



# The International Role in the Response to the HIV/AIDS Epidemic in Sub-Saharan Africa Following Violent Conflicts

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**Author Note** Our paper analyzes the response from the international community to the spread of HIV/AIDS during and after wars and genocide, with a particular focus on three case studies: Uganda, Sierra Leone, and Rwanda. Working on this paper allowed us to gain a greater understanding of an important, but often overlooked aspect of peacebuilding. We are extremely grateful for this unique opportunity to write a team research paper; it was definitely challenging, but also an extremely valuable experience. We would like to thank our editors, Sara and Maëna, for their detailed comments and dedicated work to help us improve this paper.

**Abstract** HIV/AIDS has been a global health issue for decades, one which has often been accelerated by genocide and civil war. This paper analyzes the effectiveness of the international community in dealing with the growth of the HIV/AIDS crisis following a period of violence, by focusing on three different case studies: Uganda, Sierra Leone, and Rwanda. It concludes that the most effective and successful help from the international community against HIV/AIDS is comprised of financial, technical, and structural aid to counter the crisis, and includes collaboration with local governments. However, the international community faces shortcomings if the help it provides is only financial.

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## Introduction

Human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) has been a global health crisis for decades. Africa, specifically, has struggled with this epidemic as there are almost 26 million Africans currently living with the disease (WHO Report 2009). This paper focuses on the HIV/AIDS health crisis that many African countries continue to face. Since these countries share certain socio-economic and environmental climates, they serve as strong case studies to explain the rapid increase in rates of HIV/AIDS-positive individuals as scholars can isolate certain variables to help account for the rise of the virus. In the contemporary context, Africa is enduring widespread challenges, ranging from economic marginalization to major health crises and political instability. Additionally, many African countries have weak security forces and, in numerous cases, cannot always provide adequate public services to their citizens (Olivier, Neethling, and Mokoena 2009, 49).

This paper presents societal conditions following civil war or genocide as major factors accounting for the dramatic spread of HIV/AIDS. Essentially, in conditions of poverty, powerlessness, and social instability, rates of infected patients will increase (Gisselquist 2004, 115). While some research points to war as a leading causal factor for higher rates of HIV/AIDS transmission, other research contradicts this claim. In his piece on violent conflict and the HIV/AIDS epidemic in sub-Saharan Africa, David Gisselquist cites cases in which HIV/AIDS prevalence rates decreased in periods of elongated wars, thus showing that there is no causal relationship between transmittance and extended periods of conflict. This approach explains the transmittance of HIV/AIDS during wartime conditions as a result of a lack of access to healthcare (115). This argument shifts the blame for transmittance from individuals to the use of unsterile equipment in healthcare infrastructure. According to this hypothesis, since war disrupts access to healthcare, the transmittance of HIV/AIDS is lower: people cannot access healthcare and are therefore not in contact with unsterile equipment. In times of peace with functioning healthcare infrastructure, HIV/AIDS transmittance emerges as a problem (115).

This paper analyzes the impact of wars and genocide on the spread of HIV/AIDS in three countries: Uganda, Sierra Leone, and Rwanda. Each case presents a nuanced approach that offers insight into the effectiveness of international intervention during the peacebuilding processes in containing the spread of HIV/AIDS. This piece argues that the fight against HIV/AIDS is most successful when the international community provides financial, technical, and structural aid to counter the crisis, and works in collaboration with local governments; however, there are shortcomings if this international help is only financial. In Uganda, the use of the internationally sanctioned strategy to fight HIV/AIDS, as implemented by local NGOs, the local government and international organizations, proved a winning formula. In Sierra Leone, interventions orchestrated by the international community during the peacebuilding stage allowed the country to improve its HIV/AIDS prevalence rates and HIV/AIDS education. In contrast, in Rwanda, the government used the international community's lack of policy instruction on HIV/AIDS as a way to consolidate power in the state. Before delving into specific case studies, it is important to understand the steps taken by the international community at large to fight the epidemic in Sub-Saharan Africa. Many of these broader policies will also be applied to subsequent case studies.

### The International Community and HIV/AIDS

HIV/AIDS is an ongoing, international struggle with detrimental outcomes that need to be addressed. This struggle has gained significant attention from international bodies, such as the World Bank and the World Health Organization (WHO). In 2001, the African Union (AU) took major steps to address the epidemic, including the Abuja Declaration. This pledge declared a state of emergency against the HIV/AIDS epidemic and committed the AU to fighting against it by

directing 15% of the AU's budget to the health sector (Opeyemi 2012, 46). It ultimately failed to achieve this commitment, instead relying on donor support for projects. The Abuja Declaration did succeed in improving HIV/AIDS diagnostics care, support, and prevention, and created space for higher coverage towards HIV/AIDS treatment (46-47). In 2005, the WHO passed the Maputo Resolution on the acceleration of HIV prevention efforts in the African region. This resolution called on member countries to declare 2006 a year for accelerated efforts towards HIV/AIDS prevention. Many UN agencies signed the Declaration to ensure synergy in implementing a joint plan to support containing the epidemic (47).

AU members also gathered in 2005 to sign the Gaborone Declaration, which advocated an integrated AIDS approach along detrimental to African communities (47). In 2006, the Brazzaville Commitment was launched, promising universal access in Africa by 2010 for HIV/AIDS prevention, treatment, care, and support. Key principles of the agreement included the expansion of health, social, and development programs and services, recommendations for overcoming the main obstacles for HIV/AIDS, and highlighting areas that needed support, including finance, human resources, building and strengthening systems, affordable commodities, technology and essential medicines, human rights and gender, and fostering accountability (48). However, none of these efforts adopted by the AU and external international bodies considered frameworks for mitigating impacts of HIV/AIDS in the security sector. Instead, the approaches were heavily focused on the public health and development sectors (48).

