

HIV/AIDS: Policies and programmes for blue helmets

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In the preamble to Resolution 1528 (February 2004), establishing the United Nations Operation in Cote d'Ivoire (ONUCI), the Security Council welcomed and encouraged "efforts by the United Nations to sensitise peacekeeping personnel in the prevention and control of HIV/AIDS and other communicable diseases in all its peacekeeping missions".² Similar language was used some months later in Resolutions 1542 and 1545, setting up the United Nations Stabilisation Mission in Haiti (MINUSTAH) and the United Nations Operation in Burundi (ONUB) respectively.³

All three resolutions draw on Resolution 1308 of July 2000, which recognised that the HIV/AIDS pandemic is:

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.⁴

In its debate, the Security Council focused attention on the potential link between peacekeeping and the spread of HIV and called for pre-deployment and ongoing HIV/AIDS awareness training for peacekeeping personnel.⁵

The resolutions underscore the responsibility of the Department of Peacekeeping Operations (DPKO) to include HIV/AIDS awareness and prevention strategies in its mission planning. At the same time, the diluted and formulaic wording hints at unease among many member states regarding the extent to which they are willing to engage with the issue of HIV/AIDS and peacekeeping. As a result, not only does DPKO have to design programmes that respond to the pandemic in post-conflict settings but it also has to

navigate the sensitivities of member states, in particular those that contribute troops.

DPKO has to respond to the epidemic while navigating the sensitivities of troop-contributing countries

This article initially looks at the rationale for including HIV/AIDS issues on the peacekeeping agenda and then examines DPKO's programmes for uniformed peacekeepers and the particular challenges the Department faces, at both the political and operational levels.⁶

HIV/AIDS IN THE RANKS

According to global HIV/AIDS estimates, 25 million people were HIV-positive in Sub-Saharan Africa at the end of 2003. But the epidemic does not affect this region alone. For example, some 6.5 million people are believed to be living with HIV/AIDS in South and Southeast Asia. Some projections, which New Delhi disputes, suggest that India could have as many as 20–25 million HIV/AIDS cases by 2010. China has also been highlighted as a 'next wave' country and has registered HIV/AIDS cases in all of its provinces. In mid-2002, Beijing's official national estimate put the number of people living with HIV/AIDS at one million, while some experts at least double this figure.⁷ The epidemics in Eastern Europe and Central Asia are growing rapidly.⁸ Between 1999 and 2001, the number of cases officially reported by the Russian Federation increased sixteen-fold, while "the actual number is estimated to be four to ten times higher than reported".⁹ In total, there were 4.8 million new HIV infections globally in 2003 and 2.9 million AIDS-related deaths.

In order to monitor the development of the epidemic, epidemiologists and social scientists track HIV prevalence and incidence in different population groups. Intravenous drug users, for instance, are considered a high-risk group, while data collected from women attending pre-natal clinics and blood donors are used to indicate

whether the epidemic has become generalised in the population. In developing countries, commercial sex workers, truck drivers and migrant labourers have often been considered among the key vectors of HIV transmission. More recently, soldiers have been added to the list as both a high risk and key 'bridging' group, acting as a conduit for the spread of HIV into the wider population.¹⁰ Armies are generally composed of young men of a sexually active age, imbued with a risk-taking ethos and deployed on tours of duty away from home with money in their pockets. A 1997 study found a correlation between HIV clusters in northern Namibia and the proximity of military bases. Similarly, studies on the effects of demobilisation in Uganda "revealed devastating results for the rural areas where the demobilized HIV-positive troops retired".¹¹

Accurate data on military infections, however, are scant. Few developing countries carry out periodic testing for surveillance purposes or have adequate testing facilities and may, in any case, be wary of releasing such sensitive statistics. The Namibian government, for example, has classified references to specific HIV prevalence rates in its military. As a result, data are often based on small samples, or figures that are extrapolated from unreliable national calculations using assumptions about increased military exposure to the virus. The rule of thumb for the US Department of Defence's HIV programme, for example, is to double the civilian infection rate for African militaries.

To indicate the extent of the problem in African armed forces, most analysts refer to estimates by the Defence Intelligence Agency/Armed Forces Medical Intelligence Center (DIA/AFMIC), published in 2000 in a US National Intelligence Council (NIC) report. These suggest an HIV prevalence rate of between ten and 20% in Nigeria and Ivory Coast and between 40 and 60% in war-affected countries, such as Angola and the Democratic Republic of the Congo (DRC). The AFMIC estimates allow for a large margin of error and the basis on which they were made is unclear. While also speculative, assessments by South African Defence Intelligence have produced similar findings, estimating an HIV infection rate of 50% in 1999 in the armed forces of Angola, the DRC and Malawi, 55% in the Zimbabwean army, and 60% in the Zambian military in 1998.¹²

Even if surveillance is weak, and militaries are reticent about publishing figures, they are increasingly acknowledging that HIV/AIDS is a

problem in the ranks. The South African National Defence Force (SANDF) reportedly stopped donating blood for "security reasons"¹³ and, following an internal health review in July 1999, declared HIV/AIDS to be one of its most important strategic issues.¹⁴ This sentiment is echoed in the statements of other African defence personnel, such as the Deputy Chief of the Kenyan General Staff, who recently argued that "the scourge is taking its toll on the armed forces and we need to act from within".¹⁵

