

HIV/AIDS as a Human Security Threat in West Africa

by

Ayodele Olawale Akenroye

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfilment of the requirements of the degree of

MASTER OF LAWS

Faculty of Law

University of Manitoba

Winnipeg

Copyright © 2010 by Ayodele Olawale Akenroye

ABSTRACT

This thesis seeks to explore the human security threats that AIDS constitute to the West African people. West Africa has been badly hit by the AIDS epidemic and studies conducted have situated the discourse as a public health issue only. This thesis challenges that assertion by exploring the complex issues and linkages of HIV/AIDS, Conflict and Human Security in West Africa. Using peacekeepers, women and children as case studies, this thesis analyzed and identified a model for human security in West Africa with a particular emphasis on the right to health and access to anti-retroviral drugs in view of the astronomical rise in the growth of HIV/AIDS in the West African region.

ACKNOWLEDGEMENT

I wish to express my deep gratitude to my Thesis Advisor, Dr. Evaristus Oshionebo, for his wisdom, encouragement, patience and research mentoring throughout the program. He has been a wonderful Advisor and I am greatly indebted to him for making me a fine scholar. I would also like to appreciate my external reviewer Dr. Obijiofor Aginam (United Nations University - Tokyo, Japan) for his insightful review and criticism of this thesis despite his busy schedule. Thanks are due to my internal reviewer, Prof. Darcy MacPherson (University of Manitoba) for his criticisms of the thesis.

I would like to place on record the immeasurable assistance I received from Dr. Michelle Gallant, during the course of the program. My sincere appreciation goes to Dr. Jennifer Schulz for accommodating me and putting all the resources at her disposal to assist me during this program. I am also thankful to the entire staff of the Faculty of Law, University of Manitoba including Sonja DeGannes, Maria Tepper and Pat Power.

During this program, I have benefited enormously from the friendship of Stephen Abioye, Chikerizim Igwe, Rotimi Ojo, and Ikechuckwu Agomoh. I appreciate their contributions toward the completion of this thesis.

Finally, I would like to convey my deepest regards and appreciation to my parents, Chief & Chief Mrs A.E Akenroye and my mother-in-law, Mrs P.I. Ejeye for their support and encouragement throughout the program. My love and gratitude to my beautiful and loving wife, Alero Akenroye for standing by me and understanding the demands of graduate education on our marriage. I love you.

DEDICATION

This thesis is dedicated to the people of West Africa affected by the scourge of HIV/AIDS and the raging conflicts in the region.

TABLE OF CONTENTS

Abstract	i
Acknowledgement	ii
Dedication.....	iii
Introduction	1
Structure of the Thesis	2
Chapter One: Conceptual Framework for Human Security in West Africa	
1.1 Introduction	4
1.2 Dimensions of Security	5
1.2.1 State Security	6
1.2.2 Collective Security	9
1.2.3 Common Security	10
1.3 Background to Human Security	11
1.3.1 States' interest in Human Security	16
1.4 Human Security, Human Rights and Human Development	18
1.4.1 Human Security and Human Development	18
1.4.2 Human Security and Human Rights	20
1.5 Tension between the Schools of Human Security	22
1.5.1 The Narrow School	23
1.5.2 The Broad School	24
1.5.3 Meeting Point in the Two Schools	25
1.6 Framework for Health Security in West Africa	26
1.7 Human Security and Health	31
1.8 Health as a Security Issue	34
1.9 Challenges to Health Security in West Africa	39
1.10 Conclusion	44

Chapter Two: The Impacts of HIV/AIDS on Human Security in West Africa:

Three Cases Studies

2.1	Introduction	46
2.2	Case Study One: Peacekeepers	46
2.2.1	Linking AIDS to African Military Security	48
2.2.2	Strategic Impacts of HIV/AIDS on Militaries in West Africa.....	54
2.2.3	Impacts of HIV/AIDS on International Peacekeeping in West Africa	58
2.3	Case Study Two: Women	62
2.3.1	The Vulnerability of Women to HIV/AIDS in West Africa.....	65
2.4	Case Study Three: Children	74
2.5	Conclusion	79

Chapter Three: West African Regional Strategies on HIV/AIDS

3.1	Regional Approach to HIV/AIDS in West Africa	81
3.2	Ghana	84
3.2.1	Ghana's Response to HIV/AIDS.....	85
3.2.2	Challenges	88
3.3	Nigeria	92
3.3.1	Nigeria's Response to HIV/AIDS	93
3.3.2	Private Sector Participation	97
3.3.3	Civil Society Participation	99
3.3.4	Challenges	101
3.4	West African Regional Approach to HIV/AIDS in the Military	104
3.4.1	Shortcomings of Existing Measures on HIV/AIDS within the Military	109
3.5	Conclusion	110

