International Peacekeeping and Public Health: HIV/AIDS and International Peacekeeping in the Mano River Basin

BY

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An original research presented to the University of Ghana, Legon, in partial fulfillment of the requirements for the award of the Master of Arts Degree in International Affairs

August 2003
DECLARATION

I, Samuel Otis Konotire Bel-Nono, hereby declare that this Dissertation is the product of an original research conducted by me under the supervision of Professor Ebenezer Laing of the University of Ghana. No part of it has been submitted anywhere for any purpose, and I have tried in as much as I could to acknowledge all sources of information for my work.

Date: September 2003

SAMUEL OTIS KONOTIRE BEL-NONO

Date: June 25, 2004

Professor Ebenezer Laing
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SSA – SUB-SAHARAN AFRICA  
STDs – SEXUALLY TRANSMITTED DISEASES  
STIs – SEXUALLY TRANSMITTED INFECTIONS  
TB – TUBERCULOSIS  
TCC – TROOP CONTRIBUTING COUNTRIES  
TCM – TRADITIONAL CHINESE MEDICINE  
TOR - TEMSA OIL REFINERY  
UK – UNITED KINGDOM  
UN – UNITED NATIONS  
UNAIDS – UNITED NATIONS AIDS  
UNAMSIL – UNITED NATIONS MISSION IN SIERRA LEONE  
UNDP – UNITED NATIONS DEVELOPMENT PROGRAMME  
UNESCO – UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION  
UNFPA – UNITED NATIONS FUND FOR POPULATION ACTIVITIES  
UNHCR – UNITED NATIONS HUMANITARIAN COMMITTEE ON REFUGEES  
UNOMIL – UNITED NATIONS OBSERVER MISSION IN LIBERIA  
UNLA – UGANDA NATIONAL LIBERATION ARMY  
USIP – UNITED STATES INSTITUTE OF PEACE  
VCT – VOLUNTARY COUNCILLING AND TESTING  
VRA – VOLTA RIVER AUTHORITY  
WHO – WORLD HEALTH ORGANIZATION  
WW1 – WORLD WAR 1  
ZAMBATT – ZAMBIA BATTALION
ABSTRACT

War has long been associated with disease outbreaks. This results as a consequence to the destruction and breakdown of health facilities and environmental conditions, the creation of humanitarian crisis, abuse of the rights of war-affected people, and the role of combatants as well as peacekeepers. The role of peacekeepers has come under scrutiny in recent times for the spread of communicable diseases, especially with the emergence of the Global Medical puzzle, HIV/AIDS, one of sexually transmitted diseases for which military personnel are known to be a high-risk group, and which Medical science continues to battle to find a solution to. The emergence of such diseases as Ebola and the Severe Acute Respiratory Syndrome (SARS) adds to the confusion and drama in the Medical Research Laboratories while the International Community panics with each peacekeeping mission dispatched to one of the conflict regions on the globe.

Yet the period after the Cold War witnessed an upsurge of conflicts and civil wars particularly in sub-Saharan Africa. Two of such conflicts were those fought in Liberia and Sierra Leone. These two conflicts led to the deployment of the sub-regional response force, ECOWAS Monitoring Group (ECOMOG) that entered first into Liberia and later into Sierra Leone, before it was absorbed by the international body.

Thousands of United Nations peacekeeping troops were deployed in the Mano River Basin, rising from 10,000 in Liberia in the early 1990s to over 16,000 in Sierra Leone in October 1999, making United Nations Mission in Sierra Leone (UNAMSIL), the largest
UN Mission in the world. The introduction of such a large force into the Mano River Basin (MRB) was bound to have serious public health repercussions on the host countries and the countries contributing the troops.

This study examined International Peacekeeping in the context of public health, looking at HIV/AIDS vis-à-vis peacekeepers and the implications on both the host countries and the troop contributing countries. The study found that of the over 16000 peacekeepers in the MRB, 32% came from countries with prevalence rates more than 5%. Although Ghana claimed that the prevalence rate among her troops returning from MRB was below 2%, the prevalence rate among Nigerian troops returning home was over 11%. A study among the Nigerian troops returning home showed that the risk of infection increased with the number of years spent in the basin.

It was noted that one of the most important factors for monitoring soldiers going into peacekeeping operations was the cost of pre- and post-operational screening tests. However, this cost is a barrier for most countries in sub-Sahara Africa. It was therefore recommended that the UN re-imburse troop contributing countries for these screening exercises. It was also recommended that only troops free of infection should be deployed in peacekeeping missions and there was the need for the integration of sub-regional health planning and research. The military should cooperate with civil health planners on the HIV/AIDS control and preventive measures. It is also important that health management in peacekeeping missions should incorporate local programmes.
INTRODUCTION

CHAPTER ONE

1.1. Background to the Problem. War has long been associated with disease outbreaks among both combatants and the population with whom they come into contact. According to Stephen Talugende, during the 12th century Crusades, bubonic plague and famine reduced one Christian army from 100,000 to 50,000. In 1741, the Austrian army surrendered Prague to the French because 30,000 defenders had died of typhus. During the Napoleonic wars, four French soldiers died of disease for every soldier killed in action. World War 1 (WW1) may have been responsible for the great flu pandemic of 1918 that killed at least 40 million people.¹

Records of past mortality and morbidity reports from the early part of the 20th century, have shown evidence in the years preceding the 1918 pandemic of sentinel outbreaks at training camps and barracks in the UK. Many young soldiers succumbed to a pneumonic like illness, rapidly dying after a short time. The barracks with their dormitory-like buildings were ideal for disseminating air borne diseases. When these young men came in contact with other soldiers at the front, the virus spread and mutated, becoming even more virulent. When the soldiers left the front line and returned home, they brought back more lethal forms of the bug and re-introduced it into the civilian population.² In recent times, in Uganda’s people’s war, more soldiers died of diseases such as dysentery, malaria and HIV/AIDS than those killed in action. It has been suggested that 65% of infectious diseases occur in unstable countries.³
Conflict brings economic and social dislocation, including the forced movement of refugees and internally displaced people, and resulting loss of livelihood, separation of families, collapse of health and education services, and dramatically increased instances of rape and prostitution. It removes the protection for women, children and the aged in society. The men folk are either killed, drafted into the combatant groups, or flee. This exposes the women to sexual exploitation including rape, as they are often taken as legitimate part of the spoils of war. According to Dr. Manual Carballo, over 300,000 women were raped during the Rwandan civil war. Also as a result of war, poverty and chaos force many women into sex work and prostitution, giving rise to the spread of sexually transmitted diseases/infections, including HIV/AIDS. The invasion of forests and wild animal habitats by combatants and fleeing people, dislocate these animals near to or within human populations and this may introduce some of these animal diseases into both human and domestic animal populations, some of which could be of zoonotic significance.

The crisis of conflicts often calls for peacekeeping under regional arrangement or the international body to try to resolve and mitigate the impact of the myriad of problems on the population. Peacekeeping is one of the biggest instruments of the United Nations today. The international community’s growing commitment to peacekeeping and post conflict development has meant a dramatic growth in deployment of military personnel from different parts of the world. According to the Under-Secretary-General for Peacekeeping operations, Jean-Marie Guehenno, there are 38,000 to 50,000 deployed worldwide. Yet military personnel risk contracting or spreading diseases, whether deployed as belligerents or peacekeepers. Intervention or peacekeeping forces are therefore increasingly involved in controversies bordering on economic exploitation and the spread of communicable diseases among both host nations and the troop contributing countries (TCCs). International and
national uniformed services, including peacekeepers, peace observers, national and civil
defence forces, generally rank among the population groups most affected by STIs including
HIV/AIDS. STI infection rates among these categories are 2 – 5 times higher than in the
general populace and in times of conflict, could be as much as 50 times.\footnote{6}

Several Sub-Saharan African countries and many others in Eastern Europe, Asia and Latin
America have been embroiled in conflicts, especially, after the end of the Cold War. These
conflicts, mostly brutal, genocidal and intra-state in nature, often call for outside military
intervention to try to resolve. According to a special report by the United States Institute for
Peace (USIP), the decade of the 1990s witnessed a steady climb in violence across sub-
Saharan Africa, with the number of states at war or with significant lethal conflicts doubling
from 11 in 1989 to 22 in 2000.\footnote{7} The Great Lakes Region of Central and East Africa
witnessed the genocide in Rwanda in 1994, and in the war that followed; the Hutus were
forced into the jungles of the Democratic Republic of Congo where the deadly Ebola virus
was first isolated in 1975. The Horn of Africa saw a post-Siad Barre’s Somalia degenerate
into a failed state, and Eritrea emerged out of Ethiopia after a bitter war.\footnote{8}

It is from this viewpoint that the peacekeeping missions in Liberia and Sierra Leone, be they
ECOMOG or UNAMSIL, have often been seen as a double-edged sword, keeping the peace
and spreading diseases. The flames of conflict that led to the introduction of peacekeepers in
the basin, was ignited on 24 December 1989; following Liberia’s descent into violent anarchy
when Charles Taylor launched his campaign to overthrow President Samuel Doe. This was a
time the world’s attention was focused on developments in the Gulf. Besides its scale of
brutality, the influx of refugees was felt in most parts of the sub-region. The Economic
Community of West African States (ECOWAS), concerned by the contagious nature of
conflict, created the ECOWAS Monitoring Group (ECOMOG), a military wing of the organization that dispatched troops drawn from a number of countries including Nigeria, Ghana, the Gambia, Senegal, Sierra Leone and Guinea into Liberia. According to Brig Francis Agyemfra, Charles Taylor’s intransigence forced the initial 3000 peacekeeping ECOMOG force to be increased to a 10,000 strong force and this time with a peace-enforcement mission. With the creation of United Nations Observer Mission in Liberia (UNOMIL) under the Cotonou Agreement signed on 25th July 1993, four additional battalions from non-ECOWAS countries under the auspices of the OAU were deployed alongside ECOMOG. Military observers were also deployed.

Even before the ECOWAS involvement in Liberia came to an end, the organization had become involved in another crisis in neighbouring Sierra Leone, where a rebel movement, the Revolutionary United Front (RUF), under Foday Sankoh, took up arms against the central government. Here, ECOMOG forces were absorbed by the United Nations Mission to Sierra Leone (UNAMSIL), which has been dubbed the largest ever UN force and was drawn from some 37 countries. The Liberian and Sierra Leonean conflicts have jumped the borders of the basin to engulf hitherto stable, peaceful and progressive La Côte d’Ivoire, creating a severe humanitarian crisis and threatening sub-regional peace and security. This has resulted in the deployment of UN peacekeepers in that country, while efforts continue to secure ceasefire in Liberia’s ongoing conflict, with very likely re-introduction of a peacekeeping force into that country.

The involvement of both ECOMOG and later UN intervention forces was a pragmatic response aimed at resolving the crises and achieving a long-term peace settlement. However, the presence of such a large intervention force in the region was bound to carry in
its trail repercussions with long-term consequences to both the people of the MRB and the troop contributing countries (TCCs). One such area of importance to both the countries in conflict and the TCCs was the public health implications of the force. Many people of the MRB have often described the ECOMOG Force as economic looters and vectors of diseases, especially sexually transmitted infections (STIs) with particular reference to HIV/AIDS. The public health implications of these two conflicts on military forces whether deployed as belligerents or as peacekeepers, has become an issue of concern because of the HIV/AIDS pandemic, which is particularly devastating many sub-Saharan African countries. (See Appendix).

1.2 Problem Statement. Ghana and many other African countries have been involved in external operations long before the crisis in the Mano River basin began. The issue of troops returning from these operations contaminated by disease was not an issue until their involvement in the crisis of the MRB. Ever since ECOMOG forces entered Liberia, and later Sierra Leone as ECOMOG/UNAMSIL, there has been concern about the spread of communicable diseases especially HIV/AIDS among soldiers and the consequence for society at large. In Ghana, where a pre-operational medical examination is mandatory, apparently healthy young men and women, with previous international peacekeeping experience are sometimes dropped from subsequent missions for allegedly carrying some communicable diseases from which they were free in their previous missions. In Nigeria, President Olusegun Obasanjo is alleged to have raised concern over the high rate of prevalence of the HIV/AIDS among the military, especially those who served with the ECOMOG.11 This development is creating worry and anxiety among service personnel, their families and the wider society, as people now question the rationale of peace support operations if only it replaces one problem with another – war with disease. The same
concern is also raised in the conflict countries that accused peacekeepers of introducing HIV/AIDS and other communicable diseases into their countries. According to Hirut Befecadu, the HIV/AIDS coordinator for UNAMSIL, Sierra Leone, countries want their troops protected, and the population should be protected from the soldiers as well, because most of the troops come from places where AIDS is a problem. In January 2001, the US Ambassador to the UN expressed concern that the UN had not yet initiated an adequate response to the Security Council’s Resolution 1308 of July 2001, on the transmission of HIV/AIDS between peacekeepers and civilian populations.

These concerns have the potential to erode people’s confidence in peacekeepers and make their noble task unachievable. This study was therefore an attempt to look at the issue of the spread of communicable diseases, focusing on HIV/AIDS, among peacekeepers in the Mano River Basin (MRB), and the implications for troop contributing countries (TCCs), with particular reference Ghana and Nigeria. The study attempted to examine the following pertinent public health concerns of peacekeeping in the Mano River Basin:

- The major communicable diseases likely to have public health implications for peacekeepers and the societies with whom they come into contact.

- The epidemiological picture of HIV/AIDS in the MRB compared to the situation in troop contributing countries.

- The morbidity and mortality trends of HIV/AIDS among troops returning from the MRB and the factors in the basin that favour the spread.
Implications of the spread of HIV/AIDS among peacekeepers on society in general and the response for making peacekeeping safe for peacekeepers and the general populace?

Scope. The study covers a review of common communicable diseases that pose public health risk to peacekeepers and the populations with whom they come into contact; a picture of HIV/AIDS in the MRB and the troop contributing countries of the sub-Region; the preparation of peacekeepers for deployment and the health facilities available to them in the Area of Operations (AO). It will also look at the trend of HIV/AIDS among peacekeepers and the factors promoting the spread; the implications of such a development on the wider society in the troop contributing countries especially Ghana and Nigeria, and the issue of post-operation HIV screening of troops. The study will examine the response to the spread to make peacekeeping safe.

1.3. Objectives of the Study. The objective of the study is to draw the attention of the military hierarchy and political leadership of African countries and the international community to the increasing calls for a proactive and holistic rather than a reactive approach to the health of troops on international operations, not only for their sake, but also for the sake of society at large. The study should also provide study material for troop education on HIV/AIDS and other communicable diseases they are exposed to during operations abroad.