Such concern is not limited to African armed forces. In 1988, the Royal Thai Army (RTA), for example, formed an AIDS Committee and the following year began to test its conscripts. Although much vaunted for its HIV/AIDS programme the RTA only publishes statistics on HIV prevalence among its recruits and not in the ranks. In Cambodia, reported prevalence in the military was 7% in 1997, up from 6% in 1995.¹⁶ Cambodia's 2001 Defence White Paper highlighted the spread of HIV as a key security concern, stating that "[w]ithout immediate and effective measures being taken, this enemy will not only endanger the human resources in society but will cripple the efforts of developing the armed forces' capability as well".¹⁷

In 1998, the *Hindustan Times* reported that over 6,000 members of the Indian army had tested positive in ongoing testing. The military does not have a policy of universal screening but according to sources in the Armed Forces Medical Services there have been around 5,000 cases recorded between 1990 and mid-2004.¹⁸ Data from testing among those suspected of having HIV/AIDS, military blood donors, high risk groups and those tested before being deployed abroad, suggested a cumulative rate per thousand in 2001 of 0.03 in the air force, 0.22 in the army and 0.41 in the navy. Records also show that HIV/AIDS is both the leading medical reason for being "invalided" and the second "commonest cause of mortality" in the navy; and is the fifth medical reason for being "invalided" in the army.¹⁹ Sporadic media reports from Russia suggest that there have been sharp increases in new HIV cases within the Russian Federation's armed forces.

In a 2002 report on 'next wave' countries, the NIC concluded that China and India may increasingly have to "monitor AIDS in the military to ensure that the disease does not complicate staffing among smaller, more highly trained units operating sophisticated weapons systems". Given the size of their militaries and the large pool of potential recruits, however, it is not anticipated that HIV/AIDS will have a significant impact on their military capability²⁰.

Soldiers are at high risk of contracting HIV and serving as agents for its transmission



In sub-Saharan Africa, the higher prevalence rates make HIV/AIDS a more immediate and acute issue for the armed forces. The loss of personnel compromises combat readiness, particularly an army's ability to deploy at short notice, and upsets the continuity of command and the efficacy of detachments. Training new recruits also absorbs already scarce resources. According to Lindy Heinecken, Deputy Director of the Centre for Military Studies at the South African Military Academy, the SANDF's concern was largely sparked by the high HIV rates found in soldiers between the age of 23 and 29, as officers and non-commissioned officers in this age group normally fulfil critical skilled, operational and supervisory roles. The NIC predicts that HIV/AIDS will similarly complicate staffing in the military officer corps in both Ethiopia and Nigeria, a likelihood underscored by Colonel Wale Egbewunmi, coordinator of Nigeria's Armed Forces Programme on AIDS Control:

HIV/AIDS impairs military readiness...valuable experience and skills will be lost, shortages of officers and troops may result, and less experienced personnel may have to take on more responsibilities.²¹

HIV/AIDS: AN ISSUE FOR PEACEKEEPING?

As of September 2004, the UN had over 60,000 uniformed peacekeepers – including troops, military observers and civilian police – from 100 countries deployed in missions in Africa, the Americas, Asia, Europe and the Middle East.²² According to a 2001 report by the International Crisis Group (ICG), high levels of HIV/AIDS in African armies could undermine their ability to participate in peacekeeping:

This would be a serious blow for peacekeeping operations in Africa particularly, but also more broadly as soldiers from countries with high HIV/AIDS prevalence make up 11% of UN totals; adding in countries nearing such high prevalence yields 37% of UN peacekeepers.²³

The SANDF, which has a policy of screening and excluding HIV-positive personnel prior to participation in UN missions, allegedly had problems composing an initial detachment of 93 soldiers for the United Nations Mission in the Democratic Republic of the Congo (MONUC): "SANDF first tested a group of 400 potential peacekeepers. But 90% were found to be HIV-positive. A second group of 400 produced slightly better results when tested – only 87% were positive".²⁴

High levels of HIV/AIDS in African militaries could undermine their ability to participate in peacekeeping

Despite such force-generation issues, South Africa was in September 2004 the eighth largest troop contributor, with over 1,400 peacekeepers in MONUC and more than 1,080 in ONUB. Bangladesh, India and Pakistan regularly rank among the top five troop contributors and all have a national HIV/AIDS prevalence rate of less than 1%. This should not, though, encourage a sense of complacency, as the incidence of HIV if left unchecked in any country can increase exponentially. In addition, the nature of UN peacekeeping and the political balances that are at its core require a multinational force and not, for instance, a South Asian one. Despite 'emerging' troop-contributing countries like China, the involvement of African nations is likely to remain crucial as missions evolve in their backyard and areas of strategic interest.

Beyond questioning the ability of some nations to deploy, analysts contend that HIV/AIDS levels in host nations may soon be a key variable in the calculations of member states considering whether to contribute troops to a particular mission. According to the DPKO's Force Generation and Military Personnel Service, malaria rather than HIV is the main health concern.²⁵ However, requests like the one made by Indonesia to the Security Council in 2000 for "HIV mapping in countries where peacekeepers are going to be deployed" in order to "help design a deployment strategy that minimizes the risk of peacekeepers being exposed to the disease"²⁶, suggest that HIV could become more of an issue.

Impact on HIV epidemics in host nations

In an effort to demonstrate the potentially high level of HIV among peacekeepers and, by implication, the possible 'hazard' they pose to host communities, in 2001 the US General Accounting Office (GAO) tabulated contribution levels to UN peacekeeping operations from countries with an HIV/AIDS prevalence of greater than 5%. This analysis suggested that 32% of peacekeepers with the United Nations Mission in Sierra Leone (UNAMSIL), 17% of those serving with the United Nations Mission in Ethiopia and Eritrea (UNMEE), 8% of those based in Croatia and the DRC and 6, 5 and 4% of those stationed in Western Sahara, Kosovo and East Timor respectively came from countries where prevalence was greater than 5%.

