continued to smuggle increasing amounts of cocaine, but also to corrupt senior government officials. In part because drug traffickers contributed to President Ernesto Samper’s election campaign, the U.S. twice decertified Colombia under the Foreign Assistance Act during the 1990s.⁶⁰

The Colombian government’s struggle with its enemies has been made much more difficult by the fact that the drug lords have complex ties to all political actors in Colombia, which make a military solution to the conflict elusive.⁶¹ The Colombian military claims that it needs U.S. aid to fight the guerrillas, whom it alleges are in alliance with the drug lords. In March 1998 General Harold Bedoya Pizarro, former chief of the armed forces, stated that the armed forces were the only part of the state untouched by the drug trade.⁶² Moreover, he argued that the guerrillas were in fact in the cocaine business. Reputedly, the guerrillas received \$600 million a year for guarding drug crops in their territory. General Fernando Tapias, then commander of the Colombian armed forces, made a similar argument in July 1999, when he claimed that the rebel’s drug wealth gave them an advantage over the military. For this reason, he argued that Colombia needed U.S. support to fight the drug wars.⁶³ The Colombian army has successfully employed this argument to justify requests for US military aid into the new

millennium, by equating the guerrillas they fight with the drug trade the US opposes. The challenge for the government, however, has been that factions of the armed forces are also involved in the cocaine trade, both directly and in alliance with para-military organizations.

Paramilitary groups are generally led by large land-holders, such as ranchers, who are particularly powerful in northwestern Colombia. Some of these organizations have turned to drugs to finance themselves, according even to U.S. officials. A series of scandals suggest that senior generals have links not only with the paramilitaries but also with the cocaine trade. President Samper survived an impeachment attempt following allegations that he accepted campaign funds from drug lords. Then, on a 1996 trip to New York, his presidential jet was found to hold four kilos of cocaine, which led to the arrest of three air-force officers. In November 1998 a Colombian C-130 air-force plane landed in Fort Lauderdale, Florida with 600 kilos of cocaine.⁶⁴ The security chief for the air-force base in Bogotá was arrested, along with several other members of the air-force. General Jose Manuel Sandoval, the Minister of the Air-Force, resigned after denying the existence of a “blue cartel,” a reference to air-force involvement in drug smuggling. In March 1997 even the Colombian defense minister, Guillermo Alberto Gonzalez, had to resign after revelations concerning his ties to a drug trafficker.⁶⁵ Of course, some time has passed since these embarrassing revelations. President Alvaro Uribe has a reputation for honest administration and ruthless will that has served him well in the struggle with guerrillas and the drug lords. But the narcotics trade remains a national problem.

Despite the more than three billion dollars that the United States has spent on Plan Colombia (an effort to strengthen the Colombian state and attack the drug trade) cocaine production in Colombia has not declined. Massive aerial spraying of weed-killer on coca plants has not put a dent in exports, which supporters of this policy term a “paradox,” but Colombians explain in practical terms: “General Jorge Daniel Castro, director of the Colombian national police and one of Colombia’s primary experts on the issue, described the Plan Colombia drug-enforcement paradox as a ‘complex phenomenon’ but added when pressed that he believed the traffickers were simply replanting the coca and opium plants almost as soon as the spray planes left.”⁶⁶ In 2008 and 2009 the FARC underwent a series of devastating blows, including the death of its leader, the lost of leading hostages, and the discovery of a key base. Still, the FARC has not yet been overcome, the paramilitaries remain, and the struggle seems likely to continue for years to come.

Colombia and HIV

The social upheaval caused by violence and the drug trade has created conditions that can facilitate the virus’s spread. Research has found that the HIV rate is significantly higher among people who have been forced to flee their home areas because of the fighting: “In Sucre and Cordoba it has been found that one out of every 100 displaced people is living with HIV. Research into these areas is in its infancy in its country. Ricardo Garcia, UNAIDS adviser in Colombia says that there is almost a direct relationship between the spread of the virus and the conflict.”⁶⁷ For this reason, the Global Fund to Fight AIDS, Tuberculosis and Malaria is focusing its funding on Colombia on displaced persons: “The overall goal of the project is to reduce the vulnerability of 600,000 adolescents and youths to STIs, HIV and AIDS, in 86 localities in 48 municipalities involved in situations of forced displacement. . .”⁶⁸ This international initiative will bring much needed resources to the problem, but the ongoing violence hampers HIV prevention activities in many respects.