Chapter Four: Trade-Related Aspects of Intellectual Property Rights (TRIPS) As a Barrier to Access to Essential Medications

4.1 Introduction 112

4.2 The TRIPS 113

4.3 Rationale for Patent Protection 116

4.4 How can the TRIPS Be Used to Improve Access to Essential Medications
122

4.5 Implementation of TRIPS Flexibilities in West Africa 128

 4.5.1 Local Production of ARVS 131

4.6 Conclusion 135

Chapter Five: Postscript: Towards Enhancing Human Security in West Africa..... 137

INTRODUCTION

Since 1994 when the concept of Human Security was popularised by the United Nations' Human Development Report¹ of that year, the concept has generated many scholarly works on it and it no doubt constitutes a paradigm shift in terms of the meaning of security in the international arena. As espoused by the UNDP, the concept of human security is based on equating security with people rather than territories and with development rather than arms. Since the release of the United Nations Development Report, international actors have advocated for a greater focus on human security which is concerned with the security of individuals as opposed to the traditional concept of security which essentially focuses on defending borders from external military threats and which places emphasis on the military and the arming of the military. The threshold of these advocacy efforts is that human security has more implications to the peace and security of nations and should therefore be considered alongside traditional security considerations.

Human security in the broad school of thought has several dimensions which are: Environmental Security, Political Security, Economic Security, Food Security, Health Security, Personal Security and Community Security. This thesis seeks to explore the health security challenges in the West African region.

West Africa has a peculiar terrain. The region has been riddled with conflicts ranging from the wars in Sierra Leone and Liberia, to the civil unrest in Guinea. People displaced by these conflicts are vulnerable to HIV/AIDS through contact with

¹ United Nation Development Program, *Human Development Report 1994 – New Dimension of Human Security* (New York, Oxford: Oxford University Press, 1994)

peacekeepers and local militias. Also, the brunt of the HIV/AIDS disease is borne by women and children. These three groups constitute the case studies in this thesis. The complexities of HIV/AIDS in regards to the health security of the people of West Africa are far more complex than understood. For example, HIV/AIDS poses a more fundamental threat to human security in the region than wars and armed conflicts. This thesis seeks to examine the impacts of HIV/AIDS both strategically and otherwise in the West African region.

By focusing on human security in West Africa, this thesis hopes to instigate a dialogue that will enlarge the objective of state security policy beyond the protection of territories and integrity of States, and the accumulation of military hardware and enforcement of law and order regimes, and to address the many other issues that are actually and persistently nibbling away at the security and dignity of ordinary people.

More specifically, this thesis will demonstrate the need for West African countries to adopt an expansive view of security to include non-military aspects such as HIV/AIDS.

Structure of the Thesis

Chapter One begins by conducting a brief literature review on the concept of Human Security; tracing the origin of human security to the word “security”, the dimensions of security such as state security, common security and collective security. It also examines the two schools of thought on Human security and strives to establish a meeting point in the schools of thought. The interests of States in the concept are also examined. The nexus between the concepts of human security, human right and human development is also explored. Finally, the chapter examines the theoretical framework for health security.

Chapter Two focuses on three case studies which are the groups most vulnerable to the HIV/AIDS disease: peacekeepers, women and children. The chapter begins by exploring the link between HIV/AIDS and African security, the strategic impacts of HIV/AIDS on the military in West Africa and the negative impacts the disease has on international peacekeeping in the region. Further attempts will be made in the chapter to critically examine the multidimensional impacts of HIV/AIDS on Women and Children. Analysis of the social and cultural inequalities in the family that expose women and children to the devastating effects of the disease will also be discussed in this chapter.

Chapter Three focuses on the West African regional strategies on HIV/AIDS. Documents such as the Abuja Declaration and the African Common position on HIV/AIDS will be explored. The approach adopted by West African countries will be examined, using Ghana and Nigeria as case studies. The shortcomings of regional approach to the disease will be identified and concluding remarks will be made on crafting an effective and harmonised strategy on HIV/AIDS in the West African region.

Chapter Four provides an overview of Trade-Related Aspects of Intellectual Property Rights (TRIPS), discusses the rationale for the protection of patents, and examines how TRIPS provisions can be used to improve access to essential medicines. The chapter further argues for the domestic production of antiretroviral drugs. Concluding remarks are made in this chapter on the benefits of improved access to essential medications to improve the health security of the people of West Africa.