In one sense the HIV/AIDS prevalence levels inferred by the GAO may be conservative, given that the reported prevalence of HIV among military personnel is frequently higher than among their civilian counterparts. Conversely, though, many



troop-contributing countries have a policy of mandatory testing prior to deployment, whereby they exclude those who are HIV-positive from peacekeeping missions – although the rigour with which such policies are implemented varies enormously.

Risk behaviour in the field is a key variable in the spread of HIV. The mostly low-intensity nature of peacekeeping operations brings UN troops into close proximity with host populations. Peacekeepers tend to have significantly more disposable income than locals and missions are often inadvertently drivers of the commercial sex market. According to a report by a UN Expert Group on HIV/AIDS and its Gender Implications, “in post conflict situations, peacekeeping forces may put local women at increased risk as they barter or sell sex for survival”.²⁷ Reports generated by the 1992–93 United Nations Transitional Authority in Cambodia (UNTAC) are often cited to illustrate such a scenario. Non-governmental organisations (NGOs) that worked with sex workers in Cambodia both before and after the UN mission reported that “sex workers, on average, doubled their nightly number of customers from five to ten”.²⁸ According to a study referred to by the Joint UN Programme on HIV/AIDS (UNAIDS), 45% of Dutch navy and marine personnel serving with UNTAC “had sexual contact with sex workers or other members of the local population during a five month tour of duty”, and condom use was inconsistent.²⁹ More recently, UN troops deployed in the DRC have been accused of buying sex from teenage refugees.³⁰

The Cambodian government attributed the rise of HIV in the country to UNTAC. There is little concrete evidence to either support or refute this, although there was a marked increase in HIV among blood donors between 1991 and 1995, indicating a corresponding rise in the general population.³¹ The possible impact of UNTAC, however, should be weighed against the general development of the epidemic in the region, which was not related to the presence of the peacekeeping mission. Neighbouring Thailand, for example, reported its first case of HIV in 1984³² and the epidemic was well established across Asia by 1997.³³

Similar concerns have been raised by welfare groups in East Timor, which believe that the presence of peacekeepers could exacerbate the spread of HIV in the territory. Addressing the first National AIDS Conference in East Timor in 2002, President Xanana Gusmao drew a direct comparison with UNTAC:

It’s now established that in Cambodia, UN peacekeepers actually contributed to the spread of the virus. But no education programme was given to the thousands of UN workers in East Timor who’ve come and gone.³⁴

HIV testing

The perception that peacekeepers may spread HIV has crystallised debate around the complex issue of mandatory testing. In a March 2001 letter to the Security Council, Eritrea requested that UN troops serving with UNMEE be tested for HIV. The Eritrean government argued that this was not to be seen as a “discriminatory practice” targeted at the UN but was in line with a “standard national practice that [had] been in effect since 1993”.³⁵ Ultimately Eritrea’s request was denied and this partly informed its decision not to sign a Status of Forces Agreement, which outlines the legal framework for practicalities such as the immunity of peacekeepers and their freedom of movement. Reflecting a widely held view in Sierra Leone, a local NGO, the Campaign for Good Governance, similarly called for a policy of mandatory pre-deployment testing for UNAMSIL troops and the exclusion any soldiers found to be HIV-positive.³⁶

The perception that peacekeepers may spread HIV has crystallised debate around mandatory testing

Mandatory pre-deployment HIV testing is a controversial and polarising issue. Respect for human rights has become the critical international framework for the response to HIV/AIDS and has led to a strong emphasis on informed voluntary consent and counselling,³⁷ a position considered by some analysts to be counter-productive in combating the epidemic. According to Gruskin and Loff, however, a human rights approach is not at odds with sound public health policies. The friction, they argue, comes from the misconstrued assumption that a human rights approach automatically places greater value on protecting individual rights rather than those of the larger community. In fact, Gruskin and Loff contend, a human rights approach is about making sure that public health strategies are evidence-based and openly debated. “This approach protects against unproved and potentially counterproductive strategies, even those motivated by genuine despair in the face of overwhelming public health challenges”.³⁸

Among the five permanent members of the Security Council, China, Russia and the US have national policies of mandatory pre-deployment screening for military personnel. The UK has a policy of voluntary testing, as does France, although there are some caveats in the latter’s policy.³⁹ Based on



guidance from UNAIDS and the World Health Organization (WHO), the DPKO HIV testing policy stipulates that “the sole medical criterion for the deployment and retention of a peacekeeper is fitness to perform peacekeeping duties during the term of deployment”.⁴⁰ In line with current medical and human rights guidelines, and given the generally long periods of functional capacity of HIV-positive personnel, “the HIV status of an individual is not in itself considered an indication of fitness for deployment”.⁴¹ At the same time, DPKO respects those national requirements of troop-contributing countries that may demand mandatory testing.

While the UN does not require an HIV test, a thorough pre-deployment medical is supposed to exclude those showing signs of active disease, including clinical symptoms of AIDS.⁴² However, although the UN sets the minimum medical standards, such pre-deployment health assessments are the responsibility of troop-contributing countries.⁴³ Medical examinations should include basic blood chemistry and laboratory investigations, as well as collection of a comprehensive medical history, a chest x-ray and checks of the cardiovascular, respiratory, digestive and nervous systems. Individuals suffering from AIDS should be easily identified and excluded as a result of such pre-deployment medicals. Yet concerns about the health status of soldiers, and AIDS-related deaths among recently deployed personnel in some missions, suggest that these guidelines are not being routinely followed. Furthermore, the majority of reported cases have come from countries with a stated national policy of HIV screening, indicating that even national policies are not always being implemented.