The violence has discouraged foreign researchers from collaborating with their

Colombian counterparts. There are few multinational researchers conducting studies in Colombia. Current information suggests that the HIV rates are not high, but they are rising. In 2003 the BBC News service published a report that 240,000 people had been infected by the virus, which “means that HIV is present in the blood of one of every 175 Colombians: 0.6 per cent of the population. It is the fifth leading cause of death in the working-age population, according to DANE Administrative Department of statistics. The most troubling issue is that the rate of infection is not slowing down but accelerating.”⁶⁹ Despite gaps in the statistical analyses of the epidemic in Colombia, the latter fact seems to emerge as a consensus point. The HIV epidemic is also increasingly impacting women: “In the beginning there was one HIV-positive woman for every 20 men, but today the proportion is almost one out of two. In ten years there will be gender equity. The Atlantic Coast and Norte de Santander department have already anticipated this move.”⁷⁰ Overall, the government response to this effort has not been adequate, despite some impressive activities in some departments, as UNAIDS has noted: “The National AIDS Council (NAC) was formed in 1997 as the main governing body to deal with HIV/AIDS, but it has not been functional and met only twice during 2003. In the second half of 2003, a review and evaluation of the National Strategic Plan was conducted. According to this evaluation, only 38% of planned activities were executed, and only 36% of the necessary financial resources were allocated.”⁷¹ To address this problem may require not only international resources, but also pressure upon the Colombian government to make HIV a priority.

The work of Teo Ballvé suggests the difficulties that people working to fight HIV have faced:

A few months before Myrian Cossio’s 20th birthday, in San José del Guaviare, a bustling frontier town deep in Colombia’s tropical lowlands, armed men forced her into a car. She immediately knew they were from one of the here armed groups fighting in Colombia’s decades-long civil war- army, paramilitary and guerrillas. They took her to the town’s outer limits and put a gun to her head. “We know you have AIDS, and we know you work with those whores and faggots, they told her. She had twenty four hours to leave town, or they’d kill her.”⁷²

Cossio’s history, sadly was not unique. In another case one HIV worker was asked for the names of all HIV positive people in the area by paramilitaries, presumably so they could be killed. The HIV worker fled rather than comply. He then tried to continue his work in Bogotá, only to again face threats to his life. He fled the country and sought asylum in Canada.⁷³

Both the paramilitaries and the guerrillas have persecuted HIV workers, used sexual violence as a political tool, and run brothels: “Paramilitaries and guerrillas have also discovered that brothels are effective intelligence gathering sources, often forcing prostitutes to extract bits of information from enemy clients.”⁷⁴ There are examples of homophobia and violence against gays by the United Self-Defense Force of Colombia (AUC), which seem to suggest that homophobic violence is a common part of the conflict.⁷⁵

In addition, Ballvé points out that the combatants are themselves at risk of HIV, because they are young, poorly informed, and away from their families. The military found and released the diary of Tanja Nijmeijer, a FARC guerrilla, which contained this entry for June of 2006: “I almost forgot the big news. Two comrades have HIV and there may be more. No one here uses contraceptives. The girlfriend of one of them has no idea what it means.”⁷⁶ Statistically, Colombia still has a relatively low HIV prevalence.⁷⁷ But all of these factors create serious

questions about the future.

Peru

Peru underwent a similarly bitter history. The Communist Part of Peru, better known as the Shining Path, began a conflict in 1980, which brought the nation to the brink of collapse. In 1992, however, the government captured the movement's leader, and the Shining Path appeared to be overwhelmed by 2000. The nation moved from a period of immense turmoil to one of greater stability. This may have assisted the nation's response to the HIV epidemic. Much of our information on this country comes from history of AIDS in Peru by Marcos Cueto. His work describes how, after an initial period of apathy and hysteria, the Peruvian state and society responded well to HIV, even though the disease appeared "during the hard years of hyperinflation, misgovernment and political violence."⁷⁸ Cueto and others have argued that, ironically, social and political misery may have delayed the onset of the epidemic. Many well to do, urban gays –who were the first group impacted by HIV elsewhere in Latin America– emigrated abroad given harsh conditions within the country. Perhaps more important, Cueto and others have suggested that the fear of political violence probably also limited tourism, which may have delayed the initial spread of the epidemic.⁷⁹ Peru has faced numerous challenges. It initially emphasized testing over treatment, and the government's commitment to fighting HIV has been questioned. In 2007 the Peruvian government closed tens of blood banks, after it became clear that four people were infected with HIV in the port city of Callao, because blood was not being screened.⁸⁰ Each infected person received \$100,000 compensation check in 2009, but the Pan American Health Organization estimated that one quarter of the blood supply in Peru was not being properly screened.⁸¹