1.4. Hypothesis. The basic thesis is that: Peacekeeping has become a major source of spread of communicable diseases especially HIV/AIDS in both conflict environments and troop contributing countries.
1.5. Rationale of the Study. According to Ruth Pollard (2002), 46000 military and police working as United Nations peacekeepers around the world are more likely to contract HIV than be killed in action. Yet in many developing countries, troops are often deployed in foreign lands without considering the public health implications of such deployments on the troops and the long-term effects on society at large. Pre-deployment reconnaissance trips to the operational area often place emphasis on the military feasibility studies, while ignoring the need for detailed medical reconnaissance. The rationale of this study is awareness creation for higher command responsible for putting the soldier into operations, and for the individual soldier going into operation. While command will need to review the whole concept of troop deployment abroad from the public health perspective, the individual service personnel will need to understand how susceptible he/she is to disease producing microbes that proliferate on the battlefield. The study should convince society in general to treat military conflicts as public health problems that can be ameliorated.

1.6. Literature Review. International peacekeeping and public health is topical especially on HIV/AIDS, but Literature on the subject appears to be scanty and has only started to emerge. A Joint Warfare publication by the British Armed Forces on Peace Support Operations has observed that Military Medical Services in Peace support settings are designed to provide medical services to the forces and not the indigenous population. They may however be required to support humanitarian operations and community relations projects. Living conditions in the peacekeeping environment can be very basic and could pose a considerable health and hygiene hazard. The need for an environmental and hygiene reconnaissance and monitoring are thus vital for troop health and welfare. In the book, War or Health, edited by Ilka Taipale et al, several experienced health professionals including Matti Ponteva, Kolawole T. Raheem and Kingsley K. Akinroye, and Douglas Holstock, have
put together an extra-ordinary wide-ranging examination of the interface between warfare and human health and society. Contributing on the Impact of Warfare on Medicine\textsuperscript{16}, Matti Ponteva has observed that famine, epidemics, war and death – the four apocalyptic equestrians – have been the powerful regulators of human population through the ages. The first two are often a consequence of war and an untimely death a consequence of one or more of the other three factors. Until WW1, more deaths among fighting troops occurred from infectious diseases than from wounds from the battlefield. Infectious diseases are still important causes of death in war in most parts of the world.

Kolawole T. Raheem and Kingsley K. Akinroye writing on Warfare and Health. The Case of West Africa.\textsuperscript{17} observed that many West African countries are rich in mineral and solid resources which generate more than enough funds to provide adequate health services, but violent conflicts and corruption stand in the way of achieving this goal. According to them, war in West Africa is a major cause of rapidly increasing number of refugees and consequently of increases in poverty, armed robbery and insecurity. The sudden movement of people across borders is also an uncontrolled movement of disease from one country to the other. The negative relationship between warfare and health cannot be overstated. The West African scenario suggests that the health sector cannot prosper when there is war. Communicable diseases like meningitis, polio, HIV, and helminthiasis are easy to carry across borders with the sudden movement of people. Soldiers and rebels are also a significant source of venereal disease transmission. These combatants do not practice safe sex. If they are mercenaries or peace enforcement agents and already infected with venereal diseases including HIV, it is almost certain that they will transmit the diseases across the borders. It is for example suggested that about 15,000 children were born from sexual contact between the ECOMOG troops and Liberian women during and immediately after the
It is probable that the same will happen in Sierra Leone where the same troops are actively supporting the government’s war against the rebels. This appeared to be so as the candidate, during his tour of duty in Sierra Leone as a military observer, met several women in that country who claimed they had children with troops from such troop contributing countries as Ghana, Nigeria and Guinea.

Douglas Holdstock, writing on the Morbidity and Mortality among Soldiers and Civilians, states that war and violence has been a feature of human life since before recorded history. The effects of war do not end with the last shot. As Shakespeare put it, ‘the evil that men do lives after them’. Today’s conflicts in the developing world will retard the progress of the countries concerned for decades, though the toll of ill health and premature death will be unquantifiable; not all of it will be ascribed to war when the history is written and the statistics accumulated. War and violence have been a feature of human life since and before recorded history. Before the antibiotic era, war-related infections probably killed more people, both soldiers and civilians, than war itself. Overcrowding, poor sanitation and pests such as lice and rodents often led to epidemics in besieged cities or army camps. War itself has contributed to the spread of epidemics, by refugees or by soldiers returning from overseas campaigns. He used the first written history of war by Thucydides, ‘History of the Peloponnesian War’, to illustrate this point. It gives a vivid account of the outbreak of an epidemic in Athens that sounds more like Bacillary Dysentery, Typhoid or Typhus. The Spartans were ravaging Attica, so that the Athenians were confined within their city walls, and refugees made the overcrowding worse from the surrounding countryside. The arrival of true plague infection in Europe in the mid-fourteenth century may have followed an act of war. The subsequent epidemic, the Black Death, halved the population of parts of Europe, and the economic aftermath of the disease lasted for decades.
Stephen Talugende has presented a paper on Health of Military Populations in Conflict and post-Conflict situations at the 29th Annual Conference on Global Health in times of crisis in Washington. According to him, there is much evidence that armed conflict and infectious diseases are intimately linked together. Military populations form one of the largest and historically most significant sectors of society. Making reference from a study conducted by the Civil Military Alliance on combating HIV/AIDS, he states that the world’s Armed Forces comprise about 25 million men and women in active military service. By the 1990s, 36 countries were actively engaged in armed struggles, eight confronted emerging international conflicts and 13 were in internal civil disorders. Between 1997 and 1999, 16 UN peacekeeping operations were under way in Africa, the Americas, Asia, Europe and the Middle East. Just as militaries have for all time figured centrally in human affairs, epidemics have presented a perennial problem for the military populations and for the civilians with whom they come in contact.

Ruth Pollard, writing on UN forces being more at risk from HIV than war, cited a document on the development of AIDS in Cambodia. According to her, when peacekeepers arrived in Cambodia, the country had no recorded cases of HIV and little or no commercial sex industry. Ten years later, the sex industry was widespread and Cambodia had the highest incidence of HIV in Asia. While some attribute the epidemic to the peacekeepers, others argue that the poverty and rapid social change that followed the collapse of the Khmer Rouge are more significant factors. This is the worry of the people in the Mano River Basin, where the prevalence of HIV/AIDS hitherto was among the lowest in sub-Saharan Africa, that peacekeepers would finally leave them with epidemics of sexually transmitted diseases especially HIV/AIDS.
Roger Yeager has done a lot of work on HIV/AIDS. Writing on HIV/AIDS: Implications for Development and Security in sub-Saharan Africa, stated that military forces perform a major protective role for society and are called upon to serve internally and to deploy outside their national boundaries. Today, African and other militaries are challenged by the challenging nature of threats to national and international peace and security. To a greater extent than in the past, national militaries are deployed to assist civilian relief agencies in mitigating the human impact of complex emergencies. In these close encounters, military and civilian populations face a common enemy — infectious diseases — that are especially strong under conditions of massive upheaval. During and immediately after armed conflicts throughout history, rapidly spreading diseases have killed more people than the fighting itself. In domestic and foreign conflict situations, risks of STD infections become much higher for both military personnel and civilians among whom they are deployed. In many parts of the world HIV and AIDS pose a far more serious threat to military populations than the inherently hazardous nature of their occupation.

In his article on Humanitarian and Ethical Aspect of Military and Peace Operations in the International Review of the Armed Forces medical Services, Esko Nieminen has observed that the Armed Forces recruit people at the time of their greatest risk of HIV infection, between 15 and 24 years, where more than half of all HIV infections occur. Military personnel are also vulnerable in that they are regularly away from home for long periods, are often in need of recreations to relieve stress and loneliness, and are subject to risk-enhancing alcohol and drug use. They may have feelings of invincibility, at an age in a profession that often excuse and even encourage risk-taking. Military camps and other installations are known to attract sex workers and those who deal in illicit drugs, enticing off-duty soldiers
who are sure to have cash but not necessarily condoms and sterile syringes in their pockets. Surely not using the supplied condom is an important problem and factor. One of the important ethical aspects of any military or military-like units forced to spend long periods in isolation is the natural need to socialize with the opposite sex. Extended periods of celibacy result in continuous carelessness and cause medical problems despite all attempts at counselling and advice. In the book, *The Global Agenda: Issues and Perspectives*, Laurie Garrett has contributed a topic on *Encroaching Plagues: The return of Infectious Diseases*.

According to him, since World War II, public health strategy has focussed on the eradication of microbes, using powerful medical weaponry developed during the post-war period – antibiotics, antimalarials, and vaccines. The goal was nothing less than pushing humanity through what was termed the “health transition”, leaving the age of infectious diseases permanently behind. By the turn of the century, it was thought most of the world’s population would live long lives ended only by the “chronics” – cancer, heart diseases and Alzheimer’s disease. The optimism culminated in 1978 when the member states of the UN signed the “Health for all by the year 2000” Accord. Geographic sequestration was crucial in all post-war health planning. Disease can no longer be expected to remain in their country or region of origin. In 1994, war or social unrest displaced 23 million people. As people move, unwanted microbial hitchhikers tag along.

Manuel Carballo and Jimmena Ciloniz have done a lot of work on HIV/AIDS and security. In an *HIV/AIDS and Security report*, the two have stated that AIDS has become the leading cause of death among the military in many countries. In Cambodia, 8% of military personnel were infected with HIV in 1995, with 21% in the North of the country. Between 1991 and 1995, 14% of all Royal Thai military personnel recruited from the Northern Province tested positive for HIV. The situation in Africa has been more evident and serious. Although the
extent to which HIV/AIDS has affected the security sector in all countries of the region or all military forces remains unclear because data are not forthcoming from all military forces, yet there is no reason to believe that the situation is very different between sub-Saharan countries, especially those that have deployed troops elsewhere. By 1995, the incidence of HIV/AIDS among Zimbabwean forces was 2 – 4 times higher than among civilians. In South Africa, military authorities acknowledge infection rates of 17% in general but also say some units have rates as high as 90%. Between 40% and 50% of Angola’s army are estimated to be infected with HIV, in the DRC, it is estimated at 40% - 60%, and in Nigeria 10% - 20%. The situation in Zimbabwe and Malawi could be worse as between 70% and 75% of the military is thought to be HIV-infected. In Malawi, AIDS is expected to kill up to 50% of the military by 2005. The international community’s commitment to peacekeeping and post conflict development has meant that a dramatic growth of deployment of military personnel from different parts of the world. Peacekeepers have an increased likelihood of engaging in risky sexual behaviour. The deployment of peacekeepers has also been problematic because in some instances, African peacekeepers have been deployed for long periods of time with little rotation. This observation was evident among Guinean Military Observers in Sierra Leone and probably elsewhere where they have been deployed for periods of up to three years without rotation. Several of these officers have taken wives from the local communities in which they served.

1.7 Theoretical framework. No single approach or theory can explain adequately, with comprehensiveness and subtlety, the full range of phenomena on the role of conflicts in the spread of communicable diseases. Two theories were considered – the systems theory and Military Conflicts as a Public Health Problem as espoused by Gary King and Lisa L. Martin.25
Within the past decade, the idea of environmental security has become an organizing principle of the study of international relations. Environmental security has two broad themes: first, the response to strategic military assaults on public health and the environment, and secondly, the security issues associated with environmental disruption. A modern field of "environmental security" is emerging that encompasses destruction of public health and the environment as a military strategy; the effect of "environmental warfare" on combatants and non-combatants alike and threats to national and international security. Gary King and Lisa L. Martin have looked at how war, as a public health issue will transform the international relations research agenda.

War as a public health issue will fundamentally change the perception about its causes and consequences. This approach looks at the human costs of military conflicts rather than concentrating solely on the costs and incentives facing states. Contemporary study of the causes of war among international relations specialists builds on the ideas about domestic and systemic levels factors that contribute to conflict and make its resolution difficult. Some theorists such as Gilpin limit their scope to systemic wars, occurring among great powers and leading to a substantial shift in power relations. However, the number of such wars is limited and we are typically interested in "smaller" wars as well. When war is considered as a public health problem, the question is no longer simply when war or peace is likely to occur. Instead, attention turns to the various aspects of the severity of war and the effects it has under different conditions on those living in the region. From the perspective of international relations, a key question that then arises is whether the traditional theories of causes of war will also help us to understand variations in the human costs associated with it. One of the promising steps in the research agenda is to treat variables used by public health
experts as dependent variables in the study of war. These include the measure of death from various sources as well as illness and injuries. Rather than setting an arbitrary cut-off of a number of deaths as constituting a war, we can take advantage of variation in the severity of war and its effects to test more subtle explanations of conflict. We can ask for example, what systemic conditions influence public health outcomes? Does the involvement of international organizations such as peacekeepers, contain conflict or mitigate its effects as intended? Or might such involvement have perverse effects, actually leading to greater human suffering?

Looking at war from the public health focus encourages us to ask about how to forecast and prevent war. Attention is drawn to those factors that influence the outbreak and severity of war or conflict that can be subjected to human manipulation; that is, war becomes a disease that cries out for treatment. If we discover that international organizations are indeed effective in reducing the costs of war, or that certain regime types limit the impact of war on their populations, these lessons provide a basis for policymaking and intervention.

1.8.1. Clarification of Key concepts: Key concepts used in the study are clarified here for the benefit of the non-technical reader.

Communicable disease: Diseases that one person can pass on to other people.

Epidemiology: Field of medical science that focuses on the distribution and determinants of disease frequency in populations. It analyses the relationship between environment and health.26

Vector: An animal agent responsible for the transmission of a disease from person to person or from one population to the other.
Human Immunodeficiency virus (HIV): a retro-virus that damages the human immune system thus permitting opportunistic infections to cause eventually fatal diseases. HIV is the causal agent for AIDS.

Acquired Immunodeficiency Syndrome (AIDS): The last and most severe stage of the clinical spectrum of HIV-related diseases.

HIV prevalence rate: total number of persons (usually adults aged 15-49) with HIV infection alive at any given moment in time. In this paper the author refers to High adult HIV prevalence as 7% or more and to Low adult HIV prevalence as less than 7% in accordance with the distinction made by the World Bank Strategy (1999).

Food security: exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life. (Rome Declaration on World Food Security, 1996)

Ecosystem: Within a community, living organisms together with the non-living elements constitute complex structural and functional units called ecological systems or ecosystems. Within this system, there is an intimate interaction among living organisms as well as between them and the non-living elements.