According to DPKO policy, personnel who do not meet the minimum medical criteria should be repatriated – at the cost of the troop-contributing countries if it is deemed that they were deployed in breach of the medical guidelines. Adding a financial dimension to pre-deployment medicals is perhaps one way to make their importance resonate with some member states, but it is a very politically sensitive tactic that can be difficult to implement. If personnel have to be repatriated for medical reasons, the immediacy of the situation and the natural sympathy for the individual and family involved mean that missions are unlikely to want to wrangle over the financial aspects.

One area that requires further investigation is whether the nature of deployment and peacekeeping environments could aggravate the progression of HIV to

AIDS in HIV-positive but otherwise healthy personnel. The long incubation period of HIV poses myriad challenges for militaries: it can take up to three months from the time of infection for the virus to show up in an antibody test – so that even mandatory testing cannot guarantee that all HIV-positive personnel are identified. Individuals can also be HIV-positive but have a functioning immune system. Ultimately, HIV testing remains very much a live issue and DPKO has consciously left its policy open to regular internal review, “to take into account any developments in medical treatments and recommendations with regard to HIV and AIDS”.⁴⁴

Under DPKO policy HIV status is not in itself considered an indication of fitness for deployment

Risk to peacekeepers

The focus on pre-deployment mandatory testing overlooks the risk to peacekeepers while they are in the field. As the GAO report indicated, peacekeepers may come from countries with high levels of HIV prevalence and be deployed in areas with low rates of infection. But the opposite is also true.

Nepal, for instance, has a national prevalence of around 0.5%⁴⁵ and is deploying troops to Haiti, which has the highest prevalence of any country outside of Sub-Saharan Africa.

The risk of contracting HIV thus goes both ways. Following reports of high HIV prevalence among local sex workers in Cambodia, the Indonesian military screened over 3,600 of its UNTAC peacekeepers. Twelve were found to be HIV-positive. Through a combination of pre- and post-deployment testing, and taking into account different types and sub-types of HIV predominant in Cambodia, Indonesia and Thailand, the study concluded that all but one had been infected in the mission area – a finding made more tragic by fact that “the 11 (ultimately fatal) HIV-1 infections far exceeded the only other losses (two non-disease related deaths) sustained by the Indonesian peacekeepers”.⁴⁶ Similar studies in Uruguay and the US of returning UNTAC peacekeepers found that soldiers had contracted HIV in the field⁴⁷ and, in 1993, the *Times of India* reported that as many as 45 Indian peacekeepers returning from Cambodia were HIV-positive.

A 1999 study examining HIV in the Nigerian military found HIV to be a particular risk factor for personnel involved in regional peacekeeping operations in Sierra Leone.⁴⁸

Incidence rates increased from 7% after one year [in the Operation Sandstorm area of Sierra Leone] to 10% after two years, to more than 15% after three years of duty in the operational area, for a cumulative annual risk



factor of about 2%. During the period under discussion, HIV/AIDS became the second-largest ultimate killer of deployed Nigerian soldiers, next to gunshot wounds.⁴⁹

In UN operations, uniformed peacekeepers are not deployed for such extensive periods of time – the maximum is generally a year – so the same kind of calculation would not necessarily apply. In operations such as those in Burundi and Sierra Leone, however, the UN has taken over from a regional peacekeeping operation, in which case many troops simply ‘re-hat’ and are absorbed into the UN mission.

Difficulty with data

It is hard to quantify the reciprocal risk of HIV transmission in peacekeeping settings. HIV surveillance is problematic and rarely a priority in conflict and post-conflict areas and the resulting lack of baseline data in conflict-affected countries makes it difficult to determine the impact of a peacekeeping mission. Cambodia, for instance, did not complete its first round of HIV sentinel surveillance until 1995,⁵⁰ after the UN mission in the country had already come to an end – so it is impossible to compare the status of the epidemic before and after the mission. Moreover, the breakdown of health services, the mass movement of internally displaced people and refugees and the increased vulnerability of women and children to sexual abuse and exploitation, means that conflict itself, irrespective of a peacekeeping element, may aggravate the course of the epidemic.

Specific data on peacekeepers are equally difficult to capture. Each battalion has a level I medical support that provides primary healthcare, with more specialised treatment generally being provided by a level II military medical facility. Using data from these facilities, contingents compile monthly reports on the health status of troops. Data are also available from the civilian-run UN facilities. Unfortunately, the overall reports are not always complete, or consistently filed by all missions with the Medical Support Section in New York. Moreover, the statistics do not draw a distinction between cases of HIV and instances of AIDS – which have very different implications in terms of statistical information, the health status of the individual and mission/DPKO policy.⁵¹ There is also concern that some AIDS-related deaths are being attributed to opportunistic infections as opposed to the virus itself. Additionally, troop-contributing countries are responsible for the medical records of their contingents and do not, as a

matter of course, inform the UN of the results of post-deployment HIV testing.⁵² The result is that data on HIV rates among UN peacekeepers essentially exist on three levels: official, unofficial and unknown.

Sexually transmitted infections (STIs) are often used as markers for HIV, as they increase the likelihood of HIV infection and indicate risky behaviour. However, the extent to which reported cases of STIs among troops represent the reality on the ground is questionable. The ability to diagnose varies between contingents and many individuals may seek treatment privately (outside of the mission system) because of a misinformed or justified belief that they will be disciplined by their commanding officer for having a STI. Data that are collected also need to be more closely analysed. For example, an examination of STI statistics among all uniformed and civilian personnel in MONUC found 138 cases for the period between January and July 2003, including seven cases of HIV/AIDS.⁵³ A closer look at the breakdown revealed a concentration of STI cases in one area, indicating a particular problem among troops from one troop-contributing country. Such an analysis from all mission areas would provide a more accurate picture and could be used to intensify programmes with particular contingents and guide the review of behaviour change communication strategies.

