HIV/AIDS & PEACEKEEPING
A field study of the policies of the United Nations Mission in Sierra Leone

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# Executive summary

## Field study of HIV/AIDS policies in UNAMSIL

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Executive summary

Background

The risk of HIV transmission increases in conflict and post-conflict environments. Hence, there is growing concern that peacekeepers are at risk of contracting or spreading the disease in the field. This is a potential source of friction between the United Nations (UN), host countries and members states. UN Security Council resolution 1308 of July 2000 underscores the need for the UN Department of Peacekeeping Operations (DPKO) to incorporate HIV/AIDS prevention awareness skills and advice in its training for peacekeepers. It also encourages troop-contributing countries (TCCS) to develop long-term strategies for education and prevention.

The largely anecdotal and often contradictory nature of data on HIV/AIDS in peace-support operations, however, is hampering UN efforts to respond to the issue and to evaluate intervention programmes among peacekeepers. There are also limits to DPKO’s mandate, as troops remain under national command.

Roxanne Bazergan, a Research Fellow with the Centre for South Asia Studies, International Policy Institute, King’s College London, conducted an assessment of UN HIV/AIDS policies for peacekeepers in the United Nations Mission in Sierra Leone (UNAMSIL). The project was funded by the Human Security Programme of the Canadian Department of Foreign Affairs and International Trade.

Key UN departments in New York were consulted and a field mission visited all five UN sectors in Sierra Leone between 22 April and 7 June 2002. The assessment combined interviews with individual soldiers, officers and civilians (including health and social workers and representatives of non-governmental organisations (NGOs)), with group sessions with uniformed personnel and commercial sex workers. The investigations encompassed:

- an analysis of national military policies on HIV testing and counselling;
- an examination of the scope of training and materials provided by UN mission headquarters in Mammy Yoko, Freetown, including initial reactions to the ‘awareness card’;
- understanding by TCCS of UN policy regarding HIV/AIDS (awareness training and condom distribution);
- the facilities available at unit level medical facilities and Level II and III hospitals in relation to rapid HIV testing and post-exposure prophylaxis (PEP) kits, for example;
- levels of HIV/AIDS awareness and concern among officers and how these are conveyed to troops;
- an examination of local conditions and perceptions vis-à-vis peacekeepers and HIV; and
- consultations with governmental bodies and local and international NGOs in the country.
For the purposes of this project, peacekeepers are defined as uniformed personnel, including troops, military observers (UNMO) and civilian police (Civpol). Eleven countries currently provide battalions or aviation/transport units: Bangladesh, Ghana, Guinea, Jordan, Kenya, Nepal, Nigeria, Pakistan, Russia, Ukraine and Zambia. In total, some 38 countries contribute troops, including military observers, and/or civilian police.

Field research findings

**Background situation in Sierra Leone**

Estimates of HIV/AIDS prevalence in Sierra Leone fluctuate significantly. The preliminary findings of a survey conducted by the Centers for Disease Control and Prevention in April 2002 suggest an overall national HIV prevalence rate of 4.9%. Five percent is widely viewed as the point at which the epidemic is considered to be out of control.

HIV/AIDS awareness is generally low, even among medical staff, and hospitals do not have adequate testing facilities. Blood donors are tested, but, in general, are not informed if found to be HIV-positive because of a lack of counselling capabilities and support networks. The government, previously criticised for its poor response to the epidemic, has now qualified for a World Bank Specific Investment Loan of $15 million for HIV/AIDS.

The Republic of Sierra Leone Armed Forces (RSLAF) is a high-risk group, and has a low level of HIV awareness within the ranks. It has developed an HIV/AIDS policy to be mainstreamed into strategic planning, but condom supplies are a problem and screening at recruitment has not been systematically implemented. The reproductive health component initially provided as part of the demobilisation process of former combatants was dropped, reportedly because of financial and time constraints. The Sierra Leone Police Force does not have an HIV/AIDS policy.

With regard to HIV and peacekeepers, locals do not always distinguish between previous international peacekeeping forces and UN troops. Peacekeepers are viewed as the main clients of commercial sex workers. Newspapers, local NGOs and health workers have expressed concern about pre-deployment testing procedures, especially with regard to soldiers coming from high-incidence countries in East Africa, drawing a link between the presence of peacekeepers and the incidence of HIV.

**UN peacekeepers**

Military HIV/AIDS policies are not always coherent or systematically implemented. Interviews with commanding officers and senior medical staff revealed a degree of confusion, with conflicting information sometimes being provided by senior members of the same contingent.

All contingents stated a policy of pre-deployment mandatory testing, only Zambia said that its policy allowed for the deployment of HIV-positive soldiers, on the condition that they are asymptomatic.
None of the contingents tested troops as a matter of course in the field; most stated a policy of testing post-deployment. Pre-/post- test counselling is often overlooked. There was marked confusion about policy regarding troops found to be HIV-positive in the mission, with commanding officers and medical staff often at odds. Approaches to confidentiality and permission to test also differ.

Between November 1999 and March 2002, four UNAMSIL peacekeepers officially died in mission from AIDS-related illnesses and ten were repatriated for symptomatic AIDS. This illustrates both potential weaknesses in existing national testing procedures and in general health examinations.

DPKO’s current medical support manual does not preclude HIV-positive individuals from peacekeeping operations if they do not show clinical manifestations of AIDS. It does recommend, though, that they not be deployed. The guidelines are currently being re-worked, with an emphasis on voluntary counselling and testing (VCT).

However, inadequate counselling and testing facilities would undermine efforts to provide VCT in the UNAMSIL mission. Eight of the ten battalion level medical facilities visited did not have HIV test kits. None of the medical facilities, including the Level III hospital, had PEP kits.

**HIV/AIDS awareness and training**

UNAMSIL peacekeepers are based in different and changing environments and types of living accommodation, impacting on opportunities for engaging in risky behaviour.

Induction training for officers and warrant officers includes a brief session on HIV/AIDS. However, the extent to which the information is passed down without bias is a matter of concern. The UN provides HIV/AIDS awareness booklets in English and French, yet there have been problems with distribution and varying levels of literacy means it would be useful to have information available in other forms. The HIV/AIDS awareness card being piloted in Sierra Leone has met with a warm reception, but knowledge, attitude and practice (KAP) surveys are needed to assess its impact. Ultimately, training is a command responsibility of national militaries: all claimed to provide HIV/AIDS awareness training on at least a monthly basis, but it was difficult to establish the depth of training sessions. National cultural mores and assumptions about behaviour based on military seniority impact on the kinds of training provided. Condom promotion and correct use do not form a central facet of programmes.

The new position of HIV/AIDS Policy Officer (PO) was designed to coordinate HIV/AIDS initiatives in UN missions and to provide institutional memory. But the present PO is overstretched and lacks comprehensive terms of reference, a dedicated budget line and a consistent supply of condoms.

Condom distribution by the UN is budgeted at five per soldier per week, but in fact 30 are distributed per soldier per month. Distribution relies on the cooperation of national troop commanders; some contingents do not order condoms, especially were there is a policy of non-fraternisation. UNMO and Civpol have not been included in the UNAMSIL scheme. The distribution to battalions is not properly tracked; moreover, without a KAP study it is not possible to gauge the extent to which condoms are actually being used. Many commercial sex workers said that peacekeepers would pay significantly more for sex without a condom.
Health data in the mission

Within UNAMSIL, and between the mission and DPKO headquarters, reporting mechanisms regarding the health of contingents are weak and not sufficiently systematic.

Tracking common sexually transmitted infections (STIs) could provide useful baseline data, not only because they are co-factors in HIV infection, but also because they are an indication of unprotected sex. Many battalions reported negligible to no cases of STIs. However, diagnostic procedures vary and soldiers seeking treatment outside their unit undermine any tracking procedure. In addition, there are suspicions of some battalions deliberately under-reporting. STIs do not rank high on the list of military concerns, but this must be considered in the context of Sierra Leone being malaria endemic.