Chapter Five, the final part of this thesis, concludes with some recommendations on how the impacts of HIV/AIDS can be ameliorated in West Africa and how the health security of the people can be better protected.

CHAPTER ONE

CONCEPTUAL FRAMEWORK FOR HUMAN SECURITY IN WEST

AFRICA

1.1 INTRODUCTION

Since the concept of Human Security was thrust into the vocabulary of international diplomacy, there have been controversies surrounding the concept. It has been used as a vehicle to serve different purposes by different people and States. My aim in this chapter is to conduct a short literature review on the concept of human security starting from the definition of the term 'security' and the different dimensions of security such as state or national security, common security and human security. The two schools of thought on human security will be examined and a meeting point between the two schools of thought will be explored. Attention will also be paid to the interests of States in the concept of human security. However, human security will be distinguished from human right and human development.

Having achieved a theoretical model for human security, I will seek to apply the model to the security situation in West Africa, paying particular attention to the right to health and access to medical treatment in light of the growing HIV/AIDS scourge in the region.

1.2 Dimensions of Security

In any academic discourse, defining a term of art is difficult and it is that difficulty that one encounters in attempting to define security. The concept of security¹ is highly contested in International Relations and Security Studies. However, it is not my aim in this chapter to join the dialectic of what security is about. Rather, my aim here is to trace the evolution of the concept of security.

¹ Security as has been defined as follows ‘Security itself is a relative freedom from war, coupled with a relative high expectation that defeat will not be a consequence of any war that should occur.’ Ian Bellamy, “Towards a theory of International Security” (1981) 29:1 *Political Studies* 100 at 102; “A nation is secure to the extent to which it is not in danger of having to sacrifice core values if it wishes to avoid war, and is able, if challenged, to maintain them by victory in such a war.” Walter Lippman, cited in Barry Buzan, *People, States and Fear* (Hemel Hemstead: Harvester Wheatsheaf, 1991) at 16; “Security-insecurity is defined in relation to vulnerability – both internal and external – that threatens or has the potential to bring down or weaken state structures, both territorial and institutional, and governing regimes,” Mohammed Ayoob, *The Third World Security Predicament* (Boulder: Lynne Rienner, 1995) at 10; “Security, in any objective sense, measures the absence of threats to acquired values, in a subjective sense, the absence of fear that such values will be attacked.” Arnold Wolfers, *Discord and Collaboration* (Baltimore: John Hopkins University Press, 1962) at 150; “If people, be they government ministers or private individuals, perceive an issue to threaten their lives in some way and respond politically to this, then that issue should be deemed to be a security issue” Peter Hough, *Understanding Global Security* (London: Routledge, 2004) at 12; ‘Security...implies both coercive means to check an aggressor and all manner of persuasion, bolstered by the prospect of mutually shared benefits, to transform hostility into cooperation.’ Edward A. Kolodziej, *Security and International Relations* (Cambridge: Cambridge University Press, 2005) at 25. A detailed discussion of the concept of security can be found in Ken Booth, “Security and Emancipation” (October 1991) 17:4 *Review of International Studies*, 313 – 326; Emma Rothchild, “What is Security” (Summer 1995) 124:3 *Daedalus*, *The Quest for World Order* 53 – 98; David A. Baldwin, “The Concept of Security” (Jan. 1997) 23:1 *Review of International Studies* 5 – 26; Barry Buzan, “Peace, Power and Security: Contending Concepts in the study of International Relations” (Jun 1984) 21:2 *Journal of Peace Research*, “Special Issue on Alternative Defense”, 109 – 125.

Giacomo Luciani defines security as “the ability to withstand aggression from abroad.”² Richard Ulman also defines security as “an action or sequence of events that (1) threatens drastically and over relative span of time to degrade the quality of life for the inhabitants of a state (2) threatens significantly to narrow the range of policy choices available to the government of a state or to private, nongovernmental entities (persons, groups, corporations) within the state.”³ From the above definitions, it can be observed that security is associated with the concept of securing the borders of a state from external aggressions. However, security is not limited to “national” or “state security” as the above definitions seems to suggest. Security includes the welfare of citizens of individual nations and states. Thus for the purpose of this thesis, security is “the freeing of people (as individuals and groups) from the physical and human constraints which stop them carrying out what they would freely choose.”⁴

In this sense, security relates to the emancipation of peoples from poverty, diseases, and all forms of human abuse. As Ken Booth rightly notes, “emancipation, theoretically is security”.⁵

1.2.1 State Security

The concept of security has over the years been associated with national security or state security. This is not unusual taking into cognisance the theory of Thomas Hobbes

² Giacomo Luciani, “The Economic Content of Security” (1989) 8:2 *Journal of Public Policy* 151.