Morbidity: Proportion of a population that gets infected by a particular disease.

Mutation: The process by which genetic material of plant or animal change in form.

Zoonotic diseases: Diseases that can be passed from animals to man such as Rabies, certain forms of Tuberculosis and helminthiasis.
**Lassa fever.** Lassa Fever is an acute viral illness found in certain areas of West Africa, with a rodent — *Mastomys natalensis* — as the vector. It is an endemic disease in parts of West Africa; Guinea, Liberia, Sierra Leone and Nigeria.

**Helminthiasis.** Infection with gastro-intestinal parasites commonly referred to as worms.

**UN Resolution 1308:** UN Security Council Resolution adopted by the Security Council at its 4172nd meeting on 17 July 2000 on HIV/AIDS and peacekeeping.

**Internally Displaced persons:** People forced to leave their home area to another area within the country.

**Kweku one on one:** The screening of soldiers for HIV infection, named after the popular Kweku Sakyi Addo’s programme on Ghana’s television where the guest faces the host, Kweku, to answer very challenging questions, similar to a BBC or CNN programme.

1.9. **Sources of data.** This study relied on data from primary and secondary sources. Primary sources included data from ECOMOG and UNAMSIL Field Hospitals, interviews of past and present medical staff of the hospitals and the Force Medical Office, Freetown, health records on troops from home countries before participating in the operations, information from NGOs in the region such as UNHCR, Médecins sans Frontière, ICRC, etc as well as IGOs such as the WHO. Resource persons such as Manuel Carballo, Mrs Heirut Befecadu, and Col Frank Apeagyei supported me with information and data. Secondary sources include books and the Internet.

1.10. **Arrangement of Chapters.** The study shall contains four chapters as follows:
Chapter 1. Introduction. This will cover the background and statement of the problem, objectives of the research, rationale, literature review, theoretical framework, methods and sources of data, arrangement of the chapters, and limitations.

Chapter 2. The Epidemiological Evaluation of Communicable Diseases with Emphasis on HIV/AIDS in the Study Populations

Chapter 3. Implications and response to the spread of HIV/AIDS.

Chapter 4. Observations, conclusions and recommendations.

1.11. Limitations. The work was done in an operational area where I had to combine this work with the duties of a Team Leader of a UN Observer Team. Getting hard data on such a sensitive issue as HIV/AIDS was not easy. Medical matters are CONFIDENTIAL. Military matters are SECRET. Getting medical information from the military was therefore like striking a rock for water. I had to depend on materials obtained through correspondence, books, interviews and the Internet. Serving as a UN Military Observer was both an asset and a limitation. It gave me a first hand exposure to some factors that causes the spread of diseases in the peacekeeping environment. Being far away from my supervisor too, with no libraries to consult however affected my work to some degree.
ENDNOTES


14 Warfare Publication 3-50, Peace Support Operations, A British military publication, Northwood Middlesex, p5-10


19 Stephen Talugende, Health of Military Populations in Conflict and Post-conflict situations, 29th Annual Conference, Global Health in Times of Crisis, 28 –31 May 2002 Washington D.C., USA

21 Rodger Yeager, HIV/AIDS: Implications for Development and Security in Sub-Saharan Africa, Morgantown, USA


26 P. Elliott et al., Geographical and Environmental Epidemiology, Methods for Small-Area Studies, Oxford University Press, Oxford, 1996
CHAPTER TWO

EPIDEMIOLOGICAL EVALUATION OF COMMUNICABLE DISEASES WITH EMPHASIS ON HIV/AIDS IN THE STUDY POPULATIONS

2.1. INTRODUCTION

Disease challenges in the MRB are no markedly different from the rest of West Africa. According to the US Defence Intelligence Agency of the Armed Forces Medical Intelligence Centre, diseases of potential military significance in West Africa are grouped into zoonotic diseases, vector borne diseases, Sexually Transmitted and/or blood borne diseases and other infectious diseases. These include among others Malaria, Yellow fever, Diarrhoeal diseases, Typhoid and Paratyphoid, Meningococcal Meningitis, Lassa fever, African Trypansomiasis and Sexually Transmitted Diseases. Sexually transmitted diseases include Gonorrhoea, Viral hepatitis B and C, Syphilis and HIV/AIDS.¹ Records at the Ghana Medical Battalion (GHANMED), Sierra Leone, also show that the common diseases for which both peacekeepers and the local populations seek medical intervention include malaria, typhoid fever, diarrhoeal diseases, helminthiasis and sexually transmitted infections (STIs) including HIV/AIDS.² This has further been corroborated by interviews of medical personnel of the Kenema Government Hospital and the Medical Station of the 3rd Brigade of the Republic of Sierra Leone Armed Forces (RSLAF).

Although the disease profile for most countries in the sub-region may be common, prevalence rates may differ from country to country. This raises the issue that peacekeepers may be deployed from a country of lower or higher disease prevalence than the conflict areas. Again,
peacekeepers include a large number of personnel drawn from countries outside the sub-region with difference disease patterns and prevalence rates.

2.2. REVIEW OF SOME COMMON COMMUNICABLE DISEASES IN THE MANO RIVER BASIN.

2.2.1. Malaria. This is a common disease in West Africa, and accounts for 48.5% of all cases seen by the Ghana Medical Battalion Level II in Kenema, Sierra Leone. According to Dr. Sessay Koroma, the 3rd Brigade Medical Officer of the Sierra Leone Army, over 40% medical attendance is due to Malaria.

2.2.2. Typhoid Fever. Typhoid (Enteric) fever is caused by bacteria (Salmonella typhi) and contracted by ingestion of contaminated food and water. Humans are the sole reservoir hosts. The bacterium is shed in faeces, typically for as long as 6 weeks to 3 months after infection. Prevalence is high in countries with warm climates and with less developed sanitary facilities for sewage disposal and water treatment. It is endemic in most parts of Africa.

2.2.3. Lassa Fever. This disease is very common in Eastern Sierra Leone and parts of Liberia. It is also seen in parts of Nigeria, from where it got its name – Lassa, Lassa being a town in Nigeria from where the first cases of the disease were reported. The vector for Lassa fever in the Mano River basin, Mastomys natalensis, is a rodent and encroachment upon its natural habitat, coupled with the insanitary conditions of conflict environment has forced it to invade and contaminate human habitation leading to the disease. According to records at the Ghana Level Two hospital in Kenema, since February 2002, 19 cases of Lassa have been handled, with 12 deaths. All cases were from the Zambian Battalion, stationed at Tongo
Fields. In Liberia, especially in the Zozor County and in the Northwestern part of the Lofa County, 17% of hospitalised febrile patients are due to Lassa fever. Of interest is the suspicion of Col Frank Apeagyei that Lassa infection could be transmitted through sex and therefore could be linked to HIV/AIDS. His suspicion was based on his observation that most of the soldiers who came down with Lassa were also diagnosed positive for HIV/AIDS, although he did not support this with any data.

2.2.4. Tuberculosis. Tuberculosis is highly endemic in most African countries. Tuberculosis, once thought to be on the decline, is re-emerging as a major public health hazard. The emergence of HIV/AIDS has paved the way for the resurgence of Tuberculosis, which is said to have been responsible for over 30% of all AIDS related deaths. Over one-third of the 36.1 million people living with HIV/AIDS are thought to be co-infected with TB. Of this, more than 70% live in sub-Saharan Africa.

2.2.6. Severe Acute Respiratory Syndrome (SARS). This is the latest of the disease puzzles to have hit the globe. It is a viral infection that appears to be spread by travellers. So far, SARS has been confined to some Asian countries and Canada, but the spread to other parts of the world cannot be ruled out in view of its peculiar epidemiology. Peacekeeping provides the most ideal conditions for the spread of such a disease. Troops are drawn from different countries and travel by different routes to and from their duties. For example, peacekeepers for UNAMSIL were drawn from some 37 countries including Canada and China, the hardest hit countries.

2.2.7. Sexually transmitted infections (STIs). These are occupational diseases, which affect the military all over the whole world, including peacekeepers. In the MRB, STIs
including Chlamydial urethritis and gonorrhoea are highly endemic. A 1993 survey of pregnant women in Monrovia found 25% infected with STDs including HIV/AIDS.⁴

2.3. THE HUMAN IMMUNO-DEFICIENCY VIRUS AND ACQUIRED IMMUNO-DEFICIENCY SYNDROME

HIV/AIDS was first reported in the West African sub-region in 1986. Today, some 22.5 million people live with the virus in sub-Saharan Africa, representing 80% of the world’s total. With the exception of Côte d’Ivoire and Togo with a prevalence rate of between 8% and 32% respectively, sub-regional values range between 2% and 8%. Senegal has a rate below 3%.⁵

In the eighties, when AIDS was first recognized, the prevalence remained low in many developing countries, especially in Africa. This, according to Dr. Michel Masson of the ICRC in Kenema, Sierra Leone, may be attributed to the closed nature of these societies at the time. People travelled less and were not exposed to the outside world that had been corrupted by some of these diseases of globalisation. However, as communication improved more people within these hitherto static societies started to move and be part of the globe. Worse still has been the increase in conflicts. These have created refugee crisis, increased rape cases by combatants from far and near, brought international peacekeepers into conflict areas, as well as staff of other NGOs and IGOs. The demographic dynamics have brought in their wake exotic diseases alien to these communities including HIV/AIDS.⁶ Figures 22a – 22c show graphical presentations of the HIV/AIDS problem in Africa:

2.4. EPIDEMIOLOGY OF HIV/AIDS IN THE MANO RIVER BASIN.

2.4.1. Sierra Leone. The Human Immunodeficiency Viral (HIV) infection was unknown in the Mano River Basin until the mid eighties. Both Liberians and Sierra Leoneans believe that HIV/AIDS was not an issue in their countries until the arrival of ECOMOG and UNAMSIL.
According to a document sighted at the Kenema Third Brigade Medical Centre, the rise in HIV infections were noted around the period of ECOMOG’s occupation of Sierra Leone.\(^7\)

Writing on the role of peacekeepers in the spread of the disease in Sierra Leone\(^8\), a Sierra Leonean, quoting from an article in the Guardian Newspaper, states, “The war has brought thousands of peacekeeping troops into Sierra Leone. Heavily infected states from which they have been drawn include Zambia, Kenya, and Nigeria. One study found out that of 800 of these troops tested for AIDS (mainly Nigerians), 700 proved positive.” However, that study also highlighted the HIV/AIDS problem in Sierra Leone without the peacekeepers.

According to the article, a report commissioned by the WHO and Sierra Leone’s Health Ministry, 1000 of 1500 (approximately 67%) of male Sierra Leonean soldiers and would-be recruits tested positive for HIV between 1999 and 2001.

According to the National AIDS Control Programme, National Commission for HIV/AIDS and Ministry of Health and Sanitation, HIV infection rate is currently 3.7% among children, 5.6% among youths and 5.5% among women. The national prevalence rate as at May 2002 was 4.9% including all categories of the total population of 5 million. Unfortunately, regional statistics are not available because of lack of testing/diagnostic facilities.\(^9\) Dr. Michel Masson of the ICRC put the current prevalence of HIV/AIDS in Sierra Leone at about 4%.\(^10\) However, Dr. Stevens Koroma of the Kenema Government Hospital in Kenema has stated that the prevalence rate of the disease is about 7%. Between 2000 and 2002, international organizations including the UNHCR conducted tests on women raped during the war and found that only 3% of such women tested positive. In another test among a sample of war affected local population in Sierra Leone, it was found that HIV/AIDS prevalence was 16% in 1995\(^11\). A 1995 survey conducted among sex workers in Freetown found that 27% tested positive for HIV.\(^12\)
Major James Sambo, Chairman of the HIV/AIDS Committee for the Armed Forces and a British Medical Team working along side it, estimates that between a quarter and a third of the 12000 of the Republic of Sierra Leonean Armed Forces (RSLAF) was HIV positive by 2001. According to Major Sambo, HIV/AIDS in the civil population could be on a par with the Army. Most of the military personnel in both countries are ex-rebel combatants who indulged in such activities as rape and torture of the rural populations, resulting in the estimated high prevalence rate of HIV infection among rural communities.

2.4.2. Liberia. There are no records on the prevalence of HIV infection among sex workers in Liberia. However, 8% of males attending STI clinics in one part of Monrovia in 1993, tested positive for HIV infection. Joseph K. Tellewowyen has looked at HIV/AIDS in Liberia. According to his report, the National Aids Control Programme and the Ministry of Health reported that HIV/AIDS cases were underreported. A WHO/UNAIDS report, in 1993 showed that 4% of women who went to prenatal test, tested positive for HIV; 3.2% of Liberian population of just over 3.2 million have tested positive for the disease. Most of the 60,000 rebel fighters, who were child soldiers were forced to ingest drugs to carry out the will of the warlords. Added to this factor were thousands of soldiers from various West African states who brought "God knows what" and infected the Liberian women and children. The CIA estimates that by 2001, 2.8% of the adult population of 1,832,060 Liberians, between the ages of 15 – 64 were infected. This estimate indicates that 51,298 Liberians were infected, i.e. 1 out of 62 people was infected.

2.5. HEALTH CONDITIONS IN TROOP CONTRIBUTING COUNTRIES
Most of the major diseases in the MRB are also endemic in the countries within the sub-region. HIV/AIDS problem is global. No country especially in sub-Saharan Africa is free
from the problem. When ECOMOG was expanded to take up troops from outside the sub-region, troops were brought from Kenya, Zambia and Tanzania where the prevalence rates are known to be very high. Indeed, rates in the Basin are relatively lower than most countries in Africa including West Africa.