Key recommendations in brief

i) An HIV/AIDS Task Force should be established. The inclusion of local military personnel, as well as representatives of contingents, in training strategies would boost overall initiatives. Civil–military links—between the peacekeeping element of the mission and local authorities and local/international NGOs—also need to be strengthened.

ii) The UN must develop a better understanding of national HIV/AIDS military policies as they impact directly on UN initiatives.

iii) Provision and strengthening of VCT facilities in missions:

• HIV/AIDS counsellors should accompany missions, preferably as part of the contingents if the capacity exists. The UN may need to build such capacity where it does not exist, but training for counsellors would have to take into account troop rotations; and
• testing facilities must be improved and assured at all levels.

iv) Battalions need to be briefed on the specific medical and social conditions of the immediate area in which they are being deployed. Training needs to be attuned to the evolution of a mission and needs to take into account the cultural and social conventions of both TCCS and the host nation. Emphasis should be placed on resolution 1308 during the induction process. A cooperation and reporting mechanism to institutionalise the training, identifying focal points within the different contingents, would strengthen initiatives.

v) The HIV/AIDS policy officer needs support staff and a specific budget line to produce training materials. The PO needs to be informed about condom distribution and to have a supply for training purposes.

vi) Condom supply must be accompanied by condom promotion.

vii) Training materials need to be distributed at the time of induction/training in order to have maximum impact. Other materials, such as posters and videos, are necessary given the varying levels of literacy among troops.
viii) UNMO and Civpol need to be specifically targeted and included in training initiatives and in the condom distribution programme.

ix) Combining 'sustainment' and 'self-sustainment' systems may overcome difficulties faced by some TCC medical facilities in acquiring test and PEP kits, but requisition times need to be shortened.

x) Contingents may benefit from assistance in the syndromic diagnosis and management of STIs, United Nations Population Fund (UNFPA) is a possible partner.

xi) Data collection and analysis needs to be more systematic, both within the mission and between the mission and DPKO headquarters. The UN needs a KAP survey to assess interventions, timed to coincide with troop rotations. Information regarding the health status of troops should be broken down according to nations and areas of deployment.

Final introductory note

This report reflects the reality on the ground between 22 April and 7 June 2002 in UNAMSIL. While it highlights some of the issues that pertain to HIV/AIDS in peackeeping operations more widely, it should not be viewed as a generic representation of all peacekeeping missions.

Although this project was funded by the Human Security Programme of the Canadian Department of Foreign Affairs and International Trade, the findings and recommendations are entirely those of the author. Feedback is welcome; e-mail comments to roxannebazergan@aol.com
Field study of HIV/AIDS policies in UNAMSIL

Background

1. HIV/AIDS in many developing countries, but particularly in Sub-Saharan Africa, is increasingly being seen as a development crisis. Social and economic deprivation and the denial of human security create an ideal environment for the pandemic, which, in turn, compounds existing problems. This dynamic is magnified in conflict and immediate post-conflict settings. HIV sentinel surveillance systems are, however, difficult to set up and may be impractical in unstable circumstances. The resulting lack of reliable data has contributed to the low priority given to HIV/AIDS in complex emergencies.

2. The UN Department of Peacekeeping Operations (DPKO) currently has 15 missions, involving over 45,000 troops, civilian police (Civpol) and military observers (UNMO) from some 88 countries. There has been concern that peacekeepers serving in high incidence countries could contract HIV in the field and bring the infection home to their families. At the same time, there is a perception in some quarters that peacekeepers are a vector of HIV, increasing the risk in mission areas; this could become a source of friction between the UN, host nations and member states. No causal link has been definitively established between the presence of peacekeepers and the spread of HIV.

3. UN Security Council resolution 1308 of July 2000 underscores the need for DPKO to incorporate HIV/AIDS prevention awareness skills and advice in its training for peacekeepers. It also encourages troop-contributing countries (TCCS) to provide voluntary and confidential HIV/AIDS testing and counselling and to develop long-term strategies for education and prevention.

4. The largely anecdotal and often contradictory nature of data on HIV/AIDS and peace-support operations, however, is hampering UN efforts to respond to the issue and to evaluate HIV intervention programmes among peacekeepers. Troop rotations—every six to 12 months, with some extensions—also complicate UN efforts to develop a sustainable response to HIV/AIDS in peacekeeping forces.

5. Roxanne Bazergan, Research Fellow with the Centre for South Asia Studies, International Policy Institute, King’s College London, conducted an assessment of UN HIV/AIDS policies for peacekeepers in the United Nations Mission in Sierra Leone (UNAMSIL). The project was funded by the Human Security Programme at the Canadian Department of Foreign Affairs and International Trade. The rationale for an initial focus on UNAMSIL included:

- anecdotal reports linking the rise of HIV in Sierra Leone to the UN mission;
- UNAMSIL is currently the largest UN peacekeeping operation, with an authorised strength of up to 17,500 troops; and
DPKO, in conjunction with UNAIDS, has established a new position of ‘HIV/AIDS policy officer’ (PO) in the mission and has been piloting the UNAIDS awareness card in UNAMSIL.

Methodology

6. Key departments at UN headquarters in New York were consulted and the official backing of DPKO was secured. This was necessary to gain access to troop contingents in the field, but, in so doing, due care was taken not to undermine the independence of the project.

7. In addition to interviews at UN headquarters, briefings on the nature of the project were held with departments that have an especial interest in HIV/AIDS, such as the United Nations Development Fund for Women (UNIFEM) and the United Nations Population Fund (UNFPA). The Special Advisor on HIV/AIDS to the Deputy Secretary-General was also briefed on the project.

8. A field mission to Sierra Leone on 22 April–7 June 2002 visited the bases of national contingents in all five UN sectors in the country. The assessment combined extensive interviews with individual soldiers, officers and civilians (including health and social workers and representatives of non-governmental organisations (NGOs)) and group sessions with uniformed personnel and commercial sex workers. The investigations encompassed:

• an analysis of national military policies on HIV testing and counselling;
• an examination of the scope of training and materials provided by the UN mission headquarters in Mammy Yoko, Freetown, including initial reactions to the ‘awareness card’;
• understanding by TCCS of UN policy regarding HIV/AIDS (awareness training and condom distribution);
• the facilities available at unit level medical facilities and Level II and III hospitals in relation to rapid HIV testing and post-exposure prophylaxis (PEP) kits, for example;
• levels of HIV/AIDS awareness and concern among officers and how these are conveyed to troops;
• an examination of local conditions and local perceptions vis-à-vis peacekeepers and HIV; and
• consultations with governmental bodies and local and international NGOs in the country.

9. For the purposes of this project, peacekeepers were defined as uniformed personnel, including troops, UNMO and Civpol that come under the mandate of DPKO.1

Background to UNAMSIL

10. The Revolutionary United Front (RUF) invaded Sierra Leone from Liberia in March 1991 and launched a guerrilla war. Sierra Leone had been a staging post and rear base for troops involved in the Economic Community of West African States’ Ceasefire Monitoring Group (ECOMOG)’s peacekeeping intervention in Liberia. Following the RUF invasion, ECOMOG forces were deployed to support the government in Freetown. In June 1998, the UN provided 50 military observers to assist ECOMOG’s 13,000 peacekeepers. The UN mission in Sierra Leone was established in October
1999, following the signing of the Lomé Peace Accord in July that year. The UN Security Council initially authorised a troop strength of 6,000, later increased to 17,500, working with a robust enforcement mandate under Chapter VII.\textsuperscript{2} Sierra Leone held elections in May 2002.

11. Eleven countries currently provide battalions or aviation/transport units: Bangladesh, Ghana, Guinea, Jordan, Kenya, Nepal, Nigeria, Pakistan, Russia, Ukraine and Zambia. In total some 38 countries contribute troops, including military observers, and/or civilian police. (For a full breakdown of contributions and a map of deployment see pp. 27–28.)