³ Richard H. Ulman, “Redefining Security” (1983) 8:1 *International Security* 129 at 133.

⁴ Ken Booth, “Security and Emancipation” (October 1991) 17:4 *Review of International Studies* 313 at 319.

⁵ *Ibid.*

as to the state of nature, where the life of a man was brutish, nasty and short.⁶ In its early stages, human society operated on the basis of the concept of the survival of the fittest and a reign of anarchy prevailed. To quote Thomas Hobbes, it is a ‘condition of war of man against every man.’⁷ The people decided to surrender their respective power to a central power which can be stated as the origin of the State.

This minimalist perspective of equating security with the sanctity of national borders has dominated the field of international relations for a long time.⁸ State security means the arming of States militarily; the establishment of military research centres, generally increased military spending and the propensity of States to wage war for the protection of national interest.⁹ Traditionally, security means physical and psychological security of a State which may be threatened by both internal and external forces.¹⁰ National security also has an international dimension: it means there is peace and order in the international system, and the international system is open to the exchange of ideas, trade, travel, and intercultural experience.¹¹

⁶ Hobbes also writes: “the bonds of words are too weak to bridle men’s ambition, avarice, anger, and other Passions, without the fear of some coercive Power.” That power, the Leviathan, is not attainable in the world politics as long as nation-states remain the primary units of organisation. Therefore, each must seek its own security. T. Hobbes, *Leviathan* (1651), C.B. MacPherson, ed. (New York: Penguin, 1968) at 196.

⁷ *Ibid.*

⁸ Peter Stoett, *Human and Global Security: An Exploration of Terms*, (Toronto: University of Toronto Press, 1999) at 16.

⁹ The Independent Commission on Disarmament and Security Issues (Palme Commission) *Common Security: A Blueprint for Survival* (New York: Simon and Schuster 1982) at 3.

¹⁰ *Ibid.*

¹¹ *Ibid.*

The acquisition of military gadgets is often displayed as a sign of military strength by States and this act is seen by other States as a threat to their national security. Thus, it causes a cycle of military armament by States in response to the other State's acquisition of arms.¹² This was the race that started after the Second World War and thus began the era of the Cold War. This cycle of military armament is described in security studies as a 'security dilemma.'¹³

The armament of States had grievous effects on newly independent States in the Cold War Era. Third World countries did not have the capacity to arm themselves militarily, but the arms race witnessed the deprivation of essential social services for the people by increased military spending in third world countries.¹⁴

The Peace of Westphalia that ended the Thirty Year War laid down the principle of sovereign jurisdiction within territorial limits.¹⁵ This means that all States are deemed equal, and none has the right, divine or otherwise, to interfere in the internal affairs of another.¹⁶ This principle of non intervention was further entrenched in the Charter of the

¹² *Ibid.*

¹³ Alan Collins, ed., *Contemporary Security Studies*, (Oxford: Oxford University Press, 2007) at 16.

¹⁴ *Supra* note 8.

¹⁵ Peter Stoett note 8 at 17. The term Peace of Westphalia refers to the two peace treaties of Osnabruck and Munster signed on May 15 and October 24, 1648, respectively, and written in French, that ended both the thirty years war in the Holy Roman Empire and the Eighty Years' War between Spain and the Republic of the Seven United Netherlands. The Peace of Westphalia resulted from the first modern diplomatic congress in Europe and laid the principle of state sovereignty.

¹⁶ *Ibid.*

United Nations¹⁷ and thus international law frowns at any act of aggression by one State against another State.

1.2.2 Collective Security

Another dimension of security is seen in the concept of collective security.¹⁸ Collective security refers to a condition in which States agree essentially to collectively punish aggressors that commit acts of aggression against other States. This is to avoid the repetition of the two world wars of the 1900s and it is also intended to protect the territorial integrity of individual States. The origin of collective security can be found in the words of US Secretary of State, Henry L. Stimson, in 1938 at the New York Council of Foreign Relations that, the modern state was entering into an era in which warring powers were no longer entitled to the same equally impartial and neutral treatment by the rest of the society and that in future conflicts, one or more of the combatants must be designated as wrongdoer.¹⁹ He further added: “We no longer draw a circle about them and treat them with the punctilios of the duelist's code. Instead we denounce them as lawbreakers.”²⁰

¹⁷ *Charter of the United Nations*, 26 June 1945, Can. T.S. 1945 No. 7.