2.6. EPIDEMIOLOGY OF HIV/AIDS IN TROOP CONTRIBUTING COUNTRIES

2.6.1. Ghana. According to the 2000 census, Ghana has a population of 18.8 million, with a military component of below 12,000. Though HIV/AIDS has spread more slowly in Ghana than in other countries, the disease is firmly established within the general population and shows no signs of stabilizing. According to the Ministry of Health, an estimated 350,000 adults were living with the disease in 2000, yielding an infection rate of 3.0%. The Joint United Nations Programme on HIV/AIDS also estimated a 3.0% adult prevalence at the end of 2001.\textsuperscript{16}

When HIV/AIDS was first identified in Ghana in March 1986, the national infection was 1.86%. According to the 1999 estimates, Ghana had an HIV/AIDS adult prevalence rate of 3.6%. People living with the disease by the same estimates were 340,000, while the deaths recorded for the same year for the disease was 33,000. This prevalence rate, according to many experts, is misleading. Many people living with the disease are difficult to capture in the official statistics. According to the United States Defence Intelligence Agency, Armed Forces Medical Intelligence Centre, as early as 1999, HIV-1 sero-prevalences rates were estimated at 3.6 and 72.6\% among low and high-risk urban populations respectively. The HIV sero-prevalence for low-risk rural population was estimated to be 3.0\%.\textsuperscript{17} According to Boafo Yaw Owusu Ansa, the 3.6\% prevalence rate for Ghana represents 30\% of the cases in the country as majority of the victims patronise traditional health centres, prayer camps,
private clinics; and others do not report their illnesses at all for fear of stigma and discrimination. Non-reported cases of HIV/AIDS in the country are more than the reported cases. It is reported that 130 people in Ghana are infected daily and it is estimated that 125 people would die of the dreadful disease by the year 2009 if the rate of infection continues at the estimated 3.6%\textsuperscript{18}. According to Dr Sylvia Anie-Akwetey, Director of the Ghana AIDS Commission, Ghana had attained 95% awareness rate countrywide. There had been a decline in the infection rate. The ratio had reduced from four women to one man to two women to one man. Despite this significant gains made in the awareness campaign, there had not been any significant behavioural change.\textsuperscript{19} Sentinel surveillance data in Ghana seem to suggest that HIV prevalence in Ghana during the past few years has been fairly stable in the range of 3 to 4 per cent of the adult population age 15 – 49. Although there is no evidence of a rapid increase in HIV prevalence in Ghana during the past years, most of the neighbouring countries have experienced such increases. It will require several more years of careful monitoring before any definitive statement could be made about stabilization or decline in HIV prevalence in Ghana.\textsuperscript{20}

2.6.2. Nigeria. By the 2002 estimate, Nigeria had a population of 122,443 million people of which more than 55% was below 20 years of age.\textsuperscript{21} According to President Olusegun Obasanjo, Nigeria with an HIV annual growth rate of 2.8% and a prevalence rate of 5.4% is one of the most populous countries to have crossed the 5% prevalence threshold – an explosive phase of the epidemic. The first case was diagnosed in 1986 in Nigeria. Since then there has been a steady rise from 1.8% in 1993 to 3.8% in 1994, 4.5% in 1996 and 5.4% in 1999, with youth between the ages of 19 and 24 being the most affected.\textsuperscript{22} The prevalence rate of 5.4% implies that 2.6 million adults are living with the disease. In certain states like Enugu, the HIV prevalence has increased from 2.3% in 1995 to 16.8% by 1999, an increase
of more than 700%. Similarly 8 other states in the country have prevalence above 10%.

The Defence Intelligence Agency estimates for the 1999 HIV-1 seroprevalence rate for high and low-risk urban populations as well as high and low risk rural populations are as illustrated in Table 2.1 below:

**Table 2.1: Sero-prevalence Rates (Urban versus Rural population)**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Urban Population (%)</th>
<th>Rural Population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>31</td>
<td>61</td>
</tr>
<tr>
<td>Low</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Extracted from the Defence Intelligence Agency estimates for 1999.

World Health Organization estimates that Nigeria by the end of 2001 had an established total active force of 78,500, out of which 7850 – 15700 had HIV/AIDS.

### 2.7. PEACEKEEPING FORCE AND HIV/AIDS PREVALENCE

#### 2.7.1. Size of the Peacekeeping Force.

The number of international peacekeepers deployed in the MRB has varied between 3000 at the beginning of the conflict in Liberia to over 16,000 in the UNAMSIL force in Sierra Leone. Troops were drawn from over 37 countries worldwide. The African countries that contributed troops as peacekeepers in the MRB included Nigeria, Ghana, Senegal, Guinea, Mali, Niger, The Gambia, Kenya, Zambia, Tanzania and Egypt. Nigeria has always deployed over 6000 troops in the MRB, followed by Ghana with between 1000 and 2000. Out of the 16,000 forces in Sierra Leone, 5,267 or 32% come from countries with HIV/AIDS prevalence rates more than 5%.

In terms of the percentage troop contribution by ECOWAS countries that have participated in peacekeeping operations in the MRB, on the average, not less than 90% of Ghana’s 10,000 – 12,000 strong Armed forces have served in the MRB. These soldiers are rotated every six months; as a result, a number of these personnel have served in the MRB for more than three times.
### Table 2.2: HIV/AIDS Prevalence Rates for Selected SSA Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Estb Total active forces 2001</th>
<th>National HIV/AIDS prevalence %</th>
<th>Prevalence among Forces %</th>
<th>Estb force with HIV/AIDS</th>
<th>Size of force provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>78500</td>
<td>5.06 (5.01 - 10.0)</td>
<td>11 - 20</td>
<td>7,850- 15,700</td>
<td>6000+</td>
</tr>
<tr>
<td>Ghana</td>
<td>12,000-</td>
<td>3.60 (0.11-5.0)</td>
<td>1.2 – 4.5</td>
<td>No data</td>
<td>1000+</td>
</tr>
<tr>
<td>Guinea</td>
<td>No data</td>
<td>1.54 (0.11-5.0)</td>
<td>Not available</td>
<td>No data</td>
<td>1000+</td>
</tr>
<tr>
<td>Kenya</td>
<td>15,000</td>
<td>13.95(10 -15)</td>
<td>30 – 45</td>
<td>No data</td>
<td>1000+</td>
</tr>
<tr>
<td>Zambia</td>
<td>12,000</td>
<td>19.95(15-40)</td>
<td>Above 50</td>
<td>No data</td>
<td>1000+</td>
</tr>
<tr>
<td>S. Leone</td>
<td>15000+</td>
<td>2.99(0.11-5.00)</td>
<td>7.0 - 30</td>
<td>No data</td>
<td>Nil</td>
</tr>
<tr>
<td>Liberia</td>
<td>15000+</td>
<td>2.80 (0.11-5.0)</td>
<td>7.0 - 30</td>
<td>No data</td>
<td>Nil</td>
</tr>
<tr>
<td>Tanzania</td>
<td>27,000</td>
<td>8.095(5.01 - 10.0)</td>
<td>15 - 30</td>
<td>4050-8100</td>
<td>100-</td>
</tr>
<tr>
<td>Cote d'Ivoire</td>
<td>10,000</td>
<td>10.76(10-15)</td>
<td>10 - 20</td>
<td>1390 - 2780</td>
<td>Nil</td>
</tr>
<tr>
<td>Angola</td>
<td>130,000</td>
<td>5.5</td>
<td>40 - 60</td>
<td>52200-78500</td>
<td>Nil</td>
</tr>
</tbody>
</table>

**Source:** Medilinks publication and UNAIDS (http://www.unaids.org). The ranges provided data reflects the unreliability of most data provided by most countries in the region. Prevalence rates are shown as both averages and ranges.

Of Nigeria’s over 120,000 Armed Forces, about 90% have served in the basin, with a good number of them having repeated the tours more than two times. Most soldiers from Ghana and Nigeria have had not less than three tours of duty in the MRB. The ‘recycling of troops’ and the ‘recycling of women’ between incoming and outgoing peacekeepers, increases the risk of spread of STIs and other communicable diseases the worst of which is HIV/AIDS. According to Col Frank Apeagyei, Ghanaian military personnel found to be positive for HIV...
infection most often have had one or more tours of the Mano River Basin. Table 2.2 shows force establishments and HIV/AIDS prevalence rates for some sub-Saharan African countries many of which have troops deployed in the MRB.

2.7.2. Preparation of Peacekeepers in Home Countries Prior To Deployment. Protecting military personnel from diseases and non-battle injuries is critical to maintain operational readiness, particularly on deployment. TCCs are responsible for the training and outfitting of the soldiers they make available to the UN. DPKO can advise but not dictate to member states about their HIV/AIDS programmes. Commanders at all levels are responsible for implementing an effective Force Health Protection programme. It is a medical responsibility to identify health threats and recommend appropriate countermeasures. Consideration should be given to the complete spectrum of Force Health Programme (FHP), including but not limited to infectious diseases, injury prevention and jet lag.

Preparations differ from country to country. Troops nominated for international peacekeeping duties first undergo medical examinations including HIV screening. In Ghana, the screening has been dubbed ‘Kwaku one on one’, as the screening is conducted in the presence of the nominee. Troops are then taken through instructions in peacekeeping, public health and other military operational procedures. According to Col. Frank Apeagyei, apart from medical examination of troops, health preparation takes the form of lectures and demonstrations such as condom use and field sanitation appliances. This, he views as adequate since emphasis is placed on diseases prevalent in the Area of Operation (AO).

A similar procedure is followed by Nigeria. However, unlike Ghana, Nigeria has embarked on testing its soldiers on their return home from the peacekeeping duties. The same may not
be said of some countries, especially in East, Central and Southern Africa. Some participating countries do not screen their troops for HIV infection. The prevalence among Tanzanian and Ugandan troops who took part in the ECOMOG forces in Liberia was very high, sometimes as high as 40% or more. Col. Frank Apeagyei shares the views of those who are of the opinion that the prevalence of HIV could have risen in MRB following the deployment of troops from these countries.27

2.7.3. Medical Services Available To Peacekeepers. To ensure the highest standard of medical care for peacekeepers, levels of medical support has been standardized. Health provision are available from the Basic Level involving First Aid and preventive medicine at the smallest unit level to Levels II and III Hospitals with specialist facilities. Ghana provided a Level Two facility at Kenema in Sierra Leone. Levels IV hospitals provides definitive medical care and specialist medical treatment unavailable or impossible to ensure within a Mission area. It is not cost-effective for the UN to deploy such a unit. Therefore, the host country provides the facility or a country near by. The 37 Military Hospital served as the Level Four Hospital for the Mission in both Liberia and Sierra Leone.28

2.7.3.7. Weaknesses. There is a marked difference between the management of the health of peacekeepers in the Mano River basin and the management of the health of troops during the Gulf war. During the Gulf War a comprehensive health care system was established by the US military to provide for the medical demands expected in a prolonged war with massive casualties. In addition, an extensive preventive medicine effort was initiated that included strict inspection of food sources and supplies, maintenance of field camp sanitation, institution of an arthropod vector control programme, and administration of booster doses of routine vaccinations, influenza vaccine and immune serum globulin.29 The
same may not be said of the deployment of ECOMOG, where a force of 3000, was hurriedly
thrown into Liberia to try to contain an explosive situation that was threatening to engulf the
entire region. Even under the United Nations, medical personnel for peacekeepers
complained of lack of essential logistics including diagnostic material and drugs. Military
medical services are designed to provide medical services to the forces and not the
indigenous populations.30

2.7.4. UN Policy Guidelines on the Deployment of Peacekeepers with HIV. Member
states are encouraged to carry out voluntary and confidential counselling and testing (VCCT)
to peacekeepers. One of the biggest obstacles to VCCT is cost, for which most African
countries do not have the means to carry it out. It is the opinions of many people that re-
imbursement of cost of HIV screening will make it possible for many countries in Africa to
carry out HIV screening of their peacekeeping troops before and after deployment. There are
growing concerns that the UN itself may be an unwitting agent for the spread of virus around
the world. This was implied when the former US Ambassador to the UN, Mr. Richard
Holbrooke, told the Security Council in January 2000, that AIDS was being spread among
other people by peacekeepers. Many researchers agree with Mr. Holbrooke’s statement.
However, a lack of data makes it impossible to accurately gauge the severity of the problem.
Only a handful of cases have been publicly documented, and the most reliable way to
measure the risk – mandatory testing of personnel before and after deployment abroad – is
favoured by only a few countries.31

2.7.5. Trend of HIV/AIDS Infection among Peacekeepers. It is a big concern that the
legacy of the UN should not be to bring the virus into the local environment. The legacy to
Medical examination including HIV/AIDS would voluntarily withdraw with the excuse that a pressing family problem at home demanded his presence. The prevalence rates cited for the Ghana Armed Forces (1 – 2%) therefore appear questionable against the estimated country prevalence of 3.6% that is even considered an underestimate.

2.7.5.2. **Nigeria.** Brigadier General A. Adefolalu, Commandant and Chief Consultant Surgeon at the Nigerian Army Medical Command School, Lagos, conducted a study of ECOMOG operations and found that the infection rate among Nigerian peacekeepers returning from operations in the MRB more than doubled that of the country overall and has been stated as 11%. From his preliminary findings, he concluded that, while HIV prevalence among military personnel was less than 1% in 1989/90, by 1997, it had increased to 5% and 10% by 1999. The years 1998 and 1999 also coincided with a return of troops from ECOMOG operational areas, and among them the prevalence rate was 12%. This study also looked at HIV incidence and a soldier’s length of stay in the operational area. Incidence rates increased from 7% after one year to 10% after two years and to more than 15% after three years of stay in the MRB. The studies concluded that a soldier’s risk of infection doubled for each year spent in the conflict area – suggesting a direct link between duty in the war zone and HIV transmission. (See Figure 2.1). Generally, the figures quoted for the Nigerian Armed Forces are between wide ranges of 10 – 20%.
the country providing the peacekeepers should not be to have them bring the HIV virus back home.\textsuperscript{32}

\subsection{Ghana.} In a communication to the Ghana Contingent Commander proposing post-operations screening of suspected Lassa fever patients, Lieutenant Colonel Osabutey has observed that it was an open secret that GAF had to take cognisance of the painful fact that there was a “high prevalence of therapy resistant/partially treated malaria, sexually transmitted infections including HIV/AIDS among “our troops after operations in Cambodia, Liberia, Sierra Leone, the DRC and La Cote d’Ivoire”\textsuperscript{33} With a population of less than 12,000, the Ghana Armed Forces forms just under 0.08\% of the total population. According to Col. Apeagyei, the prevalence of HIV/AIDS in the Ghana Armed Forces was 2.8\% in 1987 and went up to 4.2\% in 1999. Since then it has declined and now stands at 1.2\%. The prevalence of HIV/AIDS among Ghanaian peacekeepers was 2.2\% - 5\% at the time Ghanaian troops were first deployed in the MRB in the early 1990s; the trend has been towards reduction. According to him, the prevalence rate currently stands between 1 - 2\% among Ghanaian peacekeepers. The introduction of pre-operational HIV screening brought the prevalence rate down from 5\% in the early 1990s to about 2.5\% within a period of ten years. The rates are now said to be between 1.0 - 2.0\%.\textsuperscript{34} These figures are based on pre-operational medical examinations and sick reports. Many ordinary soldiers however disagree with these figures. Interviews of some soldiers reveal fear and worry among the ranks about the increasing suspected HIV/AIDS related deaths among soldiers and their families. In an interaction with soldiers in Sierra Leone, many soldiers said they knew several colleagues who were suffering from HIV/AIDS or had died of the disease. It even came to light that many soldiers have privately checked their HIV status unknown to their commanders. In most cases, HIV-positive soldier nominated for operations outside the country that require
2.7.5.4. **High risk group.** Although it has often been cited that women in the military are particularly vulnerable to HIV infection, it was noticed in the Mano River Basin that the situation is different. Of the over 6 Zambian Battalion (ZAMBATT VI) that has a sizeable number of female peacekeepers, personnel who succumbed to Lassa Fever infection and died as of 2003, and were found to be HIV positive, none was a female even though they lived together under the same conditions. It was the opinion of the Medical authorities that the men were more outgoing and adventurous, taking risks of breaking regulations to meet sex workers or local sex partners. Interestingly, it was found that all the six were drivers. It would appear that drivers were at an increased risk. This may be explained from the premise that drivers move more within the AO, and are often out of the spotlight of the authorities. They are therefore prone to engaging in activities that would expose them to increased risk of infection. This observation is in conformity with the findings of a Research-Action Migration and AIDS Project, involving Burkina Faso, Cote d'Ivoire, Mali, Niger, and
Senegal. The significance of this observation is that, it is this category of peacekeepers — drivers — who on retirement are more likely to continue their trade in civil life. As they travel through the country, they would continue to infect unsuspecting victims, and hence disseminate the virus along the routes they follow and use.