On the surface, the Peruvian epidemic appears to continue on the same path as its other Andean nations, in which it is largely concentrated amongst men having sex with men. Perhaps 18.5% of the men who have sex with men were HIV positive in Lima in late 2005.⁸² According to UNAIDS, in 2007 Peru had between 57,000 and 76,000 people living with HIV, of whom approximately 21,000 were women. Only 11,000 people were receiving antiretroviral medications.⁸³ This figure matches the statement of José Sebastien, the national coordinator of the government's HIV prevention and control effort, who stated in 2008 that only 10% of people living with HIV in Peru were receiving medications."⁸⁴ Clearly, much work remains to be done, even in the urban areas where we have more information. In particular, the gay community in Peru remains weak, poorly organized, and continues to face intense stigma.⁸⁵

It remains difficult, however, to evaluate the course of the epidemic in rural Peru, in part because of the worrying increase in violence, and the resurgence of guerrilla fighting. This is particularly the case in southern Peru, where the Shining Path is rebuilding, allegedly in alliance with cocaine producers and traffickers. The movement seems less brutal, however, during the 1980s, in part because it has decided that such violence was counterproductive.⁸⁶ At the time of this writing, the scale of the violence is a far-scale from the violence of the late 1980s and early 1990s. Nonetheless, the Shining Path has reemerged, there are guerrilla conflicts and military operations, and it will remain difficult to conduct HIV support and outreach in rural areas. Unsurprisingly, most of the work done on HIV has an urban focus, usually in Lima, Callao or Iquitos. We can assume that the disease is not spreading widely in the countryside, but the sentinel surveillance at this time needs considerable resources to improve. Although our data is quite imperfect, though, it still appears that the HIV epidemic in Peru is relatively low compared to some other Latin American countries, and that HIV has not exacerbated its spread.

Conclusion

Generalizing about the diverse experience of Latin America is challenging, but a number of common themes seem to emerge. In each of the cases we have discussed, the conflicts involved were civil wars or insurgencies, with the sole exception of Nicaragua. In this case, however, even though the combatants were financed by the United States, and included significant numbers of mercenaries, it is probably accurate to say that a majority of the fighters were Nicaraguans, who were based in Honduran camps just over the border. In this respect, the conflict in many respects resembled a civil war in which external actors provided support (money and bases) to one party. In neither Central America nor the Andes were these wars between states. In every case guerrilla warfare, rather than conventional fighting, characterized these wars. These conflicts were also of long-duration, and focused on the countryside, despite such counter-examples as the FARC's campaigns in Bogotá, or the Shining Path's efforts in Lima.

All of these conflicts have been characterized by violence against civilians, human-rights abuses, and the mass displacement of populations. In every case, conflict has worked to isolate these nations from tourism and trade. This may explain the relatively slow spread of HIV in each of these nations early in the epidemic. What is surprising is that the end of the fighting in some nations has not witnessed an explosion in the HIV rate, as has happened in some African nations such as Angola. The case of Colombia is unusual both because the conflict has continued almost without interruption, and because many parties to the fighting appear to have targeted HIV prevention workers and leaders in the gay community. At the national level, Colombia's epidemic still remains limited, but it is difficult to know what is taking place in the countryside. Still, the picture throughout the region appears to be relatively consistent, in that conflict appears not to be associated with higher rates of HIV. In the future, it would be useful to apply the model of Mock and her colleagues to multiple regions, including South East Asia, as part of an effort to further develop our understanding of the key variables. Based on their work, is it possible to create a model that can have predictive value, or which can help us to understand how to mitigate the harm that conflict inflicts on the health of populations?