¹⁸ Attempt here is not to consider collective security as a whole in this paper; the aim is to trace the development of the concept of security. A detailed analysis of collective security can be found in Otto Pick & Julian Critchley, *Collective Security* (London: Macmillan Press, 1974); Finkelstein, S. Marina & S. Lawrence, eds., *Collective Security* (San Francisco : Chandler, 1966); Nigel D. White, ed., *Collective Security Law* (Aldershot: Ashgate Publishers, 2003).

¹⁹ Henry L. Stimson and McGeorge Bundy, *On Active Service in Peace and War* (New York, Harper & Brothers, 1947) at 259.

²⁰ *Ibid.*

Collective security assumes that all States share a primary interest in maintaining peace in the international system and for collective security to operate, peace must be viewed as a holistic goal and threat to peace must be treated as the concern of the international system. Therefore, all members of the international community must respond promptly and effectively against threats to peace.²¹

1.2.3 Common Security

The arms race and the threats of annihilation of the human race by nuclear bombs during the Cold War which lasted for four decades increased the agitation for a change in thinking as regards security. This led to the creation of the Independent Commission on Disarmament and Security Issues headed by Olaf Palme, the late Prime Minister of Sweden.²²

The Olaf Palme report argued for a rethinking of world peace, asserting that world peace is not the exclusive preserve of the superpowers. Rather, the report asserted, each country is obliged to achieve world peace because all nations are bound together by their vulnerability to attack with nuclear, chemical and biological weapons. Palme's principle of common security asserted that countries could only find security in cooperation aimed at attaining the limitation, reduction, and eventual abolition of nuclear arms. To quote

²¹ Ho-Won Jeong, *Peace and Conflict Studies*, (Aldershot, England: Ashgate Publishing Company, 2000) at 116.

²² The Commission came out with a report in a book form titled *Common Security: A Blueprint for Survival*. *supra*, note 9.

Palme, “International Security must rest on a commitment to joint survival rather than on threat of mutual destruction.”²³

1.3 Background to Human Security

Human Security as a concept was first given prominence in the international system in 1994 by the United Nations Development Program (UNDP) which advocated a new way of thinking about the concept of security.²⁴ The UNDP argues for a departure from the State centred view of security which has been discussed above. The UNDP’s Human Development Report of 1994 popularised the term “*human security*” by suggesting that “human security is a child who did not die, a disease that did not spread, a job that was not cut, and ethnic tension that did not explode in violence, a dissident who was not silenced. Human security is not a concern with weapons; it is a concern with human life and dignity.”²⁵ However, the UNDP recognises that human security encompasses State security.

Hence the UNDP restates the conventional notion of security as “security of territory from external aggression, or as protection of national interests in foreign policy or as global security from threat of a nuclear holocaust.”²⁶ This is the concept that State power and state security will be established and expanded to sustain order and peace and the state will monopolise the right to protect its citizens.

²³ *Ibid* at xiii.

²⁴ United Nation Development Program, *Human Development Report 1994 – New Dimension of Human Security* (New York, Oxford: Oxford University Press, 1994).

²⁵ *Ibid*.

²⁶ *Ibid*.

However, the concept of human security cannot be said to have surfaced only in the 1994 Human Development Report. As far back as 1945, the then US Secretary of State reported to the US government on the results of the conference in San Francisco that set up the United Nations that:

The battle of peace has to be fought on two fronts. The first is the security front where victory spells freedom from fear. The second is the economic and social front where victory means freedom from want. Only victory on both fronts can assure the world of an enduring peace... no provisions that can be written into the Charter will enable the Security Council to make the world secure from war if men and women have no security in their homes and their jobs.²⁷

Indeed Articles 55 and 56 of the UN charter impose an affirmative obligation of member States to make joint and individual efforts to promote “universal respect for human rights and fundamental freedoms for all.”²⁸ It is not only the UN Charter that makes provision for the concept of human security. The UN Declaration of Human Rights, the UN Convention against Genocide and against Torture, the 1977 protocols and

²⁷ As quoted in UNDP, “Redefining Security: The Human Dimension” (May 1995) 94 Current History 230.

²⁸ Article 55 provides: “With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

1. higher standards of living, full employment, and conditions of economic and social progress and development;
2. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
3. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.”