12. Peacekeepers are often perceived as the élite of international forces, creating high expectations. In fact, the rank and file are mostly young, inexperienced soldiers, with varying levels of literacy. In addition, there are limits to the mandate of UNMIL, as troops remain under national command.
Field research findings

HIV/AIDS situation in Sierra Leone

13. Sierra Leone is emerging from a decade of civil war. The conflict destroyed the country’s infrastructure and its social networks; at the end of 2001 there were more than 185,000 refugees and asylum seekers and an estimated 600,000 internally displaced people (IDPs). During the war, rape became a terror tactic and large numbers of women were abducted and used as ‘sex slaves’ by rebel forces.

14. Estimates of HIV/AIDS prevalence rates in the country fluctuate significantly. The Sierra Leone National Aids Control Programme (NACP) calculated a national prevalence rate of 3.4% at the end of 1997 and 6.0% for 2000. UNAIDS estimates an adult prevalence rate of 7% in 2002 (its June 2000 figure was 2.99%, subject to a high range of uncertainty). The preliminary findings of a survey conducted by the Centers for Disease Control and Prevention in April 2002 suggest an overall HIV prevalence rate of 4.9%, with a rate of 6.1% in Freetown and 4% for areas outside of Freetown. Five percent prevalence is widely viewed as the point at which the epidemic is considered to be out of control.

15. According to the Government’s national HIV/AIDS policy for January 2002, ‘The primary mode of HIV transmission in Sierra Leone is through sexual contact and a small magnitude through blood transfusion, harmful indigenous practices and unsafe injections. Most of those infected remain unaware of their status and so represent a pool capable of transmitting the virus to new uninfected individuals.’

16. HIV/AIDS awareness is generally low, even among medical staff. The limited attempts to increase awareness have tended to concentrate on urban areas and have not been extended to the community level up country. A UNICEF survey in 2000, for example, found that more than 40% of girls aged between 15 and 19 years had not even heard of AIDS. And while 78% of urban women knew of AIDS, 48% of them did not know how to prevent infection. According to an American Refugee Committee (ARC) survey of Port Loko, only 4% of male youth and 5% of female youth interviewed knew of at least three ways to avoid infection. Levels of sexually transmitted infections (STIs)—including repeat infections—are high. Social taboos and cost undermine the use of condoms. Disbelief and denial are still the predominant reactions.

17. Hospitals do not have adequate testing facilities. Blood donors are tested, using the spot test, but, in general, they are not told if they are HIV-positive because of a lack of counselling facilities and support networks. (At present, this is also the policy position of Médecins Sans Frontières.) Many
AIDS-related deaths may be registered according to the opportunistic infection rather than the virus. Ultimately, malaria is considered a more immediate and visible threat.

18. The Sierra Leone government has been criticised for its ad hoc and uncoordinated response to the epidemic. Since the mid-1980s, programmes like the NACP and bodies like the National AIDS Co-ordinating Committee have existed but have not functioned, (although this must be viewed in the context of the conflict). The government is now taking a more strategic approach to the epidemic and has qualified for a World Bank Specific Investment Loan of $15 million for HIV/AIDS initiatives.

The armed forces and former combatants

19. The Republic of Sierra Leone Armed Forces (RSLAF) is a high-risk group. HIV tests based on clinical suspicion conducted at Wilberforce Military Hospital, Freetown, between 1998 and 2000 identified 1,000 of 1,500 male soldiers (66.7%) and 190 of 310 female soldiers (61.2%) as HIV-positive.\(^1\) The primary mode of transmission in the RSLAF is sexual contact. Awareness levels within the military community are low: according to the ARC baseline survey, only 7% of military/civilian defence force respondents knew at least three ways to avoid exposure to HIV and only 26% reported using a condom in their last sexual encounter.

20. The RSLAF, with the assistance of the International Military Advisory and Training Team (IMATT), has developed an HIV/AIDS policy, ‘based on the national policy and adapted for military purposes’. An Armed Forces AIDS Council will work with relevant government agencies and, where appropriate, NGOs and donors. HIV/AIDS and STI surveillance systems are to be set up, awareness training is to be mainstreamed into strategic military planning, and testing within the military is to be voluntary and accompanied by pre- and post-test counselling. HIV-positive personnel are not dismissed from the force. In June 2002, the RSLAF, in conjunction with the ARC, provided training for around 35 military personnel in HIV/AIDS counselling, and five were part of a further week-long ‘train-the-trainer’ session. A Knowledge, Attitude and Practice (KAP) survey is planned. The RSLAF, however, is having problems identifying a donor to supply condoms.

21. In theory, a screening process at recruitment excludes HIV-positive personnel but its implementation has not been systematic. The military reintegration process is considered a ‘missed opportunity’, as the estimated 3,000 that joined the army were not screened. In the initial stage of pre-discharge orientation, ex-combatants received a reproductive health component, with an emphasis on HIV and STIs. But the National Committee for Disarmament, Demobilisation and Reintegration dropped this element after six months, reportedly because of financial constraints and complaints by former combatants about the overall time spent (six weeks) in the demobilisation centres.\(^12\)

22. The Sierra Leone Police (SLP) force does not have an HIV/AIDS policy, highlighting a shortage of funds and other priorities. Statistics from 1996 suggested a HIV prevalence rate of 8.6% in the SLP.\(^13\) STIs are common, although the King Tom hospital, which looks after the force, does not keep records of STI diagnoses.
Perception of UNAMSIL peacekeepers

23. The general low level of HIV/AIDS awareness makes it difficult to assess local perceptions of peacekeepers with regard to HIV/AIDS. Proportioning blame can be part of the denial process and can be a diversion tactic to avoid tackling the issue. On an anecdotal level, locals comment that they had not heard of the pandemic before/during the war and hence make the tenuous connection between the emergence of HIV/AIDS as issue and the presence of peacekeepers. Health workers have reported that, while there are some who believe the peacekeepers brought the disease to Sierra Leone, they also think that it will 'leave' with them.

24. Crucially for UNAMSIL efforts, a distinction is often not made between UN peacekeepers and those who served with ECOMOG—some 13,000 troops were posted in the country, largely drawn from Nigeria, but also from Ghana, Guinea and Mali. Some of the Nigerian troops were transferred from Liberia and spent two-to-three years in the field before being rotated.

25. Many reports on HIV infection rates among peacekeepers are based on ECOMOG contingents. One report of tests (conducted on clinical suspicion) of 800 ECOMOG soldiers found an HIV prevalence rate of 87.2%. Such data are mistakenly seen by local and international organisations as reflecting the HIV prevalence rate in UNAMSIL.

26. There are also different interpretations of any given statistic. A representative of the Sierra Leone Ministry of Development, for example, posited a link between the high prevalence of HIV in the Freetown area (6.1%), indicated by the CDC study, and the concentration of UN peacekeepers, given that other urban areas with fewer peacekeepers, such as Bo, have a lower prevalence rate. In contrast, the national AIDS Programme Manager at Connaught hospital, did not believe that the data indicated a correlation between the deployment of peacekeepers and HIV levels. Freetown is an urban hub with the usual trappings and attractions of a capital city.

27. Peacekeepers have been implicated in the sexual exploitation of refugees. Locals who were interviewed during the course of this study did not put a stress on such abuses, however. The link has not clearly been made between possible sexual abuse and the spread of HIV. Yet, peacekeepers are universally identified as the main clients of commercial sex workers (CSWs). Commercial sex work is often a survival mechanism in conflict and post-conflict environments. Peacekeepers tend to have more disposable income and missions act as a magnet and driver for the sex market. A small study in 1997 reported a level of HIV infection among CSWs in Freetown as approximately 70.6%. This is attributed to peacekeepers and, to some extent, the armed forces. At the same time, this highlights the reciprocity of risk, as HIV-negative soldiers could equally contract the disease.