The World Bank has become a major international actor in the fight against HIV/AIDS, initially launching its projects to combat HIV/AIDS in 1988. However, few African countries mounted projects with the help of the World Bank: countries' activities were sparse, program coverage was low, and few resources reached domestic civil societies or communities (Mohammad and Blankhart 2007, 11). At this point, the World Bank lacked an overarching strategy to combat HIV/AIDS. While demand from governments for support and assistance was low, few donors besides the World Bank were active; the World Bank averaged about 18 million dollars per year from 1988 to 1999 in funding to African countries. Nevertheless, African governments and the World Bank were failing to adequately confront HIV/AIDS (11).

By 1998, the World Bank recognized the need to offer proper support to African countries regarding the HIV/AIDS crisis. In 1999, they implemented a new plan called the Strategy Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis, which was a partnership between the World Bank, African governments, and UNAIDS (12). It called on the World Bank to increase its advocacy to boost demand for action against HIV/AIDS as a central development issue, strengthen the banks' capacity to meet the anticipated increase in demand, expand resources for AIDS programs, and circulate knowledge about the epidemic and effective response mechanisms (12). The goal was to put HIV/AIDS at the centre of the development agenda in Africa, with the World Bank as the leaders in this effort. After studies demonstrated that the World Bank was responding too slowly to the crisis, the international institution created a new program: The Multi-Country HIV/AIDS program (MAP), designed to ensure a faster, more comprehensive, and renewable strategy (12). MAP gave African nations the authority to approve individual countries or regions into the program if they met certain qualifications, including a unified approach to HIV/AIDS, high levels of AIDS coordinating bodies, agreement to both use accelerated implementation arrangements, and channel some of the project support to NGOs, faith-based groups, and the private sector (13).

Through MAP, there was a rapid increase in World Bank support for HIV/AIDS as the number of HIV/AIDS projects increased substantially. By the end of 2005, investment for HIV/AIDS reached over 2.75 billion dollars. Employing MAP's mechanisms, the World Bank

committed 1.286 billion dollars for HIV/AIDS support to Africa in just six years, which accounted for 47% of the World Bank's investments in fighting HIV/AIDS (13). MAP provided comprehensive support for national programs, supported strategic investments at the national level, and channeled funds directly at communities and civil society organizations while recognizing the role of social mobilization in combating HIV/AIDS. MAP was effective, so it raised the funding benchmark for other donors and helped countries by ensuring long-term support through guaranteed funds for 12-15 years to any country with a sound HIV/AIDS action plan (13-14). It also addressed four critical needs: a strong political and governmental commitment to an HIV/AIDS response, the creation of a conducive institutional and resource appropriate environment where HIV/AIDS interventions could be scaled up to a national level, the increase in community participation in HIV/AIDS efforts by providing financial resources and building capacity, and the move to a multi-sectoral approach involving many governmental and NGO actors, with improved coordination (14). The World Bank recognized that the initial HIV/AIDS mechanisms were too narrowly focused on the health sector and that they instead needed to develop mechanisms that were more complex in their approaches to social and individual behaviour. As a result, they shifted to a multifaceted approach (15).

International bodies made it a priority to help combat HIV/AIDS in Sub-Saharan Africa. While initial approaches aimed solely at the public health sector were failing, these organizations assessed their original initiatives' flaws and adapted them to make a difference. Countries realized that they needed to adopt a multifaceted approach, venturing beyond the health sector. Through initiatives like MAP, financial aid was distributed in strategic ways. Before a country was deemed eligible to receive funds, they needed plans in place on how to most effectively use the money they were receiving. While the global sphere's response was originally imperfect, these new mechanisms employed by the international community saw tremendous success and worked to create lasting efforts to combat HIV/AIDS in Sub-Saharan Africa.

## Uganda

Following six years of fighting, the Ugandan civil war ended in 1986 with the National Resistance Army's (NRA) overthrow of President Tito Okello. This marked the first time in modern history that a locally based guerilla group successfully deposed an indigenous government (Kasozi 1994, 175). Yoweri Museveni, one of the main leaders of the NRA, became president and still serves today.

In "Civil War and the Spread of AIDS in Central Africa," M. R. Smallman-Raynor and A. D. Cliff explore the impact of the Ugandan conflict on the spread of HIV/AIDS in the country. Using least squares regression techniques, they illustrate the link between the ethnic recruitment of the Ugandan National Liberation Army and the spatial patterns of the spread of HIV in the 1980s through to the development of AIDS in the 1990s (Smallman-Raynor and Cliff 1991, 69). For example, many soldiers from northern Uganda travelled to the southern part of the country during the war, where HIV was spreading unnoticed, then brought back the disease with them after the war (78). The spread was facilitated by the widespread rape of women, who were potential carriers of the virus (Schoepf 2003, 554) as well as the use of prostitutes by soldiers (Smallman-Raynor and Cliff 1991, 78). Concurrently, the spread of HIV/AIDS in Uganda was also facilitated by existing behavioural norms, with condoms, one of the methods used to prevent the transmission, not well-regarded. For example, brides were often expected to get pregnant soon after their weddings, prompting many to abstain from using condoms without checking if they, or their partner, had a sexually transmissible disease (Schoepf 2003, 560). Furthermore, women in Uganda (and particularly Southern Uganda, where HIV/AIDS spread the most during the war) historically have not received support from the state and society when it comes to protection

from HIV/AIDS (Muriisa 2010, 609). Focus groups organized after the war revealed several misconceptions about the use of condoms; some believed that “condoms can slip off inside a woman during sex and will remain, causing infection and sterility,” that they can spread HIV/AIDS, or are inefficient at protecting against HIV/AIDS (Schoepf 2003, 559). Therefore, the civil war in Uganda created a perfect storm for the spread of HIV/AIDS. While no data really exists as to the proportion of the population affected by HIV/AIDS before the war (partially because it was in the 1970s, when the disease was not well-documented), there is widespread consensus among scholars that the civil war dramatically increased the spread of the disease.