Article 56 provides: “All Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55.”

the 1949 Geneva Conventions all serve as bedrock for the concept of human security as it is known today.²⁹

Scholars and researchers have advocated for the broadening of the concept of security to include non-military aspects and the promotion of economic development in poorer countries.³⁰ The Canadian and Norwegian governments hosted a bilateral talk at Lysøen, Norway in 1998 where both countries adopted the concept of human security as a new theme of foreign policy.³¹ At a meeting in 1999,³² Canada posited that “in essence, human security means safety for people both from violent and non-violent threats. It is a condition of state of being characterised by freedom from pervasive threats to people’s rights, their safety or even their lives”.³³ The Canadian and Norwegian Foreign Ministers, Lloyd Axworthy and Knut Vollebæk, referred to human security “as an umbrella concept which covers humanitarian agenda that includes support for the International Criminal

²⁹ See *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, 1465 U.N.T.S. 85; *Convention on the Prevention and Punishment of the Crime of Genocide*, 9 December 1948 78 U.N.T.S. 277; *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, 12 August 1949, 75 U.N.T.S. 31; *Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea*, 12 August 1949, 75 U.N.T.S. 85; *Geneva Convention Relative to the Protection of Civilian Persons in Time of War*, 12 August 1949, 75 U.N.T.S. 287 and *Geneva Convention Relative to the Treatment of Prisoners of War*, 12 August 1949, 75 U.N.T.S. 135.

³⁰ Robert McNamara, *The Essence of Security: Reflections in Office* (New York: Harper and Row, 1968) at 12.

³¹ Astri Suhrke, “Human Security and the Interest of States” (1999) 30:3 Security Dialogue 265.

³² Nine States attended this talk. They are Austria, Chile, Ireland, Jordan, the Netherlands, Slovenia, South Africa, Switzerland, and Thailand.

³³ ‘Human Security’: Safety for People in a Changing World’, Department of Foreign Affairs and International Trade, Ottawa, April 1999, cited in Suhrke, *supra* note 25 at 266.

Court, the ban on landmines, regulation of light arms trade, and prohibition of child soldiers”.³⁴

Canada sees the concept of human security “as a shift in perspective or orientation. It is an alternative way of seeing the world, taking people as its points of reference, rather than focusing exclusively on security of territory or governments.”³⁵ When Canada became the Security Council President in 1999, it placed human security on the Council agenda as a broad category for discussing the violations of human rights during conflicts.³⁶

The definition of the term human security has raised a lot of challenges among academics and security experts. There are several definitions of the concept of ‘human security’. Some focus mainly on threats from wars and internal conflicts, sometimes with a focus on criminal and domestic violence; others focus on threats from preventable diseases, economic hardship, financial crisis, poverty and want; while a third group considers both types of threats – often described as ‘fear’ and ‘want’, or as first- and second generation human rights – as well as the processes by which people protect themselves and are protected.³⁷

Astri Suhrke has observed that, “as a social construct, the term Human Security permits many interpretations and those who promote it are still struggling to formulate authoritative and consensual definition. But the idea clearly has roots in the central

³⁴ Suhrke, *supra* note 31 at 266.

³⁵ *Ibid.*

³⁶ *Ibid.*

³⁷ Alkire Sabina "A Vital Core that Must Be Treated with the Same Gravitas as Traditional Security Threats" (2004) 35:3 *Security Dialogue* 359-360.

principles of international humanitarian law – to civilise warfare and to aid its victims.”³⁸ Thomas and Tow also noted that human security “is a promising but still underdeveloped paradigmatic approach to understanding contemporary security politics.”³⁹ However, human security reflects a new thinking in international relations as regards the concept of security.

In 2003, the Commission on Human Security (CHS)⁴⁰ elucidated the new concept of human security, and distinguished it from human rights and human development. The CHS defines human security as efforts to “protect the vital core of all human lives in ways that enhance human freedoms and human fulfilments.”⁴¹ It conceives human security as a dynamic concept embracing themes ranging from protecting fundamental freedoms – freedoms that are the essence of life, freedom from critical and pervasive threats and situations - and using processes to build on people’s strengths and aspirations.⁴² The CHS also affirms that human security in its broadest sense involves more than the absence of violent conflicts, and that it encompasses human rights, good governance, access to education and health care, and ensuring that each individual has opportunities and choices to fulfil his or her own potential.⁴³

³⁸ Suhrke, *supra* note 31.

³⁹ Nicholas Thomas & William T. Tow, “The Utility of Human Security: Sovereignty and Humanitarian Intervention” (2002) 33:2 Security Dialogue 177.

⁴⁰ This is an august body inspired by Japan and launched during the 2000 UN Millennium Summit.

⁴¹ Commission on Human Security, “Human Security Now”, online, <http://www.humansecurity-chs.org/finalreport/English/FinalReport.pdf> (accessed 14 December 2009) [hereafter CHS Report].