28. Local impressions of condom use by UN peacekeepers are mixed (see below). Concern tends to centre on testing procedures and whether peacekeepers come from 'high-prevalence countries in East Africa'. Newspaper coverage of HIV/AIDS issues has been limited but has made reference to the presence of peacekeepers. The Sierra Leone daily, the Independent Observer, for example, accredited the increase in AIDS to 'the war and foreign troops from countries where AIDS has a high occurrence'. A report by the local NGO, the Campaign for Good Governance, states that: 'the consensus is that those ECOMOG and UNAMSIL troops who were/are HIV+ brought the virus with
them to Sierra Leone rather than contracting it here. It calls for UNAMSIL ‘to carry out compulsory testing on all troops not tested’—excluding those who are HIV-positive.” This was also the opinion of many of those interviewed, including health workers.

Peacekeepers and testing policies

UN policy on testing

29. According to current DPKO policy on HIV/AIDS, immune compromise, including AIDS, is one of the conditions that should preclude peacekeeping service, but assessments of severity should be made on an individual basis. It states that:

‘D. HIV/AIDS

Many troop-contributing countries screen their military personnel for HIV infection prior to sending them on overseas assignments. The national policies regarding enlisting and employing HIV-positive individuals in the military vary.

In UN peacekeeping operations, HIV-positive individuals who do not show clinical manifestations of AIDS are not precluded from peacekeeping service. It is however recommended that such individuals should not be selected, as treatment available within the Mission area may not be adequate to meet their special requirements. Exposure to endemic infections and exhaustive immunization requirements may also be detrimental to their health. In addition to the individual’s health concerns, there is also the risk of his or her transmitting HIV to medical personnel, fellow peacekeepers and sex workers in the mission.

Should a known HIV-positive individual be deployed in a UN mission, his/her status would be made known to the FMedO [Force Medical Officer] and attending doctor, to ensure that proper medical precautions are taken and adequate medical care provided. This information should be kept strictly "Medical-in-Confidence".

Any individual who develops clinical AIDS or its complications, should be repatriated to his home country for further treatment once the diagnosis has been made. The UN medical support system is not obliged and does not have the resources to manage this condition.19

30. In practice, DPKO has been less restrictive in the application of these guidelines. Information regarding HIV-positive individuals deployed has never been requested or volunteered in any mission and DPKO states that guidance will be changed accordingly in the next edition of the manual. Recommendations are increasingly focused on voluntary counselling and testing (see below).

National military HIV/AIDS testing policies

31. According to the UN Standard Operating Procedure (SOP), personnel in mission who do not recover from an illness within 30 days are repatriated. The UN is not, however, in a position to carry
out individual health assessments of deployed troops and it is the responsibility of TCCs to establish ‘fitness to work’. The general health criteria, interpretation of UN guidelines and the stringency of health checks vary between TCCs.

32. Some nations are reticent about supplying information on their military HIV/AIDS policies, and policies are not always coherent or systematically implemented. Interviews with commanding officers and medical staff revealed a degree of confusion, with conflicting information sometimes being provided by senior members of the same contingent. Many personnel had clearly not been briefed on their national policy. The following is a synopsis of HIV/AIDS national military testing policies vis-à-vis UN peacekeeping operations as understood and conveyed by senior personnel with the 11 UNAMSIL military contingents.

33. All the contingents stated that there is a policy of testing prospective peacekeepers before deployment. In the case of Pakistan, though, not all peacekeepers appear to be tested, since approaches seem to differ depending on the area from which troops are drawn. Extensive interviews did not conclusively resolve whether this was policy or an oversight.

34. With the exception of Zambia, all national policies prohibit HIV-positive soldiers from participating in UN peacekeeping missions. Zambia will deploy HIV-positive personnel if they are asymptomatic. Apart from Ghana and Zambia, all contingents stated a policy of testing soldiers on their return home as a matter of routine. None of the contingents tested troops as a matter of course in the field.

35. Pre-deployment HIV tests are essentially mandatory, although they are sometimes presented as being voluntary in cases where personnel opt to be part of a mission, or because it is ‘understood’ when they sign up to the army that HIV tests and other intrusive health checks are part of the package. Crucially, some nations test troops prior to deployment with UN missions, but they do not test as part of the recruitment procedure or annual medical assessments, suggesting a particularly strict interpretation of UN guidelines.

36. Tests are carried out shortly before deployment. The types of tests used vary, but all are based on testing for antibodies, meaning that there is the ‘window’ period that could potentially result in false negatives. Furthermore, the general ability of some nations to capture, store or analyse data has been called into question. Financial constraints have also interrupted some testing procedures.

37. The concept of pre-/post- test counselling is often confused with awareness training. Where policy stipulates pre-test counselling, this is often overlooked if there are a number of troops being tested—as before a mission—because of a strain on capacity. Post-test counselling is generally, but not always, offered to those found to be HIV-positive. All countries stated that soldiers would be informed if found to be HIV-positive. (Some of the militaries that screen at recruitment do not systematically inform rejected candidates of their HIV-positive status.)

38. Between November 1999 and March 2002, four UNAMSIL peacekeepers officially died in mission from AIDS-related illnesses and ten were repatriated for symptomatic AIDS (in line with SOP). According to UNAIDS, if a peacekeeper has passed a pre-deployment medical fitness examination, the likelihood of immunosuppression is approximately 5% for an average six-month deployment. This
illustrates both potential weaknesses in existing national testing procedures and in general health examinations. The UN is often under pressure to find troops for missions and TCCS have sometimes been lax in their overall interpretation of ‘fitness to work’.

39. National policies differ and are often unclear regarding personnel who are found to be HIV-positive once they are in theatre. Countries like Bangladesh, Jordan and Pakistan were emphatic in stating that such individuals would automatically be repatriated. In contrast, Kenya and Zambia stated that asymptomatic individuals would be allowed to stay in mission. Many countries appear to tie repatriation to the progression of the disease, deferring to the judgement of the Level III hospital. In some cases, commanding officers and medical personnel differed in their interpretation of policy, with commanding officers often in favour of repatriation. Some stated that they have yet to face such a decision and any instance of an HIV-positive soldier within their contingent would be a test case. Russia and Ukraine, for example, were unclear on policy. Since UN guidelines do not stipulate repatriation on HIV status alone, a given nation that wished to send an HIV-positive but otherwise ‘healthy’ peacekeeper home would have to cover the cost itself. According to the Deputy FMedO there have been no such cases.

Voluntary counselling and testing (VCT)

40. A focus on testing before deployment overlooks the reciprocity of risk—the possibility that peacekeepers can become infected in the field. DPKO guidelines are currently being reworked: in November 2001, a UNAIDS Expert Panel on HIV Testing in UN Peacekeeping Operations ‘unanimously endorsed HIV voluntary counselling and testing (VCT) for UN peacekeeping operations’. It concluded that HIV status is not an appropriate indicator of physical fitness given the long periods of functional capacity of HIV-positive personnel and that mandatory testing is discriminatory, disproportionate and not justified in terms of protecting either the health of peacekeepers in potentially harsh conditions or host populations.\(^20\)

42. The UN is often restricted to advocating norms: it can try to influence TCCS, but it cannot insist that they change their policies on mandatory testing. There are also a number of obstacles to providing VCT in the UNAMSIL mission:

- testing facilities in the field are insufficient (see below);
- counselling services are inadequate. The Jordan Level III hospital in Freetown has a psychiatrist, yet current policy is to offer counselling only on request. The stated presumption being that if an individual has requested an HIV test they are sufficiently informed. This exemplifies the aforementioned confusion between counselling and awareness. Religious practitioners accompany most battalions and could be a source of counselling, but they may not have been trained and could entrench biases;
- protocol on permission to test differs. For some TCCS, a medical officer wishing to test on clinical suspicion needs the consent (often only verbal) of the patient. In other cases, the commanding officer can grant permission. Such practices, alongside VCT, would send a confusing message to soldiers; and
confidentiality is a key issue. For VCT to be effective it has to be coupled with non-discriminatory practice. In some armed forces, however, HIV-positive personnel would be demobilised. Where HIV-positive soldiers are retained, non-discriminatory practice within the force would require a coded medical grading system, which many militaries have yet to develop. The approach of medical-in-confidence does not always apply: some medical officers are expected to inform their commanding officer if a soldier in their care is found to be HIV-positive; for others, it is left to their discretion; in still other cases, it would depend on the progression of the disease.