Nevertheless, Uganda is widely regarded as a success story when it comes to the control and reduction of HIV/AIDS after violent conflict. In 1986, at the end of the civil war, approximately 30% of adults in the country were HIV/AIDS-positive. By 1999, that number lowered to 9.9%, further decreasing to 5% by 2004 (Chickwendu 2004, 247). While HIV/AIDS is not eradicated in the country and 5% is considered a high rate according to international standards, the major decrease in the proportion of the population is a testimony to the effective strategy that was established during the peacebuilding process. The plan to counter the spread of HIV/AIDS consisted of a joint initiative between the Ugandan government and international organizations, which also involved local NGOs and faith-based organizations.

When Yoweri Museveni came to power at the end of the civil war, he immediately acknowledged the vast HIV/AIDS epidemic in Uganda, doing so publicly during a World Health Assembly in Geneva (247). This public recognition of the issue was significant in two ways. First, Museveni admitted to the problem before many other world leaders, particularly in Africa, were willing to discuss the virus publicly. This swift acknowledgment meant that potential solutions would come faster than they would in other countries, which likely reduced fatalities. The other reason why Museveni's public announcement was important is that it immediately involved the international community. As such, during the early days of the peacebuilding process in Uganda, Museveni made it clear that fighting the HIV/AIDS epidemic would be a priority under his government and the international community was encouraged to help.

In the 1990s, the general strategy used in Uganda to combat HIV was based on the ABC method - A for “Abstinence,” B for “Be Faithful,” and C for “Condoms” developed by the WHO and UNAIDS (Schoepf 2003, 555). Therefore, to counter the spread of HIV/AIDS, the government relied on promoting tactics like increased abstinence, a decrease in the number of sexual partners, and more frequent use of condoms; however, these changes in behaviour cannot happen overnight. For the ABC method to prove efficient, it required structural efforts to enact behavioural changes. In the case of Uganda, these efforts came from four main places: the government, NGOs, faith-based organizations, and the international community.

Soon after his speech in front of the World Health Assembly, Museveni established the National AIDS Control Program (ACP) under the Ministry of Health (Hogle 2002, 4). The ACP, which was the first major governmental step towards a behavioural change, consisted of an “aggressive public media campaign that included print materials, radio, billboards, and community mobilization for a grass-roots offensive against HIV” (4). In 1992, the ACP was replaced by the Uganda AIDS Commission (UAC), which was tasked with duties including preparing a National Operational Plan to guide agencies and coordinate efforts between ministries (4). In 1989, the Ministry of Education, coordinating with UNICEF, introduced a ‘family life’ curriculum in schools to preach abstinence (Schoepf 2003, 556). The same year, the ministry also mandated that teachers integrate HIV and sexual education into their curricula (Hogle 2002, 5). There was also a focus from the government to empower girls and young women, including a new law to ensure that at least one-third of Parliament was female (5). This effort by Museveni and his party to correct



gender inequalities was due in part to the uneven burden placed on Ugandan women regarding HIV/AIDS. A study from a hospital in Kampala, Uganda's capital city, revealed that "only 12 percent of spouses of hospitalized seropositive men were aware of their husbands' HIV+ status" (Schoepf 2003, 557). Furthermore, Museveni ordered the Ugandan military to hold mandatory sex education courses that included condom demonstrations (561). When discussing the government's role, it is also important to note Museveni's powerful leadership on the issue. A UNICEF report on the actions taken in Uganda to fight the epidemic highlight his actions: In 1986, after 15 years of civil strife, Uganda's new head of state, President Yoweri Museveni, responded to evidence of a serious emerging epidemic with a proactive commitment to prevention that has continued to the present. In face-to-face interactions with Ugandans at all levels, he emphasized that fighting AIDS was a patriotic duty requiring openness, communication, and strong leadership from the village level to the State House (Hogle 2002, 4).

Museveni took personal responsibility to confront the HIV/AIDS crisis as soon as the war ended. He used the burgeoning civil society and new institutions, like the ministries, to implement concrete actions. Since Museveni took over a country destabilized by war, he had leeway to create his own path to respond to the crisis. By prioritizing the fight against HIV/AIDS, he led the creation of various government-sponsored programs that coordinated and supported the response to the crisis.

With this said, the Ugandan government did not handle the HIV/AIDS crisis on its own. NGOs played a large role in providing services and contributing to behavioural changes in Uganda. More generally, NGOs are recognized as an effective tool to deal with an HIV/AIDS epidemic, and Uganda is no exception (Muriisa 2010, 606). NGOs in Uganda emerged from the post-civil war society, providing tools for conversations about HIV/AIDS and helping to mobilize communities (608). An example of such an NGO is The AIDS Support Organisation (TASO), formed in 1987 by people directly affected by HIV/AIDS. TASO, which still exists today, is one of the largest organizations providing prevention, care, and support services for those with the virus. TASO volunteers mobilized both individual interactions and broader campaigns to share the experiences of those affected by HIV/AIDS and helped foster dialogue between spouses on sex and condom use. The organization also created a newsletter targeted at teenagers that circulated comprehensive information about sex and reproductive health (Schoepf 2003, 561). Further, it provided counselling, particularly for family members and men affected by the epidemic (Muriisa 2010, 617). International organizations used external funds to provide material help for the fight against HIV/AIDS, including distributing millions of condoms to Ugandan clinics (Hogle 2002, 8).

Furthermore, in post-war Uganda, the government did not have the means to create specialized counselling centres focused on HIV/AIDS, so it relied on TASO and other NGOs to fill in the gap. (Muriisa 2010, 618) The impact of TASO and other NGOs cannot be overstated: The new government fostered a vibrant civil society of voluntary associations that eventually included more than 1,000 AIDS NGOs. The extent of collaborative social mobilization is unique in Africa. This exemplary openness created an enabling context for change, with debate, dialogue and action. Rising numbers of deaths frightened many people and, along with the policy of openness, led to frank discussion and considerable culture change (Schoepf 2003, 554).