⁴² *Ibid.*

⁴³ *Ibid.*

Justification for the concept of human security has been advanced by the former Foreign Affairs Minister of Canada, Lloyd Axworthy, on grounds that it recognizes an interconnected world where there is a common security and that the basic rights of people – not merely the absence of military conflict between states – are fundamental to world stability.⁴⁴ Axworthy further sees a connection between the concepts of national security and human security in that they are bottom-up and top-down approaches respectively, to protecting the individual.⁴⁵

1.3.1 States' interest in Human Security

Canada and Norway are the two leading countries that have rigorously pursued the concept of Human Security in the international discourse. Cooperation between the two countries dates back to the 1960s when the Norwegian-Canadian cooperation on UN peacekeeping gave rise to the concept of 'Oslo-Ottawa axis.'⁴⁶ The two countries were also involved in an informal grouping called the 'like-minded group'. Their focus is to help developing countries negotiate with the Bretton Woods Institutions, the US and transnational corporations as a friendly intermediary.⁴⁷ The involvement of Canada in the promotion of the concept of human security has created a space for Canada in international relations as a "middle power", while Norway has established itself as a force to reckon with in the international community by the promotion of powerful ideas such as human security.⁴⁸

⁴⁴ Lloyd Axworthy, "A New Scientific Field and Policy Lens" (2004) 35:3 Security Dialogue 348-349.

⁴⁵ *Ibid.*

⁴⁶ Suhrke, *supra* note 31.

⁴⁷ *Ibid.*

⁴⁸ A detailed analysis of Canada and Norway's Interest in Human Security can be found in Suhrke, note 31.

Canada believes that the core components of human security is elevating the concern for the safety or protection of people, of individual persons and their communities, particularly the most vulnerable segments of a population; treating the safety of people as integral to achieving global peace and security; addressing threats from both military and non-military sources (for example, intrastate war, state failure, human rights violations, terrorism, organized crime, drug trafficking); using new techniques and diplomatic tools in order to achieve such goals; and recognizing the emergence of non-state actors as significant players in the international system.⁴⁹ Succinctly, what Canada is arguing is that the existing network of interstate treaties and international institutions is a necessary but insufficient basis to ensure the security of people. Hence, Canada has incorporated the concept of human security into its foreign policy.⁵⁰

Canada has used its seat on the UN Security Council to advance three things: to broaden the interpretation of the Security Council's mandate to include human security issues along with traditional security issues; to reassert the primacy of the Security Council in peace and security issues; and to increase transparency of the Council's work.⁵¹ And Canada used its one month rotating seat as Security Council's President to draw attention to the protection of civilians in armed conflict.⁵² Canada's humanitarian intervention in Kosovo in 1999 without the authorisation of UN Security Council on the ground that it is for the furtherance of human security raised a lot of questions as to the

⁴⁹ Paul Heinbecker, "Human Security: The Hard Edge" (Spring 2000) 1:1 Canadian Military Journal 1.

⁵⁰ Suhrke, *supra*. note 31.

⁵¹ David Kilgour, "The UN and the Challenge of Human Security" (Winter 2000) 1:1 McGill International Review 1.

⁵² *Ibid.*

utility of the concept of human security. Minister Axworthy had suggested that Kosovo is a 'concrete expression of this human security dynamic at work.'⁵³ That act may have inadvertently laid the precedent for any country to invade another country without regard for the principles of international law in the name of human security.⁵⁴

1.4 Human Security, Human Rights and Human Development

Attempt will be made in this section of the chapter to distinguish human security from human rights and development. Human rights and human development are the two conceptual frameworks under which the protection of human beings was organised and advanced before the advent of the concept of human security. The question can be asked: are the three concepts different from each other?

1.4.1 Human Security and Human Development

Generally, both concepts are concerned with the pursuit of shared goals for human beings, values like longevity, education and other opportunities and choices. However, both concepts look at these values through different lenses. The human development approach, pioneered by the economist Mahbub ul Haq,⁵⁵ shifts the focus of development attention away from an overarching concentration on the growth of inanimate objects of

⁵³ Heather Owens & Barbara Arneil, "The Human Security Paradigm Shift: A New Lens on Canadian Foreign Policy" (Fall 1999) 7:1 Canadian Foreign Policy 6.

⁵⁴ See generally, Jutta Brunnee & Stephen J. Toope, "Canada and the Use of Force: Reclaiming Human Security", (Spring 2004) 100:2 International Journal of Canadian Institute of International Affairs) 247 – 260.