2.7.6. Mode of Transmission. Aside from the irony of HIV’s nearly universal lethality and yet its almost complete preventability, this infection is set apart from other infectious diseases by the cultural sensitivities and social stigmas attached to its major mode of transmission — sex. HIV is also distinguished by the relatively long length of its asymptomatic period before the onset of illness and death. HIV infection is acquired by three major routs — Sex, infected blood, or contaminated needles. The major mode of transmission of the disease among peacekeepers, especially those from the West African sub-Region is heterosexual relations, especially unprotected sex in which at least one partner is infected. In an interaction with soldiers from Ghana and Nigeria in Sierra Leone, all did not understand why in the mist of so many pretty women roaming the streets, one should go for anal sex. Unprotected heterosexual relations therefore appeared to account for most infections that would have taken place involving peacekeepers.

The use of contaminated syringes and needles did not appear to be a problem, though infection by this route could not be ruled out. Military personnel especially within the African culture may also resort to seeking herbal or traditional witch doctors’ protection against all forms of harm. In the process, unsteriled and contaminated sharp implements may be used for the rituals that may give rise to infection.

2.7.7. Factors Promoting Spread Of HIV/AIDS Among Peacekeepers. Military personnel are a population group that is at a special risk of exposure to sexually transmitted
diseases (STDs) including HIV. Military STI rates are generally 2 – 5 times higher than in civilian populations in peace time and up to 50 times higher or more in time of conflict. Paradoxically and fortunately, strong organization and discipline give the military significant advantages if they move decisively against HIV/AIDS. The environmental factors that raise the risk of infection of military personnel and by implication peacekeepers are many. These factors in a way support the theory of military conflicts as a public health issue. The presence of over 16,000 peacekeepers drawn from 37 countries in an environment vandalised by 10 years of war, either as a military strategy or sheer vandalism obviously had prolonged public health consequences for society. The involvement and role of peacekeepers widened the public health consequences of the conflict both in space and time.

2.7.7.1. Extended Period of Celibacy. Military and peacekeeping service often includes long periods away from their families, with the result that personnel are always looking for ways to relieve loneliness, stress and the building up of sexual tension. Soldiers from Ghana and Nigeria spend 6 months in Liberia or Sierra Leone before they are rotated. In the case of military observers (MILOBS), the period of stay is one year. The often-cited allegation that Ghanaian and Nigerian members of ECOMOG fathered and left behind 15,000 children in Liberia, if not an exaggeration, testifies to this point. As troops are rotated periodically, the local women-partners remain and are passed onto the in-coming units. These women, often described as ‘recycled women’, are major sources for the spread of STIs including HIV/AIDS among peacekeepers. According to DPKO Medical head, Dr. Christen Halle, conflict tends to bring together two groups at high-risk HIV infection – commercial sex workers and 15-24 year old men.
2.7.2. Risk-Taking Attitude. The military culture values risk taking. As observed by Manuel Carballo and Jimena Cillonez, military personnel are typically trained to take risks that can involve the loss of life. While this may be essential to their prowess in war, it nevertheless presents dilemmas from the perspective of their personal health-related behaviour. For if the same attitude to risk taking is transferred to sexual behaviour (which it often is) the risk of STIs in general and HIV/AIDS in particular may be significantly elevated as a result.39

2.7.3. Presence of Sex Workers. Military installations demand and attract the commercial sex industry. In most conflict settings, both the demand for sex by the military and the mostly female commercial sex industry that expand in response are perceived as routine and acceptable. Sex workers, pimps, and drug dealers are sure to entice off duty soldiers who are sure to have the cash but not necessarily condoms and sterile needles in their pockets. Several women the candidate talked to in Sierra Leone believed that condom use promoted HIV infection.

2.7.4. Peer Pressure. Peer pressure is one major cause of many troops engaging in risky activities that predispose them to infections and other hazards in the operational environment. The perception of invincibility among young soldiers in environments with opportunities for sexual encounters leads to an increased risk of STIs among peacekeepers.

2.7.5. Low Educational Levels. Although the military recruits and attracts highly qualified staff and trains others, military forces also recruit and attract personnel who have little previous education and who are not considered major educational material once in the
military. Demissie et al. have observed that although the evidence of the relationship between educational background and risk of STIs/HIV/AIDS is inconclusive, it is worth noting that reaching out to people in uniform who have poor education with information on HIV/AIDS has been shown to be more difficult than to better educated ones.40

2.7.7.6. **Multinational Nature.** In the Mano River Basin, personnel were drawn from some 37 countries worldwide. These countries all have different prevalence rates for different communicable diseases including HIV/AIDS. As a result of the interaction among them and the sharing of the same women, diseases peculiar to one country becomes common to all at very little cost but with maximum penalty.

2.7.7.7. **Attitude of Command to Indiscipline.** The faults of peacekeepers rest primarily with senior UN personnel who have failed to draw the line, to establish and publicize clear, precise standard of behaviour. Soldiers are trained to follow orders. Those in command positions have often failed to act when undisciplined behaviour of troops are reported to them, with the response that “boys will always be boys”.41

2.7.7.8. **Environmental influences.** The peacekeeping environment may sometimes be beset by psychological stress, boredom and fear. Military personnel often seek both sexual and emotional relationships in order to compensate for or manage the threats of danger (perceived or real) they are exposed to. Loneliness and having to deal with the stress of fear and boredom is a part of this and the use of alcohol and drugs has typically been one of the strategies all militaries have turned to. The use of alcohol and drugs nevertheless, expose people to increased risk-taking and reduced inhibition.42
CONCLUSION

Diseases within the Mano River Basin are no different from those of other countries in the sub-Region. The major diseases in the basin to which peacekeepers are exposed include Malaria, Lassa Fever, Sexually Transmitted diseases, among others. However, the major disease of concern for which peacekeepers pose a hazard to both the local population and their home countries is HIV/AIDS. Like any sexually transmitted disease, military personnel of whom peacekeepers form a part, are a high-risk group.

The prevalence of HIV/AIDS in the Mano River Basin has been difficult to establish. However, it is estimated to fall between a little under 4% to 7%. Among Troop contributing Countries, the prevalence in Ghana is put at between 3% and 3.6%; and in Nigeria, the rate is put at 5.4%. The prevalence rate of peacekeepers from Ghana is said to be 2% and is alleged to be on the decline, while Nigeria has expressed alarm at the high incidence of the disease among her troops returning from the basin (11%). Of the over 16000 peacekeepers deployed in the Mano River Basin, 32% come from countries where the prevalence rate is above 5%. Mode of transmission of the disease is mainly through heterosexual relations as a high level of promiscuity among peacekeepers and local women.
ENDNOTES

1 Defence Intelligence Agency, Armed Forces Medical Intelligence Centre, USA, January 2001.

2 Frank Apeagyei, Commanding Officer, Ghana Medical Batallion Level II Hospital, Kenema, Personal communications, April 2003.

3 Dr Sessay Koroma, Brigade Medical Officer, 3rd RSLAF Brigade, Kenema, Personal communications, April 2003.


6 Dr Michel Masson, International Committee of the Red Cross, Kenema, Sierra Leone, personal interactions, May 2003.

7 Medical Records of 3 RSLAF Brigade, Kenema, Sierra Leone, February, 2003.


9 Dr Stevens Koroma, Kenema Government Hospital, personal communications, April/May 2003.

10 Dr. Michel Masson, Head of the ICRC, Kenema, Personal Communications, April 2003.


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13 Focus on Sierra Leone: They Came, they saw ....But did they Infect? FSL, Focus, 31 May 2001.


15 Africa Online “chat room” Liberia, Designed and Maintained by Joseph K. Tellewoyan.


21 Osamwonyi Osagie, Director Census and Surveys, National Population Commission, Sustainability within the Context of Population and Natural Resources in Nigeria, a paper delivered to students of the Ghana Armed Forces Command and Staff College during a visit to Nigeria, 16 April 2002.


25 Col. Frank Apeagyei, Deputy Director, General Headquarters (Medical) and Commanding Officer, Level II Hospital, UNAMSIL, Kenema, Sierra Leone, Answers to questionnaire, April 2003.

26 Ibid.

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28 Lt Col VOA Osabutey, GhanaMed: Is it a Reality or Remains a Dream, in, The Sierra, A News Magazine of the Ghanaian Contingent serving in UNAMSIL, Mar 02 – Sep 02.


32 Ibid

33 Lt Col VOA Osabutey, Commanding Officer, GhanaMed Level II Hospital, in a correspondence with General HQ, 2002.

34 Col Frank Apeagyei, Deputy Director of Health, Ghana Armed Forces, Personal communications, April 2003.


38 Michael Fleshman, AIDS prevention in the ranks, UN targets peacekeepers, combatants in war against the disease, Africa Recovery, June 2001.


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CHAPTER THREE

IMPLICATIONS AND RESPONSE TO HIV/AIDS AMONG PEACEKEEPERS

3.1. INTRODUCTION

The effects of war do not end with the last shot. As Shakespeare put it ‘the evil that men do lives after them’. The 1618 – 1649 war left Europe devastated. Today’s conflicts in the developing world will retard their progress for decades. Though the toll of ill health and premature death will be unquantifiable; not all of it will be ascribed to war when the history is written and the statistics accumulated.\(^1\) According to Hazem Ghobarah et al.\(^2\), the direct and immediate casualties from civil wars are only the tip of the iceberg of their longer-term consequences for human misery. The human suffering caused by civil war extends well beyond the direct casualties and beyond the span of the war.

In a space of two decades, HIV/AIDS has become the leading cause of illness and death among sexually active people. In some regions the disease is fast depleting the scarce social capital of the countries. HIV/AIDS has been described by the Secretary General of the United Nations, Mr. Kofi Annan, as ‘the most formidable development challenge of our time.’ Over 20 million people have died of AIDS-related causes. At the end of 2001, some 40 million people were estimated to be living with the HIV/AIDS, over 90% of who are concentrated in resource-poor countries where a combination of poor economic conditions, weak health and social service infrastructures, and the late recognition and response to the problem has contributed to the unabated spread of the disease.
Table 3.1: Some Regional HIV/AIDS statistics as at the end of 2001 compared

<table>
<thead>
<tr>
<th>Region</th>
<th>PLWHA (million)</th>
<th>A&amp;CNA (million)</th>
<th>EA&amp;CD (million)</th>
<th>CELI (million)</th>
<th>APR (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSA</td>
<td>28.5</td>
<td>3.5</td>
<td>2.2</td>
<td>2.6</td>
<td>9.0</td>
</tr>
<tr>
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<td>0.08</td>
<td>0.03</td>
<td>0.035</td>
<td>0.3</td>
</tr>
<tr>
<td>SSE Asia</td>
<td>5.6</td>
<td>0.70</td>
<td>0.40</td>
<td>0.22</td>
<td>0.6</td>
</tr>
<tr>
<td>E. Asia &amp; the Pacific</td>
<td>1.0</td>
<td>0.27</td>
<td>0.035</td>
<td>0.003</td>
<td>0.1</td>
</tr>
<tr>
<td>L. America</td>
<td>1.5</td>
<td>0.14</td>
<td>0.06</td>
<td>0.04</td>
<td>0.5</td>
</tr>
<tr>
<td>Caribbean</td>
<td>0.42</td>
<td>0.06</td>
<td>0.04</td>
<td>0.02</td>
<td>2.3</td>
</tr>
<tr>
<td>E. Europe &amp; C. Asia</td>
<td>1.0</td>
<td>0.25</td>
<td>0.023</td>
<td>0.015</td>
<td>0.5</td>
</tr>
<tr>
<td>W. Europe</td>
<td>0.50</td>
<td>0.03</td>
<td>0.008</td>
<td>0.005</td>
<td>0.3</td>
</tr>
<tr>
<td>N. America</td>
<td>0.95</td>
<td>0.045</td>
<td>0.015</td>
<td>0.01</td>
<td>0.6</td>
</tr>
<tr>
<td>Australia &amp; N. Zealand</td>
<td>0.015</td>
<td>0.005</td>
<td>0.001-</td>
<td></td>
<td>0.1</td>
</tr>
</tbody>
</table>


UN Security Council Resolution 1308 (Appendix v), recognized the role and impact of political instability and war in the spread of HIV/AIDS, particularly in sub-Saharan Africa, where in 1999, over 60% of all conflicts were concentrated and where the spread of HIV/AIDS has affected the largest number of people. These crises reverse decades of Africa’s uneven progress toward economic modernization and political stabilization. HIV incidence and prevalence have far-reaching implications at all levels of society and their
repercussions extend far beyond the domain of public health. The seriousness of the problem facing sub-Saharan Africa becomes obvious when the HIV/AIDS statistics of the region is compared with those of other regions of the world. Statistics were compiled on people living with HIV/AIDS (PLWHA), adults and children newly infected (A&CNA), estimated adults and children deaths (EA&CD), Children Estimated Living with Infection (CELI) and Adults prevalence rates (APR).