The peacebuilding process offered a unique opportunity for the creation of NGOs because the government could start on new foundations. The same can be said of voluntary associations because the end of the civil war created new opportunities.

Faith-based organizations, like churches, were also a prominent part of the effort to counter the HIV/AIDS crisis after the war. Since they wield important power in Africa, Museveni mobilized these institutions from the start to help fight the epidemic (Hogle 2002, 6). Mission

hospitals run by churches provided some of the first hospitals that developed programs to care for HIV/AIDS-positive individuals. In addition, they participated in education programs that advocated abstinence and a limited number of sexual partners (the A and the B of the ABC strategy) (6). The Protestant Church of Uganda organized a workshop for bishops and religious leaders to help with the implementation of AIDS education programs in dioceses (7). The Catholic Church of Uganda led programs for HIV/AIDS widows and children, including organizing mobile, home-based AIDS projects (7). Furthermore, these two churches were involved with the Uganda AIDS Commission. Out of the three chairpersons of the commission, one was an Anglican bishop and the other, a Catholic bishop (7). On the contrary, the involvement of religious organizations also had negative impacts on HIV/AIDS efforts. More precisely, they opposed the "C" in the ABC strategy – the use of condoms. The UNICEF plan to fight HIV/AIDS in Uganda was forced to downplay the importance of condom usage and education due to pressures from the Vatican (Schoepf 2003, 560). Furthermore, Museveni had to fight religious leaders in Uganda to allow NGOs to discuss and promote condom usage (561). Therefore, in this case, religious organizations tried to impose their restrictive views of contraception to limit the fight against HIV/AIDS. Without a strong leader like Museveni, the promotion of condoms might have been curbed because of these objectives.

Uganda was one of the first countries to heavily invest in the fight against HIV/AIDS. Its strategy was largely successful, as evinced by falling rates following the war and the start of international intervention. What made Uganda particularly effective was that it was able to combine international expertise with local groundwork and the plan, developed by external actors, was implemented by people with a succinct understanding of Ugandan's needs. The leadership of President Yoweri Museveni is notable, as he quickly asked for help and was personally involved in the crisis. One of the main lessons to draw from Uganda is the necessity of international actors to create broad strategies, and local actors to implement those strategies. The other main lesson comes from the reluctance and pressure of religious officials and organizations to promote the usage of condoms. While the help of the international community and faith-based organizations had positive outcomes for Uganda, it could also have limited the efficiency of the strategy. In sum, the host country needs to remain in control of the overall picture and implement a strategy that is not limited in its scope because of the values of external actors.

### **Sierra Leone**

Between 1991 and 2002, Sierra Leone faced an 11-year civil war, bringing widespread human rights violations, massive population displacements, and over 50,000 deaths (Larsen et al. 2004, 240). The beginning of the civil war was marked by Revolutionary United Front (RUF) rebels invading from Liberia and terrorizing the rural and urban populations, living off profits from diamond mines. Soon, the government was unable to ensure the security of its people as RUF forces abducted children for forced labour, executed civilians, amputated legs, and perpetuated sexual violence (Gisselquist 2004, 116). Approximately 80% of schools and health clinics were destroyed or severely damaged as a result of wartime violence. By 2001, only 38% of peripheral health care units and 70% of district hospitals were functioning (Larsen et al. 2004, 240). When the war officially ended in 2002 with a UN declaration (Gisselquist 2004, 117), Sierra Leone was left in a primed condition for the dramatic spread of the HIV/AIDS epidemic due to several risk factors. These included: massive population displacement, destruction of healthcare infrastructures, high prevalence of war-related sexual violence, including rape as a terror tactic and the abduction of women into sexual slavery, peacekeeping troops from countries with high HIV/AIDS prevalence, increased commercial sexual activity, and widespread poverty and illiteracy rates (Larsen et al. 2004, 240-241).

While the civil war in Sierra Leone left brutal legacies, a major repercussion was HIV/AIDS. Due to a lack of large-scale research and the country's shifting population, minimal data exists on HIV/AIDS transmission in Sierra Leone around the time of its civil war (Richter et al. 2001, 48). As a result, there is a wide range of reports on both the transmittance rates of HIV/AIDS in Sierra Leone and the effect of civil war. In 2002, the CDC conducted a survey to determine the prevalence rate of HIV/AIDS in Sierra Leone. While the initial rate was 4.9%, further testing showed a rate of just 0.9% (Larsen et al. 2004, 240). Similarly, smaller studies demonstrated a variety of different results. A study from the late 1980s-1990s conducted in Sierra Leone's capital, Freetown, showed that the HIV/AIDS prevalence rates among commercial sex workers were 27.5%, 7.1% among blood donors, and 4.5% among patients with STIs (241). Another study from 1994 estimated a 3% prevalence rate (Richter et al. 2001, 49). In 1997, another report claimed that among women, the prevalence rate was 7% (Larsen et al. 2004, 241). In 1999, the Republic of Sierra Leone Armed Forces (RSLAF) found a 21.3% prevalence rate among men applying for military status (241). In 2000, Sierra Leone's Ministry of Health and Sanitation conducted their own research and found a 70.6% prevalence rate of HIV/AIDS in commercial sex workers in Freetown (241). While the results of all of the smaller studies may be statistically insignificant, they help to create a more complex picture of the struggle of HIV/AIDS in Sierra Leone. The dramatic differences suggest that more work is needed to determine prevalence rates in various subpopulations in Sierra Leone and highlights the fact that HIV/AIDS is a national struggle (241).