It is hard to quantify the reciprocal risk of HIV transmission in peacekeeping settings

Knowledge, Attitude and Practice (KAP) surveys are also useful tools to monitor and evaluate programmes. A KAP survey carried out by the American Refugee Council (ARC) in Sierra Leone in March 2001 included

102 UNAMSIL peacekeepers and illustrated the need for awareness programmes: of those interviewed, for instance, only 15% could name at least three ways to prevent the transmission of HIV. The ARC KAP was, however, undermined by a number of weaknesses that have affected more recent studies of peacekeeping personnel. Peacekeepers are not an homogenous group and it is not clear, for example, if all of the peacekeepers surveyed were of the same nationality or how long they had been deployed in the mission area. DPKO is currently collaborating with the Center for Disease Control to design a KAP template specifically for peacekeeping missions. This questionnaire and its implementation will have to be sensitive to not only the values of different nations but also differing deployment times and the impact these could have on opportunities for risky behaviour.

Regardless of the current lack of reliable baseline data, DPKO has had to recognise that “it is

undeniable... there is risk of peacekeepers transmitting HIV, or of contracting HIV while they are on mission".⁵⁴

MISSION POLICIES AND PROGRAMMES

In January 2001, DPKO and UNAIDS signed a cooperation framework. The resulting technical and advisory support from UNAIDS has greatly influenced DPKO's policy and its response in the field. All peacekeeping missions have either an HIV/AIDS policy adviser or, in the case of smaller missions, a focal point, to develop awareness and prevention programmes to reduce the risk of peacekeepers either contracting or transmitting HIV. As of September 2004, there were HIV/AIDS policy advisers included in the staffing tables of nine DPKO missions: Burundi, Cote d'Ivoire, the DRC, East Timor, Ethiopia/Eritrea, Haiti, Liberia and Sierra Leone and Sudan.⁵⁵

The concept of including policy advisers in peacekeeping missions is relatively new: the first was deployed in Sierra Leone in February 2001 – at the time the biggest DPKO mission, with a maximum mandated strength of 17,500 military personnel.⁵⁶ Further HIV/AIDS policy advisers were not placed in missions until 2002 – in UNMEE in July and MONUC and East Timor in September, long after these missions were established.⁵⁷ Liberia was the first mission to include an HIV/AIDS policy adviser in its staffing component from the planning stages; they are now a standard in the personnel tables of new missions and their capacity is being strengthened with the assistance of qualified UN volunteers and national policy officers. In June 2004, a joint UNAIDS–DPKO mission to Haiti deployed an HIV/AIDS policy adviser and established an HIV/AIDS programme in the mission in advance of the arrival of the main contingent of UN troops. This set a new precedent for peacekeeping operations.

The capacity of the HIV/AIDS focal points in the smaller missions to develop and maintain programmes needs to be reviewed, as HIV/AIDS programming constitutes an additional responsibility on top of their main assignments. The military and police strength of missions with HIV/AIDS focal points ranges from 44 military observers with the United Nations Military Observer Group in India and Pakistan (UNMOGIP) to around 3,640 civilian police and military observers with the United Nations Interim Administration in Kosovo (UNMIK).⁵⁸ In addition, there are significant numbers of civilian staff that need to be factored into programmes.⁵⁹

Since January 2002, UNAIDS has also funded the post of an HIV/AIDS policy adviser at DPKO headquarters to draft policy and coordinate and support mission programmes. The central elements of these programmes are awareness training, the provision of condoms and post-exposure prophylaxis (PEP) kits, voluntary confidential counselling and testing (VCCT) and limited sensitisation and awareness outreach to local vulnerable groups.

Pre-deployment training

In an effort to establish minimum standards of training across the gamut of peacekeeping issues, DPKO's Training and Evaluation Service (TES) has developed standardised training modules and organises and sponsors a number of different training courses. These range from general 'training-the-trainer' courses to enhance national peacekeeping capabilities, to programmes tailored for military observers, and from courses for emerging troop-contributing countries, such as Mongolia and the Islamic Republic of Iran, to mission-specific pre-deployment training.

Resolution 1308 identified HIV/AIDS training and pre-deployment orientation as specific tasks for DPKO⁶⁰ and the issue is now included in programmes. HIV/AIDS policy advisers are increasingly facilitating pre-deployment awareness sessions, for example in 2003 with respect to the training for Namibian and Ethiopian troops being deployed to Liberia, and in 2004 as part of the pre-deployment training for Burundi.

In-mission training

In collaboration with DPKO, UNAIDS has developed an HIV/AIDS awareness card which it distributes to peacekeeping personnel. This plastic card outlines the code of conduct governing missions and provides basic information on HIV/AIDS and how personnel can protect themselves against both sexual and occupational risk of exposure. It includes a pocket for a condom. The card is available in 11 languages – Arabic, Bengali, Chinese, English, French, Hindi, Kiswahili, Portuguese, Russian, Spanish and Urdu – and is being translated into Indonesian and Nepalese. The intention is that these cards will become a standard part of the peacekeeper's uniform.

Training cells facilitate the delivery of specialised training in missions and are central to the coordination of HIV/AIDS awareness activities for military personnel.⁶¹ The nature of deployment in a

HIV/AIDS policy advisers or focal points are included in the staffing tables of all missions



mission can, however, make it difficult to reach troops soon after deployment. In MONUC, for example, a national contingent may be scattered within the mission and changing operational imperatives have resulted in troops frequently being redeployed to different geographical areas. In 2003 this resulted in a number of contingents being in the field for some months before receiving 'induction' HIV/AIDS training. The situation in MONUC should be ameliorated by the assignment of UN volunteers to assist the HIV/AIDS policy adviser.