3.2. IMPLICATIONS OF HIV/AIDS SPREAD ON THE SUB-REGION

3.2.1. The Social and Economic Implications of HIV/AIDS. The major challenges facing Africa in this decade is to reverse the trend of economic decline which has afflicted the region since the 1970s and strengthen the capacity of the economies for participation as important and effective partners in the global economy in the next century. According to Lori Bollinger and John Stover, the impact of the disease is different from other diseases because it strikes the most productive age group and is essentially 100% fatal. The two major economic effects are a reduction in the labour supply and increased cost. Reduction in labour supply involves the loss of young adults in their most productive years, and secondly if AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates. Military personnel are recruited young and retired after serving between 15 and 25 years because of the physical demanding nature of the job. It is usually the young and the fit that are put into operations abroad. Thus, when AIDS strikes, it is usually the strong young adults of the nation that are affected. It is these that are going to shout that “all die be closin eye”. It imply of the alleged 11% of Nigerian forces returning from the MRB carrying the virus belongs to this group.
The economic effects of AIDS will be felt first by the individuals and their families, then ripple outwards to the employment and the macro-economy. The household impacts begin as soon as a member of the household starts to suffer from HIV-related illness. Many soldiers are the main breadwinners for their immediate and extended families. According to Dr A Arkutu, at the household level, the effect on the family of the death of a breadwinner is immediate and often catastrophic.

The family is reduced to poverty because of the sudden loss of income, the cost of providing care for the afflicted, the burial and funeral expenses and a run down on savings. This study could not obtain information on the impact of HIV/AIDS on income in Ghana and Nigeria. However, studies have shown that in Côte d'Ivoire, the average income of families in which a member has AIDS dropped by between 52 and 67%, expenditure on schooling was halved and food consumption dropped by 41% while expenditure on health care quadrupled. A range of studies agrees that the net effect of the epidemic on per capita gross domestic product (GDP) growth is negative and possibly substantial. For those countries with national HIV/AIDS prevalence of 20%, annual growth has been estimated to drop by an average of 2.6% points while studies have also established that rate of economic growth has fallen by 2 – 4% in sub-Saharan Africa as a result of AIDS.

3.2.2. Implications on Public Health. Health issues threaten the very development and cornerstones that are necessary for the building and maintaining the international community that is stable, democratic, and economically prosperous. Herophilus, physician to Alexander the Great, around 325 once said, “When health is absent, wisdom cannot reveal itself, strength cannot fight, wealth becomes useless, and intelligence cannot be applied”. Yet, a major casualty of warfare is health.
AIDS will affect the Health Sector for two reasons: first it will increase the number of people seeking services; and secondly, health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Rodger Yeager states that the health-care systems in Africa are stressed and later inundated as the HIV-infected person of past years become AIDS-symptomatic. AIDS attacks the health sector in two ways; it dramatically increases the number of people seeking services, and it creates an ultimately futile demand for care that is more expensive than that required for more treatable conditions.

AIDS-related cases have already overwhelmed health services in a number of African countries including Côte d'Ivoire, Malawi, Zambia, and Zimbabwe, where patients occupy between 50 and 80 per cent of hospital beds. This worsens the problem of overcrowding and increases risk of secondary infections such as TB and diarrhoea. In highly endemic countries, many caregivers are themselves HIV seropositive, others are seriously ill, and others still have died. Health is both an economic input and output. Health helps create wealth in several ways. Longer life expectancy encourages smaller families, greater investment in education, and higher rates of domestic investment as people save for retirement. By contrast, poor health combined with economically unfavourable age structure helps to explain sub-Saharan Africa’s dismal economic performance. Poor health reduces economic productivity by creating labour shortages and heightening absenteeism, redirecting resources from education and infrastructure towards increased spending on health care, and reducing individual resources by diminishing savings and imposing higher health care costs, thus leading to isolation from the global economy.
3.2.3. Implications on Education. HIV/AIDS is conceptualised as having the potential to affect education in ten different mechanisms; reduction in demand, reduction in supply, reduction in availability of resources, adjustment in response to special needs of a rapidly increasing number of orphans, adaptation to new interactions both within schools and between schools and communities, curriculum modification, altered roles that have to be adopted by teachers, the ways in which schools and the education system are organised, the planning and management of the system, and donor support for education. Most service personnel have large families in addition to extended family obligations. Unfortunately, AIDS often afflicts more than one member of the family. Consequently, many families have lost more than one family member to HIV/AIDS, resulting in the explosion in the number of orphans. In the event of ill health or death, the education of the children and the extended family dependants is thrown into disarray. By the year 2010, HIV/AIDS is expected to have created 42 millions orphans worldwide. The increased expenditure on health as a result of AIDS also diverts funds from the educational sector. Stigmatisation of children who have lost their parents through HIV/AIDS by their peers may also lead to their staying away or withdrawal from school.

3.2.4. Agriculture. Most sub-Saharan African countries depend on agriculture as the major source of foreign exchange and domestic food requirements. Over 70% of Ghana’s population is engaged in agriculture. Although Nigeria is dependent on oil exports, a large proportion of the population is still engaged in agriculture. According to Lori Bollinger and John Stover, studies conducted in Tanzania and other countries show that AIDS has adverse effects on agriculture, including loss of labour supply and remittance income. The loss of labour at any stage of the production process can significantly reduce the harvest. In addition any loss of agricultural labour is likely to cause farmers to switch to less labour
intensive crops. This may mean switching from export crops to food crops, such as from cocoa to maize and cassava production. In most African countries, women constitute the major labour force in agricultural activity. Yet it is women that are likely to suffer most from infections of troops returning from operations abroad with communicable diseases, especially the STDs. The UN Food and Agricultural Organization (FAO), on World Food Security notes that in the 27 most HIV/AIDS affected countries in Africa, seven million agricultural workers have died from AIDS since 1985. Sixteen million more deaths are likely by 2020. As the Late Burkinabe leader Sankara once said, a soldier is a civilian in uniform and a civilian is a soldier out of uniform. According to Martina Haslwimmer, the consequences of HIV/AIDS on rural populations to which many service personnel belong, visit during leave, and return to on retirement, include: the threat to rural household and community food security; a decline in the nutritional and health status of small holders and their families; a decline in educational status as children are forced to leave school; and changes in the social system, as households adapt to the impact of HIV/AIDS such as female-headed households.

Many military personnel have taken to agriculture in the developing countries as a source of supplementary income to meet social obligations. Demobilised and retired personnel are increasingly attracted to agriculture, and are investing their peacekeeping earnings, and end of service benefits (ESB) in agriculture. In Nigeria, some of the country’s top military personnel including the current President, Chief Olesugun Obasanjo, are involved in large-scale agricultural production. High morbidity and mortality rates among the military as a result of HIV/AIDS, will affect military contribution to agriculture.

3.2.5. HIV/AIDS and Security in West Africa. HIV/AIDS poses a pervasive and non-violent threat to human existence. The UN Security Council and a growing number
of world leaders have suggested that the impact of AIDS is profound enough to challenge fundamentally the security and stability of a growing number of states around the globe, and the UN Security Council defined it as an issue of human security. HIV/AIDS does not by itself cause wars, insurgencies or communal violence. It is profoundly destabilizing in several important ways, and it contributes to an environment in which individuals, communities and nations are much more vulnerable to conflict.16

In Africa, many military forces have infection rates as much as five times that of the civilian populations. There are fears of under-recruiting, impaired readiness, and a lack of experienced officers. The vulnerabilities it creates in militaries as well as in the pillars of economic growth and institutional endurance can make nations more vulnerable to both internal and external conflicts. AIDS has become a greater threat to security in general, debilitating command structures and systems and compromising the readiness and capacity of the military sector to respond to threat.

Ghana and Nigeria continue to play leading roles in the security and stability of the sub-region, being the key players in ECOMOG’s operations in both Liberia and Sierra Leone. Ghana remained the hub for a solution to the conflict in La Côte d’Ivoire, while the re-emerging civil war in Liberia will heavily depend on both Ghana and Nigeria for a solution. Thus the two must also have well-trained Armed Forces that are fit by military standards, capable of meeting the security challenges of the sub-region. Apart from the sub-regional security concerns, Ghana and Nigeria have their own domestic security problems. Ghana for example is confronted with numerous chieftaincy, ethnic, religious and land disputes that often call for the deployment of military personnel alongside the Police Force to resolve. The Konkonban-Nanumba wars, the Bawku Chieftaincy crisis, the Dagbon crisis,
are a few examples. During a Staff College visit to the Brong Ahafo Region in April 2002, it came to light that over 75% Chiefdoms were engulfed in disputes.

The primary role of the Ghana Armed Forces (GAF) is the protection of Ghana’s territorial security from outside aggression. Past claims to part of her territory by Togo has seen Ghana-Togo relations vacillating between peace and near confrontations depending on the governments in the two countries. It is generally believed that Togo, even though smaller than Ghana, has better-equipped Armed Forces. This is not acceptable for many Ghanaians, including some academics such as Professor Gilbert Keith Bluwey\textsuperscript{17}, who argue for a more robust GAF in comparison to that of Togo. An upsurge of HIV/AIDS within the Ghana Armed Forces would further tilt the scales in favour of the potential enemy.

Nigeria has all the problems faced by Ghana at the domestic front in larger proportions. Ethno-religious conflicts especially between people of a Muslim North and a Christian South is a common occurrence. With the declaration of Sharia Law in most of the Northern states, Nigeria is on a collision course from within. Armed robbery, agitation in the Delta States over oil revenue sharing, and cattle rustling, coupled with external threats such as the Bakasi fracas with the Cameroon, border disputes with Chad, and incursions from Niger, all give the country enough security challenges for the Armed Forces. As the sub-regional leader and her ambition for a seat at the Security Council, Nigeria cannot afford to maintain a military ravaged by HIV/AIDS. Military power is one of the determinants of foreign policy and balance of power. An Armed Forces bloated with HIV/AIDS sufferers as well as other equally challenging communicable diseases such as Tuberculosis may not be able to keep Nigeria one, a task that must be done, as was the battle cry of the Federal forces during the Biafra War in the 1960s.
Apart from its traditional security roles, the military by its composition including doctors, lawyers, engineers, teachers, journalists, and indeed, every profession imaginable, provides an emergency reserve force to any government in the event of disaster and industrial action by the civil society. According to Haruna Attah, in a wider national security consideration, the military should be schooled to handle some of our strategic assets such as the VRA, ECG, TOR, Ghana Water Company, to mention a few. Anytime workers of these assets decide to down their tools, soldiers could quickly be called upon to step in. The Military Hospital for example has on several occasions been pressed into action as a result of industrial action by doctors and other medical staff of the civil hospitals.

3.2.6. HIV/AIDS and Political Stability. HIV/AIDS and other poverty-related factors that endanger development naturally also pose a threat to political stability. Poverty, hunger, and crumbling socio-economic and political structures lead to a growing sense of helplessness and anger among surviving populations, which may already be divided along ethnic, religious and/or territorial lines of conflict. Governments are further weakened by their inability or unwillingness to respond and are increasingly perceived to be more a part of the problem than an instrument of its solution.

The severe and socio-economic impact of HIV/AIDS and the infiltration of the epidemic into the ruling political and military elites and middle classes of developing countries are likely to intensify the struggle for political power to control scarce State resources. Disease can decimate the ranks of skilled administrators, diminish the responsiveness of governmental institutions or reduce their resilience. This will detrimentally affect the operational effectiveness of such institutions as the Armed Forces, Police, Prosecution Service and Judiciary. HIV/AIDS may jeopardise the establishment of democracy because the next
generation of political and economic leaders is being wiped out. Citizen support and participation in democratic governance will wane, as more people develop terminal disease and are removed from the public sphere. This will slow down the development of civil society and other underpinnings of democracy, and will increase pressure on democratic transitions in Sub-Sahara Africa.20

3.2.7. Implications for International Relations and Foreign Policy. There is growing attention to the links between health, foreign policy and security. Factors such as socio-cultural environment, political and economic structures, alongside biology, individual behaviour and health systems, are increasingly transborder in nature, in that their origins reach and their consequences transcend territorial boundaries, notably the borders of sovereign states. This has led to widespread interest among health researchers, policy makers and practitioners in the emerging field of global health.

Following the end of the Cold War, and amid processes of globalization, it is argued that there is a proliferation of external factors that play a growing role in shaping domestic policy making. Foreign policy makers must therefore broaden their horizons when seeking to further the national interest. New tools of foreign policy have been debated as part of this new milieu including such ideas as health as a form of ‘soft power’ (Nye 2002) and even health as a ‘bridge for peace’ (Vass 2001).21

Jordon S. Kassalow,22 has examined why health is important to the U.S. foreign policy, and raised issues that are relevant to all countries. According to him, the nexus between foreign policy and international health became increasingly apparent in the 1990s. The early signs included the special session of the UN Security Council on the issue of HIV/AIDS,
huge debt relief packages tied to investment in health, the liberalization of trade policies to global health priorities in terms of a broad set of interests that include national security as well as economic, political, and humanitarian concerns. It is no longer possible to dismiss health problems in other countries in one’s foreign policy, as the global transmission of disease becomes a risk to all. In the international arena, diseases threaten ordered existence by exacerbating political instability, disenfranchising those without social capital, and stunting economic growth.

According to George Modelski\textsuperscript{23}, foreign policy is the set of systematic activities evolved by communities for changing the behaviour of other states and for adjusting their own activities to the environment. Foreign policy is a series of inputs and actions that a nation makes use of in influencing the behaviour of other nations in the pursuit of its prescribed goals. National interest is the key concept in foreign policy. National interest has three basic dimensions – security, economic development, and a stable world order. HIV/AIDS affect the security and socio-economic development of country and hence its national interest and foreign policy.

The US as the sole superpower after the end of the cold war plays a major role in the economies of most sub-Saharan Africa. Yet the US views the AIDS problem of African countries as directly linked to US security. According to David Gordon, there are four areas of concern about the HIV/AIDS virus: the impact on US public health; the effect on US and international troops and peacekeeping operations; the slowing of economic development where the US has significant strategic and economic interests; and the destabilization of African societies. These observations are based on the fact that AIDS has the potential to weaken US and foreign militaries and make mobilization of international force difficult.
The high prevalence of HIV/AIDS in sub-Saharan Africa is responsible for the jitteriness of the US over the deployment of her troops in Liberia. Similarly, other countries such as the UK, Canada, New Zealand, to mention a few, try not to keep their troops in Africa for long periods for fear of HIV/AIDS. Military Observers from these countries to missions in Africa therefore spend only six months, instead of the one year period when the operations are elsewhere.