A significant source of HIV/AIDS transmission in Sierra Leone is believed to come from foreign peacekeepers. As HIV/AIDS is transmitted mainly through sexual intercourse and conflict often stimulates an increase in sexual activity, the increased military presence helps explain the rise of HIV/AIDS in wartime Sierra Leone (241). The main groups affected by HIV/AIDS in Sierra Leone were commercial sex workers and peacekeeping forces. This had detrimental effects, as to condition spreads to their respective communities and creates lasting problems (241). Since the early 1990s, peacekeepers have been present in Sierra Leone and these forces frequently intermingled with commercial sex workers. The trend is a result of peacekeeping forces often possessing more wealth than the surrounding population, thus being able to purchase sex (241). Studies show that HIV/AIDS prevalence rates in military forces are typically two to five times greater than rates found among civilian populations. A study by Lori M. Newman et al. demonstrated an HIV/AIDS prevalence rate of 39.1% among military blood donors compared to a 15.3% rate in civilian blood donors. In times of conflict, military infection rates may rise to approximately 50% higher rates than in peaceful periods (241). Additionally, rates tend to be higher among military officials stationed far from home because personnel often seek respite from stress, loneliness, and sexual tensions through high-risk activities. This is evident among the many Nigerian peacekeeping forces stationed far from home in Sierra Leone for extended periods. The high risk they take in the field translates to a risk when partaking in sexual activities, as peacekeepers participate in the commercial sex trade and engage in intercourse without condoms (241-242).

Commercial sex workers represent another at-risk group because of their high number of sexual partners (ranging daily from three to ten) and low use of condoms. Studies found that commercial sex workers in Sierra Leone were willing to negotiate abstaining from using a condom in exchange for higher profits (242). Many women are forced into the commercial sex work industry because of demands to support their families, and as limited economic opportunities are available to these women, sex is often seen as a 'currency' which allows women to pay for goods. Specifically, women can leverage sex for water, food, education for their children, and passage over borders (242).



The population groups of peacekeeping forces and commercial sex workers are heavily intertwined with each other. In Sierra Leone, 32% of peacekeeping forces come from nations with HIV/AIDS prevalence rates of over 5%. This makes sex dangerous, especially given the fact that peacekeepers are primary clients of commercial sex workers. The combination of foreign military presence and the poverty of powerless women which strengthened their reliance on sex as a means of survival contributed to setting the stage for the HIV/AIDS epidemic in Sierra Leone (243).

The Economic Community of West African States (ECOWAS) played a large role in the spread of HIV/AIDS through their peacekeeping forces in Sierra Leone. They deployed a monitoring group, the Economic Community of West African States Monitoring Group (ECOMOG), with the mandate to restore peace in Sierra Leone. As their priority was armed conflict, this resulted in serious neglect towards human security dimensions and helped escalate the HIV/AIDS crisis (Opeyemi 2012, 145). The group also failed to safeguard humanitarian aspects of the mission and neglected civilian populations, resulting in the absence of monitoring or record-taking during the HIV/AIDS crisis (147). Peacekeeping forces were not tested for HIV/AIDS before or after deployment, and there was no official HIV/AIDS program in army ranks and no existing data regarding the Sierra Leone population's relationships with the ECOMOG troops. This was especially problematic due to the many interactions between Nigerian peacekeeping forces and Sierra Leone's commercial sex workers (148). While the interactions were not properly documented in Sierra Leone, this claim can be corroborated with the rising trend of HIV/AIDS prevalence in Nigeria, coinciding with the return of Nigerian ECOMOG troops back to Nigeria. Although ECOMOG troops eventually provided relative peace and security in Sierra Leone, this peace was threatened by the Nigerian peacekeeping forces who contributed to the already impending HIV/AIDS crisis. (148-149).

In the peacebuilding stage following the civil war, a major problem remained in Sierra Leone in the form of rising HIV/AIDS prevalence rates. The WHO cites a rise in prevalence of HIV/AIDS cases in the nation from 0.9% in the period directly following the war to 1.53% by 2005 (World Health Organization 2009, 6). The international community, with varying degrees of success, utilized different mechanisms in the country to combat the HIV/AIDS epidemic. The WHO was highly involved in the HIV/AIDS epidemic in Sierra Leone. A report released by WHO analyzing Sierra Leone from 2008-2013 highlighted the WHO's first strategic priority as increasing the burden of fighting HIV/AIDS, as it is quickly rising and becoming a threat to social and economic development. WHO identifies the main challenges to fighting HIV/AIDS as follows: inadequate access to key services for prevention diagnosis and care, low uptake of the PMTCT and art service, poor laboratory capacity at various levels, stigma, and discrimination against people with HIV/AIDS (6-7).

After initially slow progress in combatting HIV/AIDS in Sierra Leone, the international community eventually established programs and mechanisms with successful results. It was concluded that success is dependent on collaboration with the government, the military, NGOs, and the community. Levels of education surrounding HIV/AIDS increased, demonstrating the success of new outreach efforts as initiated by international bodies; with this said, there is still much work that needs to be done (Larsen et al. 2004, 251).

Efforts were made to successfully implement HIV/AIDS policies in the armed forces, specifically to protect military personnel from service dismissal based on their HIV/AIDS status. This policy allows personnel free access to ARV drugs to provide a safe environment for people suffering from HIV/AIDS and ultimately helps combat the stigma against the disease (Opeyemi 2012, 55). The army also introduced policies that involve education on HIV/AIDS,

integration of HIV/AIDS training activities into army curriculum and sensitizing trainers to the importance of such HIV/AIDS workshops. The army also trained soldiers' wives, female soldiers and women's groups to act as peer educators. Additionally, the army trained counsellors from each brigade and battalion on reproductive health, distribution of condoms, and the provision of ARV drugs (55).