HIV/AIDS awareness training

UNAMSIL peacekeepers are based in different and changing environments and types of living accommodation, impacting on opportunities for engaging in risky behaviour. Soldiers with the Guinea battalion, based in the major provincial town of Bo, for instance, are spread out and do not live in contained barracks, in contrast to the Pakistanis who reside in barracks in Koidu in the eastern border region. Areas of Sierra Leone have altered with the return of refugees and IDPs. Towns like Tongo (where the Zambian battalion is situated) were once ‘ghost towns’, but are now regenerating. The duties of peacekeepers also shift: from peacekeeping in a war setting to providing logistical support for elections. More relaxed periods are in many ways more dangerous in terms of HIV/AIDS.

DPKO offers train-the-trainer programmes in TCCS on request. Its curriculum has been criticised for not being culturally specific, for being insufficiently sensitive to gender issues, and for being too technical. But the obstacles to tailor-made training programmes are enormous, with some 88 countries contributing troops to UN operations. While relevant and interesting, it is beyond the scope of this report to analyse this programme, since it is conducted outside the mission area.

Induction training, which takes place approximately two weeks after arrival, lasts three-to-four days and includes a half-hour session by a representative of the Force Medical team on ‘Diseases in Sierra Leone and Preventative Measures’, encompassing HIV/AIDS. In theory, induction is obligatory for officers and has recently become compulsory for warrant officers. However, some TCCS only send a select number of officers. The information is then passed down to the rank and file. The brevity of the specific session and the ability of officers/warrant officers to convey the information without bias are potential causes for concern and underscore the importance of the awareness training provided by the Policy officer (see below).

The UN distributes booklets—Protect yourself, and those you care about against HIV/AIDS—in English and French. But these are often not the native languages of troops, a problem compounded by varying levels of literacy. There have also been problems with distribution. The policy used to be that outgoing battalions would pass on such materials to incoming troops at rotation. This was ineffective, and now the training cell caters for incoming battalions. Yet some had either not received the booklets or had received very few copies. The booklets need to accompany induction training in order have the maximum impact.
47. A UNAIDS plastic awareness card is being piloted in Sierra Leone. It includes basic facts about the transmission and nature of the disease, a ‘pocket’ to hold a condom, and it reiterates the peacekeeper’s code of conduct. Cards in English, French and Russian have been distributed; the first consignment in Arabic, Bengali, Kiswahili and Urdu arrived in early May and had not been distributed at the time of this field investigation. It is hoped that the awareness card will become part of the peacekeeper’s uniform. Overall, most military personnel seemed to be in favour of it, even those militaries that would not distribute condoms did not object to the card.

48. There was some criticism, though, that plastic was unsuitable for the hot climate and that condoms kept in the ‘pocket’ might sweat and become damaged. Ghana recently introduced a black leather pouch for military and police personnel to carry their condoms. It fits on to the belt and is an obligatory part of their uniform. It does not include the basic information carried on the awareness card, but as a military accessory to encourage condom use it is perhaps more appropriate.

49. The UN has been criticised for not carrying out KAP studies before introducing the awareness card: the card is designed to influence behaviour, but without baseline data it is hard to evaluate its impact. However, with troop rotations it is possible to get such data, as long as studies are carefully coordinated with the time of arrival and departure.

50. In light of reports implicating peacekeepers in abuses of refugees and locals, training on the code of conduct and stricter enforcement of a reworked code are ideas circulating within the UN. Yet, any change to the code would need to be approved by the UN General Assembly and member states would need to reach consensus. Ultimately, this would probably result in a diluted code, much like the present one.

51. Currently, there is no standardisation of sanctions for conduct infractions. Discipline is largely the responsibility of contingents. The UN can repatriate soldiers on disciplinary grounds, but this is an option of last resort and a potentially contentious area vis-à-vis relationships with TCCS.

52. Training on ‘responsible relationships’ has been mooted as another means of tackling conduct issues. The child protection advisor has introduced a train-the-trainer programme for military personnel to enhance peacekeepers’ knowledge about child rights and to raise awareness of abuses. The new scheme includes a community monitoring and reporting system that links Child Protection Committees at the battalion level with Provincial/District Child Protection Committees. The intention is effectively to ‘bind in’ the military and to institutionalise the training. A similar cooperation and reporting mechanism via an HIV/AIDS task force could strengthen TCCS training initiatives.

53. Training is a command responsibility and UN HIV/AIDS interventions rely on national militaries engaging with the issue. It is the responsibility of TCCS to train troops before, during and after deployment. (Assessing the importance of HIV/AIDS awareness training in the various contingents was hampered by the possible false sense of magnitude accorded to the issue by the interviewees, arising from the fact that they were being interviewed.) All TCCS claimed that some form of ‘training’ is provided on at least a monthly basis. In their approaches, though, it was not always possible to discern HIV/AIDS awareness training from casual, less formal references to the dangers of the pandemic. The UN training cell asks for updates on training being carried out and stated that it was satisfied with the levels of HIV/AIDS awareness training.
Different battalions have their own mechanisms: in some cases, commanding officers assume a lead and include HIV/AIDS awareness in more general military directives, mentioning it at roll call, highlighting the chain of command. Others rely on the medical staff to convey the message. Religious practitioners also have a role, although, in certain instances, lectures are ‘motivational’ and do not make direct reference to the disease and modes of transmission. Moreover, the suggestion is that, in awareness sessions, some contingents play on the stigma associated with the disease and the potential repercussions for professional military careers. This could undermine efforts to introduce VCT.

Correct condom use and promotion is not a central facet of training programmes.

HIV/AIDS policy officer

The new position of HIV/AIDS policy officer was designed to coordinate HIV/AIDS initiatives in UN peacekeeping operations and to provide institutional memory in order to increase the sustainability of interventions. The PO has been an element of UNAMSIL since February 2001. However, lack of ‘comprehensive’ terms of reference, no dedicated budget line and poor communication with DPKO in New York have reportedly undermined the post.

The PO provides specific HIV/AIDS awareness sessions for troops, but is overstretched and needs a back-up structure to keep pace with troop rotations—one individual is not sufficient. Visibility and credibility may be enhanced if support staff included a local and a person with military credentials. The PO is not sufficiently briefed on the individual HIV/AIDS policies of TCCS, which impact directly on the feasibility of UN initiatives. (It should be noted, though, that relations between the current PO and the contingents are positive and troops seem receptive to the PO as an individual.) Condoms are budgeted and available to troops (see below), but not for the PO’s training sessions. Yet, condom promotion is a key element of awareness initiatives and condoms need to be distributed with the awareness card.

The PO is a member of the HIV/AIDS theme group, which includes other UN agencies and assists the Sierra Leone government with strategies and the identification of entry points. The United Nations Development Fund for Women (UNIFEM) country programme advisor, for example, has been made available to the PO. In addition, UNAMSIL should establish an HIV/AIDS task force.