3.3. RESPONSE TO HIV/AIDS SPREAD AMONG PEACEKEEPERS

Despite the fact that HIV/AIDS prevalence rates are high and probably increasing in many military settings, there are at the same time many opportunities for intervening to prevent further spread of the disease using the strength of military culture, discipline and teamwork and command hierarchies. Within most military forces, there are well-established institutional mechanisms that can be used for training, education, medical care and management of people with health and social problems and counselling. Changing the perception and behaviour of soldiers can produce significant benefits for the general population. Uniformed services also present a unique opportunity for HIV prevention and education to a large captive audience.24

3.3.1. Response by the United Nations. The Joint United Nations Programme on HIV/AIDS (UNAIDS), established in 1996, is a cosponsored programme that brings together UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO, and the World Bank in a common effort against the epidemic. The UNAIDS cosponsors bring to this effort complementary mandates and multisectoral experience ranging from education and socio-economic development to women's reproductive health. They are committed to joint planning and action, giving UNAIDS a cooperative advantage. As the main advocate for global action
on HIV/AIDS, UNAIDS leads, strengthens and supports an expanded response aimed at
preventing the transmission of HIV, providing care and support, reducing the vulnerability of
individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

The guiding principles include, strengthening of countries’ capacity for long-term action
ranging from prevention and care to impact alleviation; identifying and using technically
sound policies, strategies and tools; through societal and structural changes reduce the
vulnerability of women, young people, migrants, drug users, sexual and ethnic minorities and
military personnel especially peacekeepers. Policies should support societal, political and
legal responsibility of individuals to exercise their responsibility to protect themselves and
others from HIV infection. The role of external partners, including UNAIDS, is to support
and build on national action. It is in recognition of the havoc being caused by the
HIV/AIDS menace in many developing countries especially in Africa that the Security
Council came out with Resolution 1308 (Appendix 1) in an attempt to address the one disease
that has defied all attempts to fight and control. The resolution asks the Secretary General to
take steps to provide predeployment orientation and ongoing training for peacekeeping
personnel on the prevention of HIV/AIDS. The Emergency Response Department (ERD) of
the UN is tasked to help respond to the UN Security Council Resolution 1308, and help
prevent, control and treat HIV/AIDS in communities affected by conflict, including
peacekeeping troops, humanitarian workers and vulnerable populations. The key objectives
include mainstreaming uniformed services as a major risk group, strengthening regional
capacity to deal with HIV/AIDS in uniformed services, providing necessary support for the
implementation of the cooperation framework between UNAIDS and DPKO, and facilitating
mobilization of resources. ERD is working closely with UNAIDS and DPKO to provide
HIV/AIDS briefings to departing peacekeepers and attach UNAIDS focal points to all
peacekeeping operations. This will be extended to cover affected populations in crisis countries through the Resident Co-ordinator System (RCS) and a Co-ordinating unit will be established within ERD. ERD/UNAIDS with DPKO and RCS actions should among other things emphasise global strategy to respond to the HIV/AIDS epidemic within peacekeeping operations including populations most affected by the epidemic. The strategy presently focuses on countries providing peacekeepers and their capacity building through support to national/regional networks of experts and centres addressing HIV/AIDS among uniformed services, and reinforcing south-south cooperation as well as outreach programmes through public information on HIV/AIDS among uniformed services and populations affected by the presence of military personnel.26

The first step in mitigating future risks is to increase the awareness of peacekeepers and those with whom they come into contact locally, about the causes of HIV/AIDS and the ways of preventing its spread. The Training and Evaluation Service in the DPKO has developed a comprehensive module on medical issues for national level senior trainers, 80% of which was dedicated to HIV/AIDS awareness and prevention. The Service, the Department, UNAIDS, and the Civilian Military Alliance to Combat HIV/AIDS has also collaborated in producing a number of publications that have been distributed to all participants of the ‘Train the Trainer’ courses. Apart from the training perspective, the Medical Support Unit of the Department has been reactivated in an ICG Report on HIV/AIDS as a security issue. To combat the HIV/AIDS problem, it was recommended that the international donors community support and fund a ‘war chest’ of US$10 billion annually for the war on AIDS fund as called for by the UN Secretary General, Mr. Kofi Annan and endorsed by the World Bank President, James Wolfensohn. The international donor community should acknowledge that this is not a one time measure but a long-term commitment of at least a decade. The G8, the US and the
EU should commit themselves to this programme by doubling their current global spending on HIV/AIDS. It is important that the restriction of donor support for the Armed Forces be reviewed with regards to support for HIV/AIDS control and prevention.

The UN Secretary General should enlist a high level council of former leaders to develop and push for a political strategy for implementing the declaration for action adopted by the General Assembly Special session on AIDS in June 2001. Leaders of the donor nations affected countries, and UN institutions should give the war on AIDS the urgency and serious priority it deserves, and provide health workers on the front lines with the political support needed to accomplish their tasks. The UN Security Council should fulfil its responsibility in oversight of peacekeeping missions by requiring comprehensive HIV prevention education of all peacekeeping troops and actively supporting prevention education in communities in which they serve. Peacekeeping operations provide an opportunity to work with the UN to link national efforts to global peacekeeping efforts. Secondly, governments of affected countries should develop specific and prioritised national AIDS strategies in consultation with non-governmental organizations, people living with AIDS, the private sector, and donors. Developing countries in Africa should dedicate 15% of their annual public spending to AIDS and other public health priorities. The private sector should dramatically increase its investment in the global war on AIDS. Pharmaceutical companies should increase access to essential drugs and *antiretroviral* therapies for those in need in the developing countries.\(^{27}\)

The World Bank has established a multisectoral AIDS Campaign Team for Africa (ACTAfrica) based in the Office of the Regional Vice President for Africa. The high level placement of ACTAfrica underscores the Bank’s commitment to HIV/AIDS and care. This enables the team to maximize collaboration among the various sector families. The
team serves as a focal point and a clearinghouse on HIV/AIDS. It will provide a variety of services including supporting implementation of the Multi-Country AIDS Programme (MAPS), supporting African countries through knowledge dissemination and exchange, and supporting Bank country teams in addressing HIV/AIDS in their country assistance strategies. It will also assist in building HIV/AIDS impact assessment into existing environmental and/or social assessment processes, stressing and expanding the Bank’s partnership with UNAIDS as well as with key agencies, non-governmental organizations and donors.28

3.3.2. UNAMSIL HIV/AIDS Awareness Programmes. The UN has tasked each peacekeeping Mission with the primary responsibility of the well-being of its peacekeepers. Missions have been urged to provide appropriate sensitisation training on HIV/AIDS to all military and civilian peacekeepers. In order for UNAMSIL to realise this responsibility, the Mission Training Cell, together with the Force Medical Branch and the Focal Point in-charge of the campaign against HIV/AIDS under Ms Hirut Befecadu (Coordinator HIV/AIDS) conducts in the Mission Area HIV/AIDS awareness-training programme for all peacekeepers troops of UNAMSIL. The training is designed to reactivate the basic knowledge of the dangers of the disease and to develop the capacity of peacekeepers to protect themselves and become advocates and principal actors for awareness creation in the prevention and spread of HIV/AIDS amongst peers and in the communities with whom they are in contact.29

3.3.3. Sub-Regional Response to the spread of HIV/AIDS. On return to their respective countries, very few of these soldiers undergo medical examination to establish their health status. Pre-operational HIV screening may be viewed as a panic reaction to stem HIV menace. In an interview with the Assistant Director of Medical Services of the
Ghana Armed Forces, Lt Col Tamakloe, he attributed the non-testing of soldiers returning from operations to lack of funds. According to him, even the pre-operational screening of troops is becoming a burden. Data is therefore lacking on many communicable diseases including HIV/AIDS. The discovery that 11 – 15% of Nigerian troops returning from MRB test positive for HIV virus, according to President Obasanjo, was one of the watershed events of his government’s approach to the epidemic. In Zambia, where recruitment of military personnel was opened to HIV carriers, the government recently decided to debar the recruitment of people found to be positive from joining the Armed Forces. Although human rights activists have criticised this move, the measure is intended to reduce the high prevalence of the disease among Zambian soldiers, as well as protect individuals with the HIV infection from the rigorous military training that may hasten the development of full blown AIDS and consequently their death.

In Ghana and Nigeria, the command structures have permitted the introduction of integrated sustainable HIV/AIDS/STI/TB prevention and care into their health delivery systems. Task Forces under the guidance of USAID and coordinated by Family Health, in consultation with military representatives from the two countries and some other sub-Sahara African countries, have developed comprehensive packages that would support the integration of HIV/AIDS into existing systems and structures of the uniformed services. These packages involve advocacy at the highest levels to mandate vital policies such as ensuring that STI treatment at clinics is kept off individuals’ records, and inclusion of condoms in travel kits, adequate supplies of STI drugs, and continued service if HIV-positive. Quantitative assessment is routinely conducted to find out how officers and the ranks perceive risk and risky behaviour, where they seek treatment for STIs, when they use condoms, what they do for recreation, whom they listen to for information about HIV/AIDS/STI/TB, and what they value. Strategic
planning based on an assessment of the potential for integrating HIV/AIDS programming is factored into existing systems and structures. Behaviour change communication (BCC) based on the assessment helps to develop peer educator network, interpersonal and group communication strategies, using local mass media. Basic and in-service training on HIV/AIDS for all recruits and personnel is emphasised and condom distribution and policies, including the promotion of 100% condom use policies in the local and surrounding communities, are promoted. Strengthening STI services within health delivery systems used by military personnel, quality HIV voluntary counselling and testing (VCT) services and care and support for those affected including quality clinical services and support groups for people living with HIV/AIDS (PLWHA) and their families are included.32

Demobilisation presents challenges and opportunities for the spread of HIV/AIDS. The challenge is to reach troops prior to demobilisation with HIV/AIDS prevention and care education and information, before they function as a bridge population to the general community. This presents an opportunity to take advantage of this process to create a cadre of change agents to release back into the general community. In Nigeria, the NACA’s HIV/AIDS Emergency Action Plan (HEAP) is built around two strategic components: Creation of an enabling environment and Specific HIV/AIDS interventions. HEAP identifies over 200 activities, centred on 15 strategies, which the Federal Government intends to pursue over the period 2001 – 2004. Most activities under HEAP are conceived as short term, high impact interventions whose implementation will form the base for a medium term Plan for HIV/AIDS in Nigeria. HEAP would therefore serve as an important testing ground for deriving best practices, coordinating strategies and high impact responses and as a bridge to the definition of a longer-term vision for the future. The first strategic component of creation of an enabling environment:33 removal of Socio-Cultural barriers where NACA and
other implementing partners will address the need to sensitise the general public and support the advocacy and activities through development of legislation and policies centred on human rights of PLWHAs. It will remove information barriers by developing information base at all national and state levels for reliable and timely flow of information to decision makers and programme implementers, and working with key ministries to establish an overall framework for HIV/AIDS research. It will also remove systemic barriers to address the organizational needs of both NACA and HEAP. Lastly, it will catalyse Community-Based Responses, and mobilise the local community, which is fundamental to the success of HEAP. This would involve the creation of a community-based fund to ensure unobstructed flow of resources to local communities. The fund would support community mobilisation, selection and training of community volunteers, and the design and implementation of community action plan (CAP). In the second component, four separate but linked strategies to address the development of specific HIV/AIDS interventions were specified. High-risk populations are targeted. This covers high-risk/non high-risk youth populations and empowerment of women to negotiate safe sex. It also deals more importantly with the Armed Forces and the Police. It also looks at the prevention of infection from mothers to children, Commercial Sex workers, interventions in Prisons and Immigrations, as well as Transport workers. Secondly, interventions for the General Population would focus on providing health workers with materials and training related to syndromic management of STIs, developing policies and regulations with reference to safe blood supply as well providing structures and systems for affordable VCT services.34

3.4. MAKING PEACEKEEPING SAFE FOR PEACEKEEPERS

Several limitations against HIV/AIDS control programmes have been identified. According to Prof Ibironke Akinsete, unstable political situation, lack of political will and commitment, competing priorities in other areas, and lack of multisectoral approach are the
major factors. Most programmes, despite good intentions, are donor driven; most donors do not sponsor programmes that are designed for the military including health care. Weakness in general planning and programming including information systems management and poor data on HIV/AIDS epidemiology are also irksome areas. The military for example provide scanty data on the disease prevalence among their ranks although they constitute one of the major areas of concern. Persons living with HIV/AIDS were often reluctant to actively participate in prevention and control activities.\textsuperscript{35}

Dr. M. M. Ogbalu et al.\textsuperscript{36} have identified lack of coordination of activities at the grass root level as the major problem facing HIV/AIDS control in most developing countries. Most activities are run as vertical programmes to the former health services. This has constituted one of the major obstacles to an effective and coordinated approach to HIV/AIDS control in these countries. The answer lies in a full integration of HIV/AIDS control into PHC programmes and PHC workers should be given continuing educational programmes involving periodic training workshops to bring them up to date on new concepts in PHC and HIV/AIDS control. The curriculum for institutions should be reviewed to incorporate current concepts on HIV/AIDS prevention and control such as Information, Education and Communication (IEC) as the main strategy for the control of HIV/AIDS. All PHC workers should be involved in IEC activities at the Health centres, outreach programmes and home visits, using locally produced materials tailored to the local conditions in terms of culture, language and level of education. They would provide pre- and post-screening counselling especially for those that are HIV-positive, including their families. Trainers should carry out Health Information Systems Surveillance as part of PHC implementation to collect data covering information from the most peripheral clinics and outreach centres to comprehensive health centres in each area. The data will be very useful for monitoring trends
in HIV infection and mortality. PHC workers should treat opportunistic infections associated with HIV/AIDS with modalities for referral of more complicated cases. Patients who need Home based care especially people living with HIV/AIDS as well as their families may also be referred to PHC workers.