Surveys from the 1990s found that knowledge about HIV/AIDS in Sierra Leone was insufficient. Young people, ages 13-19, largely believed there was an existing vaccine for HIV/AIDS and that it was curable. In addition, many believed only people with symptoms could transmit HIV/AIDS and were, for example, unaware that a mother could transmit HIV/AIDS to her unborn child (Richter et al. 2001, 49). These attitudes put Sierra Leone's youth at risk. Further, 19% of college students in Freetown believed that HIV/AIDS was a conspiracy theory to prevent Africans from reproduction; of those college students, most believed it is the man's responsibility to promote safer sex (49). Therefore, because of various misperceptions, the perceived threat of HIV/AIDS was low. For cultural reasons, people preferred injections over pills but generally did not care if their medical equipment was sterile, which did not help the situation (50-51). While combating HIV/AIDS in Africa, it is important to remember the developed world's history of abusing Africans, which can account for certain issues, including distrust among college students regarding the HIV/AIDS epidemic. It is also important to remember that in addition to HIV/AIDS, Africa is suffering from many factors that result in a more immediate threat to their survival, such as warring rebel groups and health threats like malaria (52). The international community recognized the dire need for education to stress the importance of using sterile equipment and to normalize the use of condoms while suppressing the notion that women are subordinate in sexual relations (52-53).

As such, there are countless internationally led efforts channelled towards preventative training among Sierra Leone's civil community. They offer testing and counselling services, which enable individuals to get pre-tested for HIV/AIDS, including same-day testing and a risk assessment test (Bhoobun 2014, 514). They also offer post-testing follow-ups, HIV/AIDS preventive counselling and, when necessary, referral for medication and support groups. Programs like this have been successfully implemented by the global community throughout sub-Saharan Africa and often lower cases of HIV/AIDS. In Sierra Leone, research surveys, aided by WHO, found that only 13% of women and 8% of men have ever received an HIV/AIDS test. Statistics show HIV/AIDS testing is more common among people with higher levels of education and wealth, those who have never been married and reside in urban areas; the survey also found that young adults are more willing to receive testing than the older population, confirming the importance of education efforts (Bhoobun 2014, 515-518).

While the benefits of education and prevention programs are evident and young adults in urban areas are willing to be tested, other useful strategies have been implemented by the international community (519) including recognizing the importance of cultural factors. For example, healers are an integral part of Sierra Leone society and were considered as a useful resource to promote HIV/AIDS education. Additional methods included the use of theatres, another important cultural institution in Sierra Leone, to spread HIV/AIDS prevention messages as well (Richter et al. 2001, 53-54).

Additionally, there was also a need to better treatment systems, as it has been revealed that even with increased knowledge about HIV/AIDS, those who contracted it did not seek out treatment (Larsen et al. 2004, 251). It was also found that many are heavily reliant on access to free condoms provided by international bodies. Even when humanitarian support groups begin to leave Sierra Leone, it is vital to ensure condoms are left reasonably priced. While success has been

proven with the international community's aid in Sierra Leone, the work is not yet complete. The nation requires the remaining presence of international bodies to help maintain their HIV/AIDS prevention programs (252).

When thoroughly analyzed, Sierra Leone embodies international involvement in terms of its country's experience with HIV/AIDS. Firstly, international peacekeeping forces played a large role in the spread of HIV/AIDS during its civil war because there were no mechanisms in place to monitor the incoming soldiers or their interactions with the native population of Sierra Leone; this was particularly evident for commercialized sex workers. What can be learned from this is that HIV/AIDS is an issue extending well beyond the public health sector; it is instead a wide-ranging epidemic that demands a multifaceted approach. That approach was used by the World Bank and further acted on (Mohammad and Blackhart 2007, 15). The second way the international community was crucial in Sierra Leone's battle with the HIV/AIDS epidemic was through shaping mechanisms to combat HIV/AIDS as evinced by programs provided by the military and civil society. As learned from past mistakes, the military now takes precautions to monitor HIV/AIDS and educate its ranks about associated dangers (Opeyemi 2012, 55). The international community also found that the civil society in Sierra Leone lacked proper HIV/AIDS education and that the misconceptions found about HIV/AIDS in Sierra Leone are not only troubling but also detrimental to public health (Richter et al. 2001, 49-53). People also need access to condoms and HIV/AIDS medication. While programs led by the international community are starting to show success in terms of education, there is still much to be done in Sierra Leone.

### **Rwanda**

Conflict in Rwanda existed in two stages from October 1990 to March 2002. Stage one, spanning from 1990 to 1994, involved internal fighting within Rwanda and involvement from external countries (McInnes 2011, 500). Stage two, from 1997 to 2002, mainly occurred outside of Rwanda, as the spread of Rwandan refugees to the Democratic Republic of Congo helped trigger conflict there. Going into the war, Rwanda was already quite vulnerable to HIV due to an outbreak in the decade before the genocide, as there had been in other Sub-Saharan African countries (501). This outbreak was in part due to the fact that Rwanda had a relatively high population density, which caused outbreaks in cities to multiply. Furthermore, Rwanda was and remains an impoverished country, with over half of the country living below the poverty line, thus facing issues with accessibility to HIV/AIDS treatment and information (501). Consequently, by being in an already susceptible position prior to conflict, there was a credible possibility that conditions would worsen during the war.

During the genocide stage, external forces from neighbouring countries and the UN became involved in Rwanda and countries like Zaire, Uganda, and Burundi deployed troops to help quell the fighting (500). This could have led to a mixing of different groups with, for example, soldiers who had multiple sexual partners during their time in Rwanda, increasing the chances of becoming HIV-positive and spreading it to others. Furthermore, refugees were fleeing Rwanda during the conflict; over one million left in 1994 and another two million left after the genocide ended (500). Sexual intercourse between refugees or host country nationals provided another avenue for transmission in West Africa.