Condom distribution

Condoms are budgeted at five per soldier per week, but in fact 30 are distributed per soldier per month. Each of the mission’s five sectors has a supply officer who is sent three-months’ stock at a time. Distribution of condoms relies on the cooperation of national troop commanders, as battalions have to submit orders every month to the sector. Those requesting condoms have always asked for the maximum amount.
60. Most battalions have found the system straightforward, but there have been some problems with distribution. Difficulties with the new electronic system meant that Nibatt xi’s requisition of March 2002, for example, went though too late in the month to qualify (orders have to arrive mid-month and cannot be back dated). Fortunately, they had sufficient supplies. Zambatt xi, which had already been in theatre for five months, was not aware of the availability of condoms, and did not think that they would qualify under self-sustainment (see section on mission hospital facilities), even though the po had lectured them and the previous Zambian battalion had utilised the facility. Zambatt xi had brought six-months’ supply of condoms with them.

61. Those contingents that order condoms generally distribute them direct to the troops without an individual request having to be made. Some battalions have additional stocks of their own.

62. The Bangladeshi, Jordanian, Nepalese and Pakistani contingents have not, in general, ordered condoms. (Small numbers have been ordered by the Bangladeshi logistics unit, for example, which might reflect the differing policies of commanders). Nepbatt did keep a box of condoms at its medical facility, but it did not encourage distribution. Often a policy of non-fraternisation is in force, in which case the availability of condoms would seem to contravene a military order. Distribution of condoms is sometimes seen as encouraging sexual liaisons. In these countries, condoms are also widely associated with family planning.

63. The distribution of condoms to battalions is not being properly tracked. The information exists at the sector level, but it is not systematically collated. This results in oversights, such as that of Zambatt xi, and also suggests that there is a shortage of stocks when, in fact, there could be a surplus (since some contingents are not placing orders and the supply unit orders condoms calculated on the full strength of all the contingents). According to the supply unit and the United Nations Population Fund (UNFPA), there are two orders in the pipeline for 1.3m (an urgent request) and 3m condoms.

64. The HIV/AIDS PO needs to be informed of condom distribution and, critically, needs a supply for training purposes, as condom distribution is not the same as condom promotion. Currently, only male condoms are distributed; some female peacekeepers expressed an interest in female condoms, but the general impression is that they would require heavy marketing if they were introduced.

65. Kap studies are needed to gauge whether condoms are actually being used by peacekeepers. Many commercial sex workers said that peacekeepers would pay significantly more for sex without a condom. Peacekeepers, meanwhile, claimed that local girls preferred not to use a condom. Quasi relationships also develop, at which point many stop using condoms. At the same time, local health workers felt that the use of condoms by peacekeepers had increased.

Military observers and civilian police

66. There are currently some 257 Unmo from 31 countries. They are usually dispatched for one year, and are deployed throughout Sierra Leone in some 11 different teams. They are moved individually within the country as required. There are around 91 Civpol from 18 nations deployed in groups of
two-to-four personnel at the regional and divisional offices of the s.l.p. Civpol are rotated on an annual basis, but can have an extension of up to six months.

67. Neither UNMO nor Civpol are included in the condom distribution scheme within UNAMSIL, as they receive mission subsistence allowance and are expected to purchase their own condoms. According to DPKO, though, they should qualify for the distribution programme, as all mission members should have free condoms.

68. As they arrive individually and are not part of an organised battalion, they tend to fall through the cracks of training programmes. UNMO are mostly officers with a minimum of six-to-eight years experience, and there is an assumption that such military seniority will guide their behaviour. A similar assumption exists in regard to Civpol. However, their close proximity to the local population, mobility within the country, and looser chains of command suggest that UNMO and Civpol need to be specifically targeted in HIV/AIDS interventions.

Mission hospital facilities

69. UN medical support for peacekeeping missions has been standardised. Basic first aid is provided at the unit level. Each battalion has Level I medical support, providing first-line primary health care, stabilisation and enabling evacuation of casualties to the next level. Level II hospitals have the expertise and facilities to carry out some surgical interventions and basic dental work. Level III, in addition to the features of Levels II and I, has the capability to provide specialised in-patient treatment and surgery, as well as extensive diagnostic services. Level IV facilities, including specialist medical treatment, rehabilitation and convalescence are outside the mission, sought in the host country, neighbouring state or within a TCC. 21

70. Most facilities are ‘wet lease’—UN pays rent for equipment plus reimbursement for maintenance, which is a national responsibility. Self-sustainment covers the cost of drugs and consumables, with reimbursement from the UN according to Memorandums of Understanding (MOU). Level I facilities are reimbursed at a set rate per soldier per month. The Ghana Level II is ‘dry lease’—the UN pays for equipment and performs maintenance. The Ghana Level II is not on self-sustainment, which means that commodities are supplied by the UN. Requisitions take around three months.

71. Peacekeepers are not supposed to be ‘walking blood banks’. Bloods supplies for UN operations come from commercial sources in Australia and the Netherlands and are monitored by the World Health Organisation. UNAMSIL’s Level III hospital receives 70 units of blood a month and can supply Level I and II facilities on request (although they would need to be able to cross-match blood types).

72. The Bangladeshi Level II in Magburaka had not been requesting blood and stated that, if transfusions were required, it would use donations from the battalion, which is common practice in Bangladesh. It has blood-testing facilities and highlighted the low level of infection in Bangladesh. As mentioned above, the ‘window period’ risks false negatives. In addition, making assumptions of low prevalence in the ranks based on cultural and social conventions is not sound medical practice.
The Level II covers the Nigerian battalion in Makeni. The suggestion being that the Nigerian troops could supply blood in a similar manner. This seems an unnecessary task and risk, given the free supply of screened blood that is available. It is important to note, though, that no transfusions had been carried out and that Banmed II said that it would alter its practice.

73. Blood-testing facilities are insufficient: eight of the ten battalion level medical facilities visited did not have test kits. The Ghana Level II hospital was running so low that it had to pool samples.

74. None of the medical facilities, including the Level III Jordanian-run hospital, had PEP kits. (In one incident, a Jordanian dentist was injured while treating an HIV-positive patient—anti-retroviral drugs had to be requested from British forces.) Many medical officers stated that the cost is prohibitive or that PEP kits are not easily available via domestic supply channels. The Level II Ghana hospital claimed that it had made a requisition for PEP kits, and complained that the process takes too long.

75. A suggested drug standard for Level I facilities, dated 10 May 2002, from the DPKO medical support unit, included five PEP kits, which could be procured through UNFPA. Prior to receiving the memo, the supply unit at UNAMSIL had been unclear whether PEP kits were included in the medical MOU. PEP kits need to be accompanied by clear terms of reference in regard to use and definitions of occupational hazard specific to UN missions.

Sexually transmitted infections

76. Tracking common STIs could provide useful baseline data, not only because they are co-factors in HIV infection, but also because they are a sign of unprotected sex. Level I hospitals send numerical monthly reports to the FMedO on the health status of troops, including the number of STIs.

77. In interviews, many battalions reported negligible to no cases of STIs, suggesting that the message on safe sex or abstinence is getting through. However, diagnostic procedures and abilities vary between countries. And some carry out monthly basic health checks, while others treat those complaining of symptoms. In certain cases, there is a suspicion of deliberate under-reporting by battalions. In addition, some soldiers go to external clinics because of a misinformed or justified belief that they may be disciplined for having an STI. Some Level I facilities reported that troops from other contingents were seeking attention for STIs and, as a result, would not be recorded in official reports as Level I medical facilities only record the health status of their own troops (and sometimes that of the UNMO/Civpol who are based near them).

78. STIs do not rank high on the list of military concerns, but this must be considered in the context of Sierra Leone being malaria endemic. In April 2002, for example, Kenbatt XI reported nine STIs and 424 cases of malaria; in January 2002, Guinbatt II reported 28 STIs and 185 cases of malaria; and, between November 2001 and May 2002, Nepbatt I reported a total of 238 cases of malaria, 330 skin infections and no STIs. Malaria is a more obvious military concern, since it takes soldiers out of action immediately. Lack of concern regarding STIs does not necessarily symbolise a lackadaisical attitude
towards HIV/AIDS, but, rather, it underlines the need for more education on STIs as both aggravating factors and behavioural indicators.