3.4.1. Leadership Factor. One of the factors compounding the impact of the epidemic on the African continent over the past decade is the failure of many leaders to acknowledge the problem and take decisive action to stop the spread. In some of the worst affected areas such as South Africa, Zimbabwe, and Kenya, President Mbeki, Mugabe and former President Moi had times been slow to even accept the link between the HIV virus and AIDS, let alone to promote preventive measures against it within their societies. The vital importance of such leadership can be seen in cases where leaders took up the challenge, for example in Uganda, Thailand, and Brazil, and significantly reduced the infection rates. In Senegal, when the first cases occurred in 1986, the government took immediate steps to set up a national AIDS programme with visible political leadership. The government engaged religious leaders and educational materials were developed disseminated through Mosques and Churches. Senior government and religious leaders used radio and television to get the word out, and the NGO community and civil society were mobilized and trained in HIV prevention. Sex education was introduced in schools, blood screening became routine and special outreach programmes for sex workers and mobile populations were widely implemented. As a result, Senegal has an HIV infection rate of less than 1.8% of its adult population, one of the lowest in Sub-Saharan Africa. Similarly, Uganda slashed its infection rates by half when the President launched a broad based multisectoral campaign, requiring all government officials to talk about preventing the spread of HIV/AIDS in every public speech. Massive education efforts were mounted with the involvement of the military, the mass media, and civic leaders
to reduce the stigma and to change risk behaviour. Access to voluntary HIV counselling and testing, STD treatment and very basic AIDS care and support was dramatically increased and ongoing surveillance studies to track the epidemic and target available resources were institutionalised. The overall HIV prevalence in adult populations declined from 14% in early 1990 to 8% in 2000. In both success stories, political commitment at the highest levels coupled with comprehensive action has led to real results. What are needed now is the political will and the financial resources to repeat these success stories on a larger scale.37 According to the UN Secretary General, Mr. Kofi Annan38, in the war against HIV/AIDS, there is no “us and them”, no “developed and developing countries”, no “rich and poor” – only a common enemy that knows no frontiers and threatens all peoples. It is essential to maintain the momentum and monitor the progress.

3.4.2. Raising public awareness. Raising public awareness is the fastest way to reach large populations. Bringing together public health practitioners and security experts in order to address the pandemic in such military programmes as planning for peacekeeping operations, demobilization and even military training is essential. According to Forman and Carballo, in the past, development practitioners once shunned any working relations with the military, but it is impossible now to avoid this institution if any preventive programme is to work.39 It is also important that in mission areas, HIV/AIDS control programmes incorporate local programmes.

3.4.3. Making Use of Religion. Religion is one of the most important social institutions with pervasive effects on various aspects of people’s lives, attitudes and behaviour. Religion affects both group and individual behaviour and has been identified as an important means of passing on information. Many believers hold information of religion on reproductive
health behaviour and sexuality of young people in particular and the society in general, especially in terms of sexual morality, fidelity and chastity before marriage. Since religious leaders have this advantage, coupled with the fact that they often command captive audience, they could be effective allies in combating the spread of HIV/AIDS in the sub-region.40

3.4.4. Using Traditional Science. HIV/AIDS is currently incurable by western drugs and there is little or no definite protocol for effective management of the opportunistic diseases in most hospitals in several countries of the West Africa sub-region. Traditional medicine, although controversial among medical scientists probably because little is known about its potential for curing the sick, continues to be sought openly or blindly by those living with HIV/AIDS everywhere in the world, more often than not in a desperate bid for a cure. The Chinese and Indians are spending large resources in search for cure using Traditional Chinese Medicine (TCM) and Ayurveda of India. It is generally believed among African Traditional Medical practitioners that there is no disease without an effective remedy somewhere in the bush. A search in Africa for such herbs will afford people with HIV/AIDS to live a relatively more comfortable life and perhaps with longer life expectancy.41 Nana Drobo of Ghana and others in Nigeria and the Cameroon and indeed other African countries have made claims that have not been substantiated but also more importantly have not been disproved. African countries should intensify research into the field of herbal medicine.

3.4.5. Using Child education tools. Chinasa Orgi, has suggested four ways, which parents can use to communicate with their children, and wards on the issue of preventing HIV/AIDS. These points can be applied in the military setting with Military Command structure assuming the role of the parents. These four ways are interaction, inquiry, directive influence and strategic influence. Interaction involves openness, accessibility,
friendliness, and being approachable and sympathetic. A command structure that interacts with the men would be able to pass continuously messages on prevention of HIV/AIDS to his troops. Inquiry involves listening, asking questions, clarifying and being approachable and sympathetic to each other. This would help soldiers living with HIV infection to overcome the agony of stigmatisation. Directive influence involves pulling together various opinions and ideas into a plan, providing specific recommendations, setting standards, fulfilling and eliciting promises, challenging poor performance, setting priorities, commendation of good performance, setting priorities and guides for implementing activities. Many soldiers often have very mature, problem solving ideas and opinions that if given the opportunity by command, could contribute to ways of addressing the menace of the disease within the ranks. Bi-weekly Commanding Officers durbars on HIV/AIDS could pay dividends in the reduction of the prevalence of the disease among troops. Strategic influence involves getting things done. This is achieved by stimulating others behaviour by honestly showing feelings, motives, and concern, convincing others, shaping their behaviour through constructive criticisms and providing a favourable atmosphere and support to achieve results.

The effects of war extend well beyond the span of the war. The socio-economic implications of HIV/AIDS among peacekeepers, especially in sub-Saharan Africa, are issues that will continue to attract the attention of the international community as conflicts continue to arise and peacekeepers continue to be dispatched to these areas. Although attempts by the World body and other international organizations are vital in finding answers to the problem, local factors such as political and military leadership are vital for a long term and lasting solution to these problems.
ENDNOTES


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CHAPTER 4

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1. SUMMARY OF FINDINGS AND CONCLUSIONS

This study was designed to look at the public health aspect of peacekeeping in the conflicts in the Mano River Basin from the perspective of spread of communicable diseases. The study focused on HIV/AIDS and the implications of the spread by peacekeepers on Troop contributing countries with particular reference to Ghana and Nigeria. The study reviewed some common communicable diseases in MRB of potential risk to peacekeepers. The major diseases in this category were, Malaria, Lassa Fever, Typhoid Fever, *Tuberculosis*, Cholera, Diarrhoeal Diseases, and sexually transmitted infections (STIs) including HIV/AIDS. The study reviewed a condition that is not prevalent in the region but has the potential to become a problem by its peculiar transmission pattern – through travellers. This is the SARS problem that is a worry to some countries including some TCCs, specifically Canada and China.

Turning to HIV/AIDS, the study looked at the prevalence in MRB. It found that the conflict had made it difficult to obtain reliable statistics on HIV/AIDS prevalence rates. It was established that the disease was first reported in the two countries in 1986 and was never considered a problem until the arrival of ECOMOG, which most people in these countries blame for the introduction of the disease in their countries. Prevalence rates now range from 3% to 8% in both countries. The rates among sex workers could go up to 60% or more.
The next step was to look at the prevailing health conditions and the HIV/AIDS prevalence in TCCs (Ghana and Nigeria). The research reveals that the major diseases in the MRB do not differ markedly from those in the TCCs in the sub-region. Looking at HIV/AIDS in TCCs, it established that like MRB, HIV/AIDS was first reported in both Ghana and Nigeria in 1986 with prevalence rates below 2% at the time. The situation has since changed and both countries recognise the infection now constitutes a problem. Whereas the prevalence rates in Ghana are put at 3.6%, Nigeria has a prevalence rate of 5.4%. The figures among sex workers in the two countries vary between 30 and 70%.

Next looking at HIV/AIDS and peacekeepers, the study established that of the over 16000 troops from some 37 countries that were in the region, 5,267 or 32% come from countries with HIV/AIDS prevalence rates of more than 5%. On the prevalence among peacekeepers, Ghana has been a bit vague on definite statistics, insisting that the infection was on the decline from a high of 4.5% at the beginning of the ECOMOG days, and now below the 2% mark. The prevalence of HIV/AIDS in the Nigerian military has been put at between 10% and 20% with one study putting the prevalence of the disease among Nigerian peacekeepers returning from the MRB at 11% - 12%. It was also concluded that the chances of infection increased with the length of stay in the basin. It was also significantly noted that ZAMBATT had lost some twelve soldiers to Lassa fever. All the deceased were found to be AIDS patients. It is unlikely that these soldiers got infected in the basin but were probably infected prior to deployment. One Bangladeshi soldier was also diagnosed HIV positive when he reported sick at the GHANMED in 2003. It was
gathered from interviews with troops that the major mode of transmission of the disease was through heterosexual relations.

The study also looked at the implications of the spread of HIV/AIDS on the wider society, especially in the area of socio-economic development, education, Agriculture, security, governance and political stability and International Relations and Foreign Policy. It established that in all these areas, the spread of HIV/AIDS had serious implications on society that is drawing the development of most of sub-Saharan African countries back. It then looked at the response and measures that need to be taken to make peacekeeping safe for peacekeepers and the wider society. The role of the UN, other international organizations, and countries in the sub-region were emphasised.

Generally the study established that:

- Military personnel are a high-risk group to STIs including HIV/AIDS. Infection rates may be 2 to 5 times as much as the civil rates in peacetime and could rise above 50 times during conflict.
- Although military personnel constitute a high-risk group, military training and discipline provides a unique opportunity in which preventive measures can be provided to a large captive and influential audience.
- Infection among military personnel is not only a threat to them, but also their families and society in general. Preventive programmes within the military are most effective if there is close collaboration with civil health programmes.
- The single most important factor responsible for high STI infection is the deployment of military personnel far from their accustomed communities and
from their families for varying lengths of time. This frees them from traditional social controls, removes them from regular spouses and sexual partners and thereby encourages contact with non-regular sexual partners and sex workers.

➢ Cost of pre- and post-deployment HIV screening discourages several countries from conducting the tests for their troops. This point is particularly important for many African countries confronted with financial problems that make it difficult for them to carry out these vital tests on their peacekeepers.

4.2. RECOMMENDATIONS

4.2.1. Based on the work, the study recommends the following:

➢ A major problem facing many countries in screening military personnel proceeding on peacekeeping duties and when they return is the cost of such tests. The UN (DPKO) should re-imburse TCCs for such screening exercise.

➢ Notwithstanding objections by human right activists, troop contributing countries and DPKO should ensure that only troops testing HIV-negative are deployed in peacekeeping settings.

➢ Military HIV/AIDS prevention programmes should be linked to national programmes and data from the military should be made available for planning and research as a national effort.
There is the need for the integration of sub-regional health planning for the prevention of HIV/AIDS both at the political and Ministerial levels including the Defence Ministries.

Both military and political leadership should be more involved in finding a solution to the menace in the military as part of national and sub-regional control measures.

HIV/AIDS prevention programmes in peacekeeping missions should incorporate local programmes and involve local health authorities.
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APPENDIX I

HIV prevalence in adults in sub-Saharan Africa, end 2001

- 20 – 39%
- 10 – 20%
- 5 – 10%
- 1 – 5%
- 0 – 1%
- Trend data unavailable outside region

UNAIDS

World Health Organization
APPENDIX II

Number of people living with HIV/AIDS in sub-Saharan Africa, 1980-2001

Source: UNAIDS, 2001
APPENDIX III


Source: UNAIDS, 2003
APPENDIX IV

Leading causes of death in Africa, 2000
Resolution 1308 (2000)

Adopted by the Security Council at its 4172nd meeting,
On 17 July 2000

The Security Council,

Deeply concerned by the extent of the HIV/AIDS pandemic worldwide and by the severity of the crisis in Africa in particular.


Emphasizing the important roles of the General Assembly and the Economic and Social Council in addressing HIV/AIDS,

Stressing the need for coordinated efforts of all relevant United Nations organizations to address the HIV/AIDS pandemic in line with their respective mandates and to assist, wherever possible, in global efforts against the pandemic,

Commending the efforts by UNAIDS to coordinate and intensify efforts to address HIV/AIDS in all appropriate forums,

Recalling also the 28 February 2000 special meeting of the Economic and Social Council, held in partnership with the President of the Security Council, on the development aspects of the HIV/AIDS pandemic,

Welcoming the decision by the General Assembly to include in the agenda of its fifty-fourth session an additional item of an urgent and important character entitled "review of the problem of HIV/AIDS in all its aspects", and encouraging further action to address the problem of HIV/AIDS.

Recognizing that the spread of HIV/AIDS can have a uniquely devastating impact on all sectors and levels of society.

Reaffirming the importance of a coordinated international response to the HIV/AIDS pandemic, given its possible growing impact on social instability and emergency situations,

Further recognizing that the HIV/AIDS pandemic is also exacerbated by conditions of violence and instability, which increase the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care,

Stressing that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security,

Recognizing the need to incorporated HIV/AIDS prevention awareness skills and advice in aspects of the United Nation Department of Peacekeeping Operations’ training for peacekeeping
personnel, and welcoming the 20 March 2000 report of the United Nations Special Committee on Peacekeeping Operations (A/54/839) which affirmed this need and the efforts already made by the United Nations Secretariat in this regard.

Taking note of the call of the Secretary-General in his report to the Millennium Assembly (A/54/2000) for coordinated and intensified international action to reduce the HIV infection rates in persons 15 to 24 years of age by 25 per cent by the year 2010,

Noting with satisfaction the 13th International AIDS Conference, held from 9 to 14 July 2000 in Durban, South Africa, which was the first conference of this type to be held in a developing country and which drew significant attention to the magnitude of the HIV/AIDS pandemic in sub-Saharan Africa, and further noting that this Conference was an important opportunity for leaders and scientists to discuss the epidemiology of HIV/AIDS and estimates of resources needed to address HIV/AIDS, as well as issues related to access to care, mother to child transmission, prevention, and development of vaccines,

Bearing in mind the Council's primary responsibility for the maintenance of international peace and security,

1. Expresses concern at the potential damaging impact of HIV/AIDS on the health of international peacekeeping personnel, including support personnel;

2. Recognizes the efforts of those Member States which have acknowledged the problem of HIV/AIDS and, where applicable, have developed national programmes, and encourages all interested Member States which have not already done so to consider developing, in cooperation with the international community and UNAIDS, where appropriate, effective long-term strategies for HIV/AIDS education, prevention, voluntary and confidential testing and counseling, and treatment of their personnel, as an important part of their preparation for their participation in peacekeeping operations;

3. Requests the Secretary-General to take further steps towards the provision of training for peacekeeping personnel on issues related to preventing the spread of HIV/AIDS and to continue the further development of Pre-deployment orientation and ongoing training for all peacekeeping personnel on these issues;

4. Encourages interested Member States to increase international cooperation among their relevant national bodies to assist with the creation and execution of policies for HIV/AIDS presentation, voluntary and confidential testing and counseling, and treatment for personnel to be deployed in international peacekeeping operations;

5. Encourages, in this context, UNAIDS to continue to strengthen its cooperation with interested Member States to further develop its country profiles in order to reflect best practices and countries policies on HIV/AIDS prevention education, testing, counseling and treatment;

6. Expresses keen interest in additional discussion among relevant United Nations bodies, Member States, industry and other relevant organizations to make progress, inter alia, on the question of access to treatment and care, and on prevention.