The cultural diversity of missions also poses a challenge. There may be over 30 different military and police contributors in any one peacekeeping operation – in Liberia, for example, 60 countries currently contribute uniformed personnel. In addition to the obvious language barriers, this makes it difficult to ensure that awareness sessions are culturally sensitive. In MONUC, troop-contributing countries are requested to bring their national HIV awareness material with them. This reinforces messages in relevant languages and styles. Yet, many countries do not have such material and those that do often limit their display to the medical units.

UNMEE has tried to break down cultural barriers by developing a two-week peer-education programme. Such a 'military-to-military' approach creates capacity within contingents to maintain the momentum of awareness-raising initiatives and may be more successful in translating knowledge into appropriate preventative behaviour. Similarly, in Liberia – currently DPKO's biggest mission with around 15,000 uniformed personnel – the HIV/AIDS unit plans to conduct five day 'training-the-trainer' courses, the aim being to ensure that contingents have at least four trainers in their ranks. In Sierra Leone, the peacekeeping mission has partnered with the United Nations Population Fund (UNFPA) and the United Nations Development Fund for Women (UNIFEM) in the design and implementation of a peer education programme, which includes material on HIV/AIDS, gender and human rights.

The rotation of uniformed peacekeepers is a major hurdle to all efforts to create sustainable programmes. Tours of duty range from four to 12 months and contingents deploy and rotate at different times. As a result, a new peer education programme is required at each rotation. While there is often some overlap between the forward team of a newly deployed contingent and the last detachment of the initial contingent, there is usually insufficient time to provide intensive training programmes and the

hand-over period may not be the best time to capture attention for HIV/AIDS sensitisation. One suggestion has been to specifically delay the rotation of those trained as peer educators so that they can train a new team of educators from among incoming troop contingents.⁶² Such delays would, however, require specific agreements with each troop contributing country at each rotation. The ability of those trained as peer educators to train future trainers would also need to be examined, as there is a risk that information could become diluted as it is passed down over time.

An alternative approach would be to create a network of those trained as peer educators to build the internal capacity of national militaries to provide HIV/AIDS awareness training. Such a network does not currently exist and would require a significant amount of maintenance and lobbying with member states, as well as support from DPKO and other agencies and institutions working with national militaries, such as UNAIDS and the US Department of Defence.

Military observers and civilian police pose an additional challenge as they arrive individually and are not part of an organised battalion. This creates the risk that, unless specifically targeted, training programmes will miss such personnel. Military observers are deployed in small teams within the mission and can be moved within and between sectors as required. Civilian police tend to be based with local police forces in regional or divisional offices (although some missions also have special police units, similar to battalions). The overall mobility of these two groups adds to the difficulty

of ensuring that they receive ongoing training. In addition, military observers are mostly officers with a minimum of six to eight years of experience and it is sometimes assumed that seniority will ensure appropriate behaviour. A similar assumption exists with regard to civilian police, although DPKO is trying to tackle this by "actively seeking police officers that have experience as HIV peer educators or coordinators when selecting candidates for deployment,"⁶³ the aim being to create some HIV/AIDS training capacity within the police ranks.

Across the board, the engagement of senior personnel within the mission is crucial, including the Special Representative of the Secretary-General, the Force Commander, the Police Commissioner and the Chief Military Observer. Making use of the military command structure – through directives and standard operating procedures issued by UN Headquarters and the Force Commander to sector and contingent commanders – assists in main-

The rotation of peacekeepers is a major hurdle to efforts to create sustainable programmes



streaming the issue and generating recognition of the importance of HIV/AIDS to the uniformed services. This can help counter the tendency for the issue to be sidelined as only in the remit of medical personnel. Mission HIV/AIDS task forces with high-level representation, including contingent commanders, are also useful mechanisms to ensure integration and coordination of training activities, programme planning and trouble-shooting. Such task forces are gradually being set up in existing missions, following success in UNMEE, and should be included from the outset in new missions.

Religious leaders who accompany troops in the field are another group that is increasingly being harnessed. In UNMEE, training for the Bangladeshi, Jordanian and Kenyan battalions has included Catholic, Muslim and Protestant leaders, and has demonstrated a key role for such leaders in inculcating responsible behaviour and respect for the host population as part of HIV/AIDS initiatives. As Dr Halle, former Chief of DPKO's Medical Support Section, underscored:

I do not expect a Muslim imam to promote the use of condoms. Nor do I expect a Catholic padre to do that. But what I have every right to expect, and where they do comply, is in talking about how you treat the people around you, especially the most vulnerable, the women and children.⁶⁴

Condoms and PEP Kits

DPKO has a memorandum of understanding with UNFPA to ensure a consistent and economical supply of male and female condoms. The intention is not to encourage sexual liaisons, especially given concern about sexual exploitation in post-conflict settings, but it is simplistic to assume that by restricting the supply of condoms, sexual activity would automatically subside. Condoms need to be distributed to personnel, but in the context of a policy of 'zero tolerance' of sexual abuse and exploitation, and alongside clear messages about what is acceptable behaviour.

The distribution of condoms at the battalion level relies on the cooperation of contingent commanders. This is a delicate cultural and religious issue, illustrated by a contingent commander reportedly burning a consignment of condoms. Missions need to ensure that contingents are aware of condom availability while making it clear that commanders are not obliged to distribute them to their troops. Although some nations are more reticent than others about providing condoms,

policies and practice on the ground often change with the rotation commanders and are not necessarily the result of a national directive.