Problems with data

79. The monthly reports sent to the FMedO by Level I facilities are collated to reflect the mission as a whole and forwarded to DPKO in New York. However, during the collation process, crucial information is effectively lost. The UN is often uncomfortable with distinguishing between contingents or singling out troop contributing countries in its reports on missions. But if it is to assess HIV/AIDS interventions using, for example, STI rates, it needs to consider the TCCs on an individual basis. This could help to make interventions more culturally specific and sensitive to the different environments in which peacekeepers are deployed in Sierra Leone. Moreover, the data, once sent to DPKO, seemingly end up in a void, rather than with the medical support unit where it can be properly processed.

80. Within the mission, reporting mechanisms are weak and not sufficiently systematic. Failings in the monitoring of condom distribution have been highlighted above, as have possible discrepancies in the reporting of STIs. Communication between the Level III hospital and the FMedO also needs to be improved. As well as a monthly report, the Level III sends a more detailed daily report on admissions and discharges. Concerned with making the two reports tally, the Level III has not necessarily been informing the FMedO of patients found to be HIV-positive if clinical suspicion was not part of the original reason for admission. As a result, the FMedO might only be aware—even in numerical terms—of those HIV-positive patients who need to be repatriated. Level III monthly reports are also not national specific.

81. Between February and May 2002, around 60 HIV tests were carried out at the Level III, many on individual request. This information is also not being conveyed to the FMedO. The number of personnel requesting HIV tests, in addition to the test results themselves, constitutes important data.

82. The handover time at troop rotation varies between a matter of hours and a couple of weeks. Not all medical facilities leave their general health records for incoming battalions, even if they are of the same nationality, and the quality of briefings on the situation on the ground vary enormously. The monthly reports could provide a location specific indication of the kind and extent of health risks in the area—not only regarding STIs/HIV, but also malaria.

83. TCCs do not generally inform the UN of HIV prevalence in their ranks or of the results of tests carried out on returning troops.

84. Many of the Level I and II facilities offer services to the local community and have built up ‘partnerships’ with local hospitals. This is a potentially rich source of data for public health workers in Sierra Leone. The Pakistani Level II conducted an HIV/AIDS study, including HIV testing with verbal consent, in Konu district. Such projects are potentially useful sources of information. Yet they could present some dilemmas in regard to medical ethics if they are not properly designed, which could reflect badly on the UN.
Key recommendations

i) An HIV/AIDS Task Force should be established. The inclusion of local military personnel, as well as representatives of contingents, in training strategies would boost overall initiatives. Civil–military links also need to be strengthened in order to improve community outreach and to develop programmes addressing the vulnerability of the host population, given the high levels of sexual interaction with peacekeepers. An HIV/AIDS Task Force could also assist in identifying necessary channels of communication to ensure the optimum use of data and assistance currently provided by UN military medical facilities, though it would have to be sensitive to potential concerns regarding ‘mission creep’.

ii) The UN must develop a better understanding of national HIV/AIDS military policies as they impact directly on UN initiatives. Encouraging soldiers to test when it could lead to their dismissal and when national health care is scant could be seen as disingenuous.

iii) Provision and strengthening of VCT facilities in missions:
   - HIV/AIDS counsellors should accompany missions, preferably as part of the contingents if the capacity exists—Ghanbatt V, for example, has an HIV counselling committee, including medical personnel, a chaplain and a regimental sergeant major and is chaired by the deputy commanding officer. At the outset of negotiations with TCCS for the future deployment of troops, it should be stipulated that trained counsellors be included. The UN may need to build such capacity where it does not exist, but training in mission for counsellors would have to take account of troop rotations.
   - Testing facilities must be improved and assured at all levels.

iv) Battalions need to be briefed on the specific medical and social conditions of the immediate area in which they are being deployed. Training needs to be attuned to the evolution of a mission and should take into account the cultural and social mores of both TCCS and the host nation. Emphasis should be placed on resolution 1308 during the induction process. Training on responsible relationships and gender issues should be a key part of HIV/AIDS awareness training. Groups that work with vulnerable populations and CSWS could be involved in developing and providing such training. A cooperation and reporting mechanism, with identified focal points within contingents and committees at different levels of the mission and in the host nation, (similar to the child protection programme), would bolster and institutionalise training initiatives thus strengthening the sustainability of efforts.

v) Training materials need to be distributed at the time of induction/training for maximum impact. Other materials like posters and videos, in addition to the booklets and awareness cards, are necessary, especially given the varying levels of literacy among troops.
vi) The HIV/AIDS policy officer needs comprehensive terms of reference, support staff and a specific budget line to produce training materials. The PO needs to be informed about condom distribution and have a supply for training purposes.

vii) Condom supply must be accompanied by condom promotion. There is possibility of a partnership with UNFPA, which, as the supplier of condoms, could assume that extra role.

viii) UNMO and Civpol need to be specifically targeted and included in training initiatives and in the condom distribution programme.

ix) Combining 'sustainment' and 'self-sustainment' systems may overcome difficulties faced by some TCC medical facilities in acquiring test and PEP kits, but UN requisition times need to be shortened.

x) Contingents may benefit from assistance in the syndromic diagnosis and management of STIs, UNFPA is a possible partner.

xi) Data collection and analysis must be more systematic, both within the mission and between the mission and DPKO headquarters. The UN needs a KAP survey to assess interventions, timed to coincide with troop rotations. The UN should also develop a specific system for ensuring that a certain minimum level of information is conveyed during the handover period at troop rotations, for example the design of a report template for outgoing medical staff to complete. Information regarding the health status of troops should be broken down according to nations and areas of deployment.
1 Civilian personnel are also a matter of concern but are outside the remit of this study as the lines of command and the nature of UN jurisdiction vis-à-vis civilians are different to those regarding military personnel. This assessment does not include a specific examination of gender issues. For reference, a study by the Centre for International Health, Boston University School of Public Health, conducted in April 2002, (publishing date to be confirmed) focuses on the nexus between HIV/AIDS, gender and conflict.

2 For an overview of ECOMOG and UN interventions in Sierra Leone, including the changing fortunes of the UN mission, see Adekeye Adebajo, ‘Building Peace in West Africa: Liberia, Sierra Leone and Guinea-Bissau’, International Peace Academy Occasional Paper Series, (Lynne Rienner, Colorado, 2002).

3 Figures from the US Committee for Refugees 2002 Country Report: Sierra Leone, see www.refugees.org/world/countryrpt/africa/sierra_leone.htm


7 UNAIDS cited by Associates for Global Change, op. cit.

8 The rates may be lower when the specimens are evaluated under optimal laboratory quality assured conditions.


11 Summary of presentation by Dr Samba, see ‘HIV/AIDS in Sierra Leone’, Report on Proceedings of Retreat, (Freetown, Sierra Leone, 13–16 April, 2001), p. 16.

12 Mr Williams, Director of programmes, Planned Parenthood Association of Sierra Leone (PPASL).


14 See summary of presentation by Dr Samba, op. cit.

15 Some of Nigeria’s ECOMOG troops were subsumed into the UN mission. By now, though, they would have been rotated, although individuals may have returned having in theory fulfilled Nigeria’s health criteria. (See section on testing).

16 Ministry of Health and Sanitation, National AIDS Control Programme Report, 2000. Statistic for 1997, cited by Associates for Global Change, op. cit. It is important to note, though, that there are different categories of CSWs in Sierra Leone and their risk levels differ as do their clientele and levels of self-esteem. As a result, such surveys should not be considered to be representative of all CSWS.