One of the most pressing issues regarding the spread of HIV was the rise in rape during the genocide. There were high rates of Tutsi women who were raped by the Hutu with the intention of both deliberate attacks and chaos (502). This number varies between 200,000 and 500,000 women raped with many survivors, especially in and around the capital city of Kigali (Elbe 2002, 167-168). There was a belief held by some Hutu that they needed to rape the Tutsi and that raping was a weapon to help bring down the enemy side by killing them through the

spreading of diseases. Thus, the raping of Tutsis became an important organized method of the genocide, along with murder (McInnes 2011, 502). Witnesses to the genocide claimed that they heard HIV-positive people announce that they aimed to infect Tutsi women through rape "as an ultimate punishment that would guarantee long-suffering and death" (502). Furthermore, there were claims from the Rwandan Minister of Health Joseph Karemera that "captured women were taken to HIV-positive soldiers specifically to be raped" (Elbe 2002, 169). It is difficult to determine how many women were infected because of this, and how many people who thought they were transmitting HIV to others actually had the disease. This is due to a lack of access to proper testing throughout the conflict. Moreover, the violent nature of rape, prevalent during the genocide, allowed for more open cuts and wounds on women's bodies, meaning there was a higher chance of the virus entering the body (170). As men deliberately aimed to infect the women, it is likely that women were repeatedly raped, thus increasing their odds of contracting HIV (170).

Using HIV as a weapon of war brings up many complex issues. The first one is that it is hard to draw a line between rape with the intent to give them a fatal disease versus another reason. Although both are brutal acts, one involves deliberate murder, while the other does not, though it is still a severe crime (170). While dealing with war crimes at the end of the genocide, it was difficult to prove who was perpetrating the crimes, which meant that people could get away with actively trying to infect women while they continued to suffer and die from the transmission of diseases. Another issue that emerged pertaining to war crimes was the differentiation between combatant and civilian (170). In using HIV as a weapon, and with the genocide in general, everyday citizens who were not necessarily in armies raped Tutsis with the intent to spread HIV. Contracting HIV/AIDS in the midst of conflict created a deadlier scenario than if diagnosed during a time of peace. During periods of stability, a person can go to a doctor, get tested, and ultimately undergo treatment for the disease. However, during wartime, concerns are about more immediate issues, such as avoiding conflict-related death and injury. Therefore, when faced with an illness that does not require immediate care to survive, it would go ignored and untreated, making treatment more difficult for the individual in the long-run and increasing their likelihood of spreading the disease to others (173).

Although statistics on HIV-positive Tutsi women show increasing rates during the conflict, there was an overall decline in infected people, specifically during the second stage of conflict (McInnes 2011, 503). Following the end of the genocide, the government actively introduced large-scale measures to combat the spread of HIV, including allowing citizens to access treatments, testing, and guidance. The next section will provide a more detailed evaluation of the government and the effectiveness of government-mandated HIV treatments.

Prior to the genocide, Rwanda was dealing with an outbreak of HIV/AIDS. The previous government tried to implement services to help people afflicted, yet they were forced to stop addressing it once the genocide began (Thomson 2010, 557-558). During this time, the number of people affected by the illness drastically increased, while the number of available health professionals decreased, as the health infrastructure in the country crumbled and people – including medical personnel – fled to safer areas (556). Within the population of Rwanda, eleven to thirteen percent of the population was infected, making it one of the most gravely affected African countries at the time (557). Furthermore, during the genocide, sexual violence, particularly against women, occurred with over 250,000 women raped, facilitating the spread of HIV/AIDS (557). Afterwards, women, who were particularly vulnerable to the disease's spread, were left as the country's majority.

With a significant sector of the population affected by HIV, the post-genocide government felt it was essential to implement treatment and prevention programs. The government

contributed large sums of money and resources to ensure a drastic reduction in HIV (557). The government then took this aid and distributed it domestically. Local health centers led in administering services and counselling to those with HIV/AIDS, which was overseen by provincial committees to ensure that resources were delivered (558). This commitment to aiding civilians was highly praised by the international community, and, in 2007, Rwanda was named one of eight countries for the One UN Reform Initiative in celebration of the government's efforts in treatment, aid and support for those living with HIV (558). Furthermore, the government rolled out its Vision 2020 plan to deal with HIV, which granted universal access to treatment and care services (558) and gave the impression that the country was on a positive, and even progressive path, towards dealing with citizens living with HIV/AIDS.

Regardless of how effective the government's plans may have seemed at first, in practice, it was a fraudulent scheme in order for the government to consolidate power. The genocide ended in 1994 with the Rwandan Patriotic Front (RPF) victorious and in power, and they have since tried to shift the country into a state of autocratic rule through a combination of securing power and weakening those who dissent against the government (559). Actions removed the fear of political opponents and silenced those critical of the government in both the media and human rights circles (560). To this day, the RPF aims to gain total control over both the citizens and the entire country.

This consolidation pertains to the issue of HIV/AIDS treatment in the country because RPF loyalists are placed in low-level administration positions, such as those that provide HIV aid services (559). National policies may appear abundant and as sending Rwanda towards their goal of universal treatment and eradication of HIV/AIDS. However, in reality, only certain people can receive this treatment. With local government facilities administering treatments, the services act as instruments of state power by forcing citizens to be dependent on the state for continued care (559). Moreover, the state possesses the power to deem only certain people eligible to receive care based on arbitrary requirements that reward RPF supporters. In order to be treated, a person must have membership in either a non-governmental organization or in a community-based organization (560). These groups do not allow automatic membership and individuals require approval by local government officials who are, as previously mentioned, RPF loyalists who only accept government supporters.

The international community applauds the work done in Rwanda yet is misled by the government, which presents skewed information to prove that their supposedly universal program is working. Rwanda claimed that seventy percent of those with HIV/AIDS use antiretroviral services administered by the government's programs (560). Yet, this has been distorted by only giving the international community data from within government-approved organizations and claiming that this is the case for the entire country (560). This raises the question of why the international community has not looked deeper into the programs run in Rwanda to see where their aid is going. International donors should feel an obligation to investigate considering how much aid Rwanda receives annually – in 2015, 30 to 40 percent of the country's national budget came from international aid (Hasselskog et al. 2017, 4). In an interview with international donors, almost all interviewees said there were “worrying trends of authoritarianism within the political leadership” in the country (Thomson 2010, 573). Despite this, they have continued to allow Rwanda to take charge because “politically the donors need success stories as much as the recipients need the aid” (Zorbes 2011, 110). A second and more pressing reason is that Rwanda made it nearly impossible for international donors to have any say in their national policy process. The country has been commended for its ability to “ensure national ownership of development policies and programs,” and they developed an aid policy plan to dictate the exact relationship



between donors and the government (Hasselskog et al. 2017, 4). This relationship is understood to be Rwandan officials handling the policy process, which is deemed only “Rwandan business” (5). From here, the government decides where exactly international aid goes without any consideration of how the donor may want to allocate their aid. Furthermore, if the donors are unsatisfied with the programs put in place, Rwanda operates according to a general sentiment: “if you don’t like it, we don’t need your money” (7). Consequently, these two reasons made it nearly impossible for international donors to look deeper into or try to involve themselves more in the Rwandan policy process.