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- ¹ Nancy B. Mock, Sambe Duarte, et al., “Conflict and HIV: A framework for risk assessment to prevent HIV in conflict-afflicted settings in Africa,” *Emerging Themes in Epidemiology* (2004) 1:6, 1-16.
2. For a brief description of Asia’s epidemic see Barnett and Whiteside, 14; Irwin, Millen and Fallows, 8-10
 3. Beyrer, 57-58, 140-146.
 4. Beyrer, 63-65.
 5. Beyrer, 197-203.
 6. Smallman-Raynor, 550-563; Hooper, 42-51, 767-771.
 7. Beyrer, 198-199.
 8. Irwin, Millen and Fallows, 35-37; see also Elbe; and Mock, et al; the latter work is a careful study that creates a useful typology of the factors in war that influence the spread of HIV, and suggests that the character of the conflict may be important to this process.
 9. Irwin, Millen and Fallows, 36.
 10. Youde, 199.
 11. Beyrer, 140, 145.
 12. World Bank, *Confronting AIDS*, 161.
 13. Hooper, 42-51.
 14. For examples of the use of rape as a weapon (and even the intentional transmission of HIV) see Youde, 200.
 15. Beyrer, 63-65.
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 17. Elbe. Garrett, “The Lessons of HIV/AIDS,” 54-56. Beyrer, 198-199; Irwin, Millen and Fallows, 35-37.
 18. Garrett, “The Lessons of HIV/AIDS.” 57.
 19. For a history of these uprisings and their origins see LaFaber, *Inevitable Revolutions*.
 20. Booth and Walker, 50, 70-71.
 21. Paris, 112.
 22. www.usaid.gov/our_work/global_health/aids/countries/lac/caregion.pdf, accessed on April 20, 2003.
 23. “Honduras,” *Mesoamérica*, vol. 21:12 (December 2002), 4.
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 26. “AIDS in Central America: ‘95 Update,” *Mesoamérica*, vol. 15:1 (January 1996), 3. A year earlier Honduras’s figures had been even more striking. See Van Wichen, 11.
 27. “Honduras: AIDS’ Rapid Growth,” *Mesoamérica*, vol.13:5 (May 1994), 10.
 28. Trujillo, 31.
 29. www.usaid.gov/our_work/global_health/aids/countries/lac/caregion.pdf, accessed on April 20, 2003.
 30. Trujillo, 34.
 31. Chelala, 154.

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32. AIDSCAP, 17.
 33. Zapata, N. et al, 23. For more on the presence of U.S. military forces as a possible source for the virus see Low, et al., "AIDS in Nicaragua," 697.
 34. Mendez Ordoñez, 8.
 35. Figueroa, 10. See also Figueroa, 70. It still remains true that the gay community was heavily impacted with more than a third of gay men in the city of San Pedro Sula testing positive for HIV in the mid-1990s. Trujillo, 36.
 36. Estudio Multicéntrico Centroamericano de Prevalencia de VIH/ITS y Comportamientos en poblaciones específicas en Honduras, www.pasca.org/estudio/informes/ni/revista_emc_ho.pdf accessed on April 14, 2003, 5.
 37. Estudio Multicéntrico Centroamericano de Prevalencia de VIH/ITS y Comportamientos en poblaciones específicas en Honduras, www.pasca.org/estudio/informes/ni/revista_emc_ho.pdf accessed on April 14, 2003, p. 3.
 38. Figueroa, 17. See also Trujillo, 21.
 39. Summerfield, 967.
 40. Figueroa, 66. For maps of AIDS' prevalence in Honduras see Trujillo, 25-26.
 41. Mendez Ordoñez, 9. For a careful breakdown of AIDS cases by city in Honduras see Mendez Ordoñez, 55. See also Figueroa, 61. For a brief analysis of the epidemiology of the Honduran AIDS epidemic see "Antecedentes de la epidemia en Honduras," www.pasca.org/nograficas/situacion/antecedentes.honduras.pdf. Accessed on April 20, 2003.
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 43. Low, et al., "AIDS and Migrant Populations in Nicaragua," 1593.
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 45. Low, et al., "AIDS in Nicaragua," 688. For a highly critical look at changes to the Nicaraguan health care system after the Sandinista defeat see Hopkinson and Chalmers.
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