17 Independent Observer, 29 May 2002, p. 3. It does not specify whether it is referring to UN or ECOMOG troops, or both.


22 Using the induction schedule for BANLOG-2 and BANENGR-2, April 2002, as an example.
### Peacekeeping troop contributions to UNAMSIL, June 2002  (Source: UNDPKO)

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List of interviews in Sierra Leone

UNAMSIL headquarters Mammy Yoko

Bureau of Investigation OIC Mona Glasspoole
Chief Military Observer Major General Syed Athar Ali (Pakistan)
Chief of Policy and Planning Hagoss Gebremedhin
Chief of Political Affairs Peter Tingwa
Chief of Public Information Margaret Novicki
Chief-of-Staff Brigadier James Ellery (UK)
Child Protection Advisor Bituin Gonzales
Deputy Force Commander Major General Martin Luther Agwai (Nigeria)
Deputy Force Medical Officer Lieutenant Colonel Syed Tehseen Kazmi (Pakistan)
Deputy srsg for Governance and Stabilisation Alan Doss
Deputy srsg for Operations and Management Behrooz Sadry
Force Commander Lieutenant General Daniel Ishmael Oponde (Kenya)
Force Training Unit Lieutenant Colonel Thapa Pralhad (Nepal) and Major Shariar (Bangladesh)
General Supply Unit OIC Michel Vogt; mov section Tony Singleton
HIV/AIDS Policy Officer Hirut Befecadu
Human Rights Officer Patrice Vahard
Police Commissioner Joseph Dankwa (Ghana); Superintendent Blair McKnight
Provost Marshall Colonel Waheed Ahmad Shah (Pakistan)
UNAMSIL radio reporter Abu S. Tarawalie

Contingents

Bangladesh Banned 11 (Magburaka)
Level 11 hospital Commanding Officer Abdus Shahid Khan; second-in-command Lieutenant Colonel Anm S. Alam
Psychiatrist Major Aziz
Head pathologist Major Debashish
Bangladesh Banbatt vi (Magburaka)
Second-in-command Lieutenant Colonel Mohiuddeen
Imam Afsar Uddin
Level 1 hospital Senior Medical Officer Lieutenant Colonel Hasnat;
Medical specialist Major Habib

Ghana (Kenema)
Sector and Contingent Commander Brigadier General George Ayibonte
Level 11 hospital Physician Specialist Lieutenant Colonel Ametepi;
Matron Lieutenant Colonel Esther Dennis

Ghanbatt v (Kenema)
Commanding Officer Kwame Opoku-Adusei
Chaplain Reverand Father Lieutenant Ack Kemetse
Level 1 hospital Senior Medical Officer Captain Kutin; Medical Officer Captain Acorlor;
Pharmacist Lieutenant Christine Oko

Guinea (Bo)
Commanding Officer Colonel Mamadu Camara
Level 1 hospital Senior Medical Officer Doctor Dione Moriba;
Medical Warrant Officer Robert K. Saoromou

Jordan Level 111 hospital (Freetown)
Commanding Officer Colonel Doctor Kamel M. Bawaneh
Dental surgeon Lieutenant Colonel Doctor Ahmed T. Zawahren
Internist/Cardiologist Lieutenant Colonel Ghassan
Medical Technologist Captain Azez-sh Barhoum

Kenya (Masiaka)
Level 1 hospital Regimental Medical Officer Captain K.D. Chepsiror
Protestant Chaplain Reverand Michael Nzuki Kimindu
Imam Captain Abdulmalik Abdalla
Roman Catholic Father Lucas Gatobu

Nepal (Moyamba)
Commanding Officer Colonel Victor Jung Rana
Level 1 hospital Captain Doctor Mukunda
Nurse Major Kamala Subba
Nigeria Nibatt xi (Makeni)

Commanding Officer Lieutenant Colonel O.O. Keshinro
Level 1 hospital Senior Medical Officer Lieutenant Doctor C.J.C. Igboanusi; Chief Nursing Officer Major Hilary Dubagarì; Quartermaster Captain Beryo

Nigeria Nibatt ix (Goderich)

Commanding Officer Colonel M.D. Abubakar
Level 1 facilities Doctor Lieutenant Bamidele Ganiyu

Pakistan (Koidu)

Chief-of-Staff Lieutenant Colonel Shafqat Nawaz Khan
Level 11 hospital Commanding Officer Lieutenant Colonel Babar; Pathologist Major M.N. Asif; Gynecologist Major Samina Baqar; Sister Lieutenant Nabeela Rama

Russia (Lungi)

Commanding Officer Colonel Ivan Nikitin
Infirmary Lieutenant Colonel Vladimir Kurkin; Captain Alexander Zadvornov; First Lieutenant Andrei Perervozchikov; Interpreter First Lieutenant Felix Oganyan

Ukraine (Lungi)

Level 1 hospital Chief Medical Officer Major Valentin Prylin; Lieutenant Colonel Volodimir Blikhar; Lieutenant Colonel Andrej Ketrar; Lieutenant Colonel Petro Vîlnîj; Lieutenant Colonel Vasiliy Melnik
Interpreters Senior Lieutenant Scripnicov and Captain Matsko Roman
Aviation Unit Facilities Senior Doctor Major Alexander Mydynski; Senior Lieutenant Oleg Birlutskyi

Zambia (Tongo)

Commanding Officer Lieutenant Colonel Morgan Sitwaloa
Level 1 hospital Senior Medical Officer Lieutenant Colonel Frida S. Kazembe

Local actors and International NGOs

American Refugee Committee (ARC) Doctor Mustaffa
Bo Government Hospital Head Doctor Thomas Rogers; Matron Nancy Bayoh
Bumpah Community Health Centre (Koidu) Biofinda Kamanda and Millicent Swaraoy
Connaught Hospital (Freetown) National Aids Control Programme Manager Doctor B. Kargbo; Pathologist Doctor Walker
International Military Advisory and Training Team (IMATT) Medical Advisor Lieutenant Colonel Colonel Cliff Dieppe (UK); Nurse Lieutenant Colonel Doreen Smith (US)
Kenema Government Hospital Medical Superintendent Doctor Kabba Koita; District Medical Officer Doctor Stevens; Blood Technicians Mohamed Aufullah and Adonis Gaward
King Tom’s Hospital Head Doctor S.K. Kamara; Matron Angela Sesay; Technician Mark Kaklom
Koidu Government Hospital Doctor Momodu Sesay
Kuimayei Rural Development (Bo) Community Worker Alice L.B.N Samba
Magburaka Government Hospital Chief Advisor Edmund Polie Sankoh; Senior Medical Officer Doctor Sultan Forna
Makeni Government Hospital Chief Doctor Kamara; Health Educator Abu Conteh; Laboratory Technician Sam Bangura
Marie Stopes Clinical Services Coordinator Mrs Green
Masiaka Community Health Centre Health Officer Mano Mansaray; Immunisation Officer Borbor Say
Médecins Sans Frontières Anonymous sources
Moyamba Government Hospital District Medical Officer Doctor Joseph N. Kandeh; Medical Officer in Charge Doctor S.M. Kenneh; Laboratory Technician Edmund Mboka
Planned Parenthood Association of Sierra Leone (PPASL) Director of Programmes David Williams
Sierra Leone Police Force Senior Assistant Kadi Fakondo
Sierra Leone Red Cross (Moyamba) OIC Marvel Vincent
Society for Women and AIDS in Africa, Sierra Leone President Isatta Wurie (Msc viriology)
Wilberforce Military Hospital Doctor Samba
Women in Crisis Movement Director Juliana Konteh; Pastor Kalila Kmora
World Bank Representative Richard Lynn Ground
World Health Organisation Representative Dr J. Saweka
World Vision (Koidu) OIC Bernard Kidula
United Nations Development Fund for Women Jebbeh Foster
United Nations Population Fund Director Doctor Mamadou Diallo; National Programmes Officer Mariama Diarra
United States Ambassador to Sierra Leone Peter Chaveas

More informal group interviews/discussions were also held with troops, UNMO, Civpol and commercial sex workers (at the Women in Crisis Group).