Due to its lack of involvement, the international community has seemingly ruined its chances of peacebuilding with the aim of strong governance in Rwanda. The RPF dictated its terms for acquiring aid and how it should be distributed, thus continuing on their track of strengthening their power by using aid to rule the lives of citizens. What one can learn from this scenario is that the international community should not accept having no say in the policymaking process and should fight to increase their power. This may seem like a sharp contrast to the general notion of the nation-donor relationship, as most people currently believe in “national ownership” of aid that must be “consistent with a recipient state’s own priorities” (2). However, there is a fine line between national ownership and complete control, with no input and monitoring from the donors. This can be seen as worrisome as it raises the following question: how are unbiased people expected to evaluate the implications of the policies and their accurate success rates? In the case of the HIV/AIDS programs, the international community cannot monitor how these are doing; they can only rely on false reports from the RPF. In sum, the international community must strive to hold nations accountable for their aid and enact policy inspections to ensure that they are used and implemented to avoid elite political gain. Aid from international donors has provided the Rwandan government with an unprecedented degree of strength, and simultaneously, international praise. Rwanda’s government was rewarded for incorrect data, allowing them to consolidate power by winning over the support from other countries for their work on HIV/AIDS. This further prevents international donors from looking deeper into the issues within the country.

## Conclusion

A common pattern is evident among Uganda, Sierra Leone, and Rwanda. HIV/AIDS rates increase during periods of prolonged conflict, leaving the issue to be dealt with during the peacebuilding stage to deal with the issue. Programs are then implemented with or without the help of international aid and supervision. As this paper demonstrated, the amount of foreign intervention, or lack thereof, shaped the outcome of the containment of HIV/AIDS.

HIV was present in Uganda because of certain social norms. People often did not check if their partners had HIV, there was an inconsistent use of condoms, and a widespread lack of knowledge about HIV/AIDS. During the Ugandan civil war, HIV/AIDS spread through northern forces, contaminating southern civilians through rape and prostitution. However, after its civil war, Uganda has been successful in reducing its HIV/AIDS prevalence rates. By announcing its state of crisis about HIV/AIDS, Uganda gained support from many international bodies. Therefore, during its peacebuilding stage, efficient strategies were put in place to deal with the epidemic. Through the use of aid from international organizations, NGOs and faith-based groups, the Ugandan government is currently in a solid position to fight HIV/AIDS.

Sierra Leone also underwent a mass spread of HIV/AIDS as a result of its civil war. This is in part attributable to rape, but mainly to the relationship between commercial sex workers and international peacekeeping forces from countries with high HIV/AIDS prevalence rates. The international community was and remains highly involved in the reconstruction phase of Sierra

Leone to combat HIV/AIDS. With the help and contribution of international bodies, Sierra Leone successfully implemented re-education programs about HIV/AIDS into its military and civil society. While there is still much advancement necessary, progress has been made to reduce the rate of HIV/AIDS in Sierra Leone and educate people about the importance of contraception and HIV/AIDS knowledge. The work is not yet done in Sierra Leone as they still rely on the continued aid of international bodies to educate their people about the dangers of HIV/AIDS, the strategies to avoid the disease as well as provide financial support to prevent it.

Rwanda was in a prime position for the increase of HIV/AIDS, seeing as how the country was amid a surge in HIV/AIDS before the genocide began. Therefore, given that people did not have time for proper treatment or were deliberately trying to transmit the disease during the conflict, rates of transmission became even higher. Following conflict, the government made it a priority to combat the HIV/AIDS epidemic, or so it seemed. The international community of donors was enthused to see a supposedly successful program implementation and was also kept outside of helping to create these programs. This, in turn, allowed the RPF to implement programs in line with their agenda. Consequently, the Rwandan government used the HIV/AIDS program as part of its strategy to consolidate power. Only certain people were given access to HIV/AIDS treatment, specifically, those who were supportive of the RPF, as well as members of RPF-approved community groups. Therefore, citizens are then dependent on treatments and aid, and the government can become increasingly autocratic, as people are forced to support it regardless. Foreign influence on these programs is also nonexistent as Rwanda actively discouraged donors from involving themselves in policy, and they continue to receive misleading statistics to indicate greater successes of the program, which causes a belief that these programs are working and that they should not press for more involvement. Ultimately, Rwanda and international donors in the country are not as successful in fighting HIV/AIDS as it may appear.

As shown, Uganda, Rwanda, and Sierra Leone all experienced conflicts which resulted in the spread of HIV/AIDS. Similar factors found in these cases were the influence of foreign peacekeeping forces, the effects of rape, and the presence of commercialized sex workers. Each country used different approaches to address these issues. Specifically, Rwanda limited international intervention, and while the international community believes in the success of the Rwandan government in combatting HIV/AIDS, the reality is that without international presence and supervision, the government has used the crisis to consolidate its power. In Uganda and Sierra Leone, the international community is part of the equation. They provide aid, help with implementing strategies, but most importantly remain present. Donors conduct research to track the effectiveness of their programs and aid, therefore ensuring that this aid is allocated to people who need it. In the end, when the international community intervenes in countries struggling with reconstruction and HIV/AIDS, positive patterns emerge. Stress should be placed on international bodies to continue their aid programs as, when present, they are mostly successful.

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