The DPKO testing policy stipulates that force medical officers and chief medical officers in missions are responsible for ensuring that PEP kits are available in cases of occupational exposure to HIV or sexual assault. To date, DPKO's medical support section has not had any reports of peacekeepers contracting HIV through occupational exposure. Missions receive screened blood supplies and peacekeepers are not viewed as 'walking blood banks'.⁶⁵

The distribution of condoms at the battalion level relies on the cooperation of contingent commanders

Voluntary Confidential Counselling and Testing (VCCT)

The provision of VCCT is a central element of DPKO's HIV/AIDS programme, as it provides "the scope for individuals to make informed and independent decisions to find out their HIV status and is a critical component in influencing behaviour and preventing further transmission".⁶⁶

East Timor was the first mission to establish VCCT facilities in January 2003, and the experiences of this mission formed the basis for the initiatives in UNMEE, UNMIK and UNMIL. The extent to which East Timor can be used as a blueprint for all missions is, however, limited as there are mission-specific challenges that need to be taken into account. In MONUC, for example, the movement of personnel is a complex issue. The size of the country often necessitates travel by plane, which needs to be authorised and justified. The bureaucracy will therefore need to be inventive in order to maintain the confidentiality of individuals needing to travel for VCCT and roaming facilities may need to be considered to ensure that all contingents have access.

Rapid test kits can be procured from UNFPA and most missions either have the internal capacity to carry out a confirmatory test or have an agreement with a local or regional provider to do so.⁶⁶ A major challenge lies in providing counselling capacity and ensuring that counselling and testing services are accessible. DPKO's testing policy strongly recommends that an HIV/AIDS focal point, certified to provide pre- and post-test counselling, is included in contingents of over 200 personnel. Yet there is often confusion between general awareness training and the specifics of counselling, and many countries simply do not have such expertise in their ranks, or do not prioritise the deployment of such personnel. DPKO is currently designing and supporting programmes to train counsellors through intensive,



two-week sessions. Such programmes recognise that training specifically identified military and police personnel is critical in order to establish sufficient capacity at the battalion level to increase the accessibility of testing and counselling services for troops, overcome potential language barriers and contribute to building national capacities.

A potential concern within the ranks, however, is the degree to which the principle of confidentiality is applied. Some military medical officers are expected to inform their commanding officer if a soldier is found to be HIV-positive, while others can use their discretion as to whether senior staff are informed. There is also the risk that test kits may be used for mandatory testing – there have been cases of military-run medical facilities carrying out precautionary testing on patients prior to basic surgery without the individual's knowledge or consent. Concerns about confidentiality, combined with the rotation of uniformed peacekeepers, mean that UN civilian staff members are ultimately the mainstay of most mission VCCT facilities.

Outreach to local communities

The central mandate of an HIV/AIDS unit is internal to the mission, but peacekeepers do not operate in a vacuum and there is some outreach to local populations. This ranges from including local personnel in training programmes – UNMIK, for instance, included members of the Kosovo police force and public health staff in its counsellor training sessions – to specifically tailored projects for vulnerable communities. In the DRC, for example, the national military asked MONUC to provide initial training for its uniformed personnel and a longer term programme is now being designed by the military with the support of UNAIDS. In East Timor, programmes have included the local police force and in Liberia the mission is building capacity for HIV/AIDS sensitisation projects as part of the demobilisation programme.

UNAMSIL has worked closely with the Society for Women and AIDS in Africa (Sierra Leone chapter). Projects that involve local women's groups not only reach the most vulnerable but also strengthen training for peacekeepers, as the testimonies of local women provide a different perspective on HIV/AIDS and the broader issue of sexual exploitation.

ENGAGING WITH MEMBER STATES

While DPKO's mandate broadly includes training, executive direction, management and logistical support for UN peacekeeping operations, engaging member states remains a crucial factor in the success of initiatives, as peacekeepers are essentially national soldiers in blue helmets.

HIV/AIDS awareness and sensitisation programmes are premised on changing people's attitudes and risk behaviour. This entails reversing ingrained habits and assumptions, which is hard to achieve if limited to pre-deployment and in-mission training. HIV/AIDS training should ideally be on-going and that provided by DPKO should only consolidate previous country-level awareness and prevention activities, but this is often not the case. A 2004 study of HIV/AIDS knowledge and risk-related sexual behaviour among Nigerian naval personnel, for instance, found that 52% believed that a cure for AIDS was available in Nigeria. Of male respondents, 33% had had sexual contact with a female sex worker, of whom 41% had not used a condom in their most recent sexual encounter.⁶⁸ Nigeria is currently the third largest contributor of peacekeeping personnel.

In the 2001 General Assembly Declaration of Commitment on HIV/AIDS, member states undertook to have in place, by 2003, "national strategies to address the spread of HIV among national uniformed services" and to ensure the inclusion of HIV/AIDS awareness in guidelines for those involved in international peacekeeping operations.⁶⁹

In the 2003 progress report on the global response to the HIV/AIDS epidemic, 78% of reporting countries stated that they had a national HIV/AIDS strategy for the uniformed services.⁷⁰ Most of the 20 top-ranking military and police contributors submitted updates on the implementation of the 2001 Declaration of Commitment on HIV/AIDS. It is not clear, however, which of these countries have an HIV/AIDS strategy specifically for the uniformed services and how actively such strategies are being implemented.

The UNAIDS Office on AIDS, Security and Humanitarian Response (SHR) has set up a global initiative, with programmes being developed in over 60 countries, to provide support for the development and/or strengthening of national HIV/AIDS awareness and prevention programmes in national militaries, with a particular focus on young recruits and future peacekeepers. It has also developed a

Some military medical officers are expected to inform their commanding officer if a soldier is found to be HIV-positive

peer education kit for the uniformed services, which provides basic information on HIV/AIDS and guidance on approaching issues such as stigma and discrimination, risk assessment, gender coercion and sexual violence, voluntary counselling and testing and condom use. This is being distributed to national ministries of defence and is being used by DPKO in missions. There are also other initiatives to support militaries at the national level, such as the US Department of Defence HIV/AIDS Prevention Programme (DHAPP), which offers resource support to selected non-US militaries.

CONCLUSION

Addressing HIV/AIDS is an internal support function of a peacekeeping mission rather than an operational objective. The issue has to compete with more traditional priorities, such as disarmament, demobilisation and reintegration, as well as other 'soft security' issues, such as human rights and gender training (although these areas are often interlinked). The fluid and diverse nature of troop deployments makes it difficult to design and maintain culturally specific interventions. Yet, while there is gradual recognition within national uniformed services that HIV/AIDS in the ranks has to be addressed, the problem with regard to peacekeeping is that the issue gets mired in

accusations and counter-accusations about who is spreading HIV. Instead of considering HIV/AIDS as a global problem that needs a multi-sectoral response, some troop-contributing countries perceive the DPKO programmes to be an attack on the integrity and reputation of their armed forces. The defensive knee-jerk reaction is often to focus on stand-alone HIV testing procedures, when more time and funds need to be invested in awareness and prevention in order to reduce the risk of personnel contracting HIV and/or spreading the virus.

The tendency is to focus on HIV testing when more time and money need to be invested in awareness and prevention

In collaboration with UNAIDS, DPKO is examining its overall approach, from the particulars of a given mission, to lessons learnt across operations. The findings of knowledge, attitude and practice surveys will be crucial, both in terms of assessing and informing the design of DPKO-led programmes, and by providing key advocacy material to garner the support of member states. Such surveys will provide a more accurate picture of the current situation

and, arguably in some cases doctored, STI and HIV/AIDS statistics, as they will seek to capture both 'best practice' and the specific factors in individual contingents that potentially put peacekeepers and host communities at risk.

Notes

- 1 The views expressed herein are those of the author and do not necessarily reflect the views of the United Nations.
- 2 *Security Council Resolution 1528 (S/RES/1528)*, Adopted by the Security Council at its 4918th meeting, on 27 February 2004, p 1.
- 3 *Security Council Resolution 1542, (S/RES/1542)*, 30 April 2004. The language in Resolution 1545, 21 May 2004, differs slightly: "Welcoming with satisfaction and encouraging the efforts of the United Nations Organization to enhance the awareness of peacekeeping personnel on the need to prevent and combat HIV/AIDS and other communicable diseases".
- 4 *Security Council Resolution 1308 (S/RES/1308)*, 17 July 2000, p1.
- 5 *Security Council Resolution 1308 (S/RES/1308)*, op cit.
- 6 This article focuses on the strategic implications of HIV/AIDS for peacekeeping but it should be acknowledged that the immediate impact is on the individual who may face stigma, discrimination, economic and psychological problems in addition to the virus itself. This article also centres on the uniformed element of a mission but many of the issues raised regarding risk and vulnerability would also apply to civilian personnel.
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- 19 M Singh, *Armed Forces of India AIDS Control Programme*, presentation at Asia Pacific Military Medicine Conference XIII, Bangkok, 11—16 May 2003.
- 20 National Intelligence Council, op cite, p 26.
- 21 International Crisis Group, *HIV/AIDS As a security issue*, Washington/Brussels, 2001.
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 - 54 Jean-Marie Guehenno, op cit.
 - 55 The HIV/AIDS adviser in Sudan was deployed as part of the advance mission in anticipation of a UN peacekeeping operation in 2005.
 - 56 The Security Council first established UNAMSIL in October 1999, the mandate was revised in February 2000 and its size was expanded through a series of mandates.
 - 57 The UN Mission in Ethiopia and Eritrea was established in September 2000, the mission in DRC in November 1999 and the UN transitional Authority in East Timor in October 1999, later to become UNMISSET in the post independent period.
 - 58 UNMIK is currently recruiting a UN Volunteer to work on a full time basis on HIV/AIDS issues.
 - 59 This article focuses on the particular challenges of developing HIV/AIDS programmes for the uniformed element of peacekeeping operations. However, HIV/AIDS policy advisers also need to include local and international civilian staff. Given its size, UNMIK is something of an anomaly, it was originally envisaged that an HIV/AIDS policy adviser would be deployed in Kosovo when the concept first developed, but this did not



materialise.

- 60 The resolution makes the request to the Secretary-General, DPKO would be the implementing Department for such a request.
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About this paper

Like sexworkers, injecting drug-users, long-distance truck drivers and migrant workers, military personnel are considered a high risk group for HIV infection and HIV/AIDS has been identified by the United Nations as a key issue for the uniformed services. In the peacekeeping context, personnel are at high risk of both contracting HIV and transmitting the virus to host populations and the United Nations Department of Peacekeeping Operations (DPKO) has been tasked with incorporating HIV/AIDS awareness and prevention strategies into its mission planning. Implementing such activities in post-conflict settings is, however, a complex and difficult undertaking. The issue is also a sensitive one and some troop-contributing countries perceive DPKO programmes as an attack on the integrity and reputation of their armed forces.

This paper examines the rationale for including HIV/AIDS issues on the peacekeeping agenda, DPKO's programmes for the peacekeepers and the particular challenges the Department faces, at both the political and operational levels.

About the author

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