⁵⁵ Commission on Human Security, "Human Security Now", online, <http://www.humansecurity-chs.org/finalreport/English/FinalReport.pdf> 8 (accessed 14 December 2009). Also cited in Séverine Deneulin, "Ideas related to Human Development," online, http://www.idrc.ca/en/ev-146686-201-1-DO_TOPIC.html (accessed 14 December 2009).

convenience, such as commodities produced in a given country (reflected in the GDP or the GNP), to the quality and richness of human lives, which depend on a number of influences, of which commodity production is only one.⁵⁶ Human development is concerned with removing the various hindrances that restrain and restrict human life and prevent its blossoming.⁵⁷ Human development is also concerned with increasing peoples' choices to live the lives they value, but as a development strategy, it is not explicit as to its goals. Human security, on the other hand, keeps the individual at the centre of attention by accounting for the unforeseen downfalls or reversals of development.⁵⁸ Thus, whereas human development is the ultimate stage in a people's aspiration for a decent existence, human security provides them with the tools of attaining that goal. As Bertrand Ramcharan writes, "the lack of freedom saps the creative capacity of the people and impoverishes them. Where people are free, they are inspired to create and produce".⁵⁹ As Nobel Laureate Amartya Sen said in his famous book "Development as Freedom":

Freedom are not only the primary ends of development, they are also among its principal means. In addition to acknowledging, foundationally, the evaluative importance of freedom, we also have to understand the remarkable empirical connection that links freedoms of different kinds with one another. Political freedoms (in the form of free speech and elections) help to promote economic security. Social opportunities (in the form of education and health facilities) facilitate economic participation. Economic facilities (in the form of opportunities for participation in trade and production) can help to generate personal abundance as well as public

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

⁵⁸ See CHS Report, *supra* note 41. This viewpoint was stated in Weissberg, M., "Conceptualising Human Security" (2003) 37:3 *Swords & Ploughshares: A Journal of International Affairs* 1 at 4.

⁵⁹ Bertrand Ramcharan, 'Human Rights and Human Security,' online, <http://www.humansecurity-chs.org/activities/outreach/ramcharan.pdf> 2 (accessed 14 December 2009).

resources for social facilities. Freedom of different kinds can strengthen one another.⁶⁰

Ellen Seidensticker also notes that sustainability and self-reliance, not just ameliorating a temporary situation, is central to promoting human security.⁶¹ Human security therefore targets securing those aspects of individual lives that are either overlooked or glossed over in the pursuit of the general goodness of a society as canvassed by human development.

The difference between human security and human development lies between the general and the particular. Human security identifies gaps in the infrastructure of protection as advanced by human development which is the general concept, and also finds ways of strengthening and improving it, thus providing its specificity.

1.4.2 *Human Security and Human Rights*

With respect to the relationship between human security and human rights, both concepts are mutually reinforcing and, like human development and human security, are complementary. Certainly, respect for human rights is at the core of human security (both seek to protect and empower people); the protection and empowering of people. The relationship between human security and human rights is succinctly stated by the Commission on Human Security (CHS) thus:

[w]e reaffirm the conviction that Human Rights and the attributes stemming from human dignity constitute a normative framework and a conceptual reference point which must necessarily be applied to the construction and

⁶⁰ Amartya Sen, *Development as Freedom* (New York : Knopf Publishers, 1999) at 11.

⁶¹ Ellen Seidensticker, a Seminar on Human Security, Human Rights, and Human Development, Kennedy School, Harvard University, 5 February 2002, online, <http://www.humansecurity-chs.org/activities/outreach/0206harvard.pdf> (accessed 14 December 2009).

implementation of the notion of human security. In the same manner, while acknowledging that norms and principles of International Humanitarian Law are essential components for the construction of human security, we emphasize that the latter cannot be restricted to situations of current or past armed conflict but constitute a generally applicable concept.⁶²

The CHS' view of the relationship between human rights and human security, Kevin Boyle and Sigmund Simonsen observe,⁶³ is much similar to that advanced by the International Commission on Intervention and State Sovereignty (ICISS), which places an emphasis, just as the CHS has done, on the protection of fundamental freedoms of peoples:

[t]he traditional, narrow perception of security leaves out the most elementary and legitimate concerns of ordinary people regarding security in their daily lives. It also diverts enormous amount of national wealth and human resources into armament and armed forces, while countries fail to protect their citizens from chronic insecurities of hunger, disease, inadequate shelter, crime, unemployment, social conflict and environmental hazard. When rape is used as an instrument of war and ethnic cleansing, when thousands are killed by floods resulting in a ravaged countryside and when citizens are killed by their own security forces, then it is just insufficient to think of national territorial security alone. The concept of human security can and does embrace such diverse circumstances.⁶⁴

Boyle and Simonsen trace the relationship between human rights and human security to the early stages of the former's development. In his State of the Union address on 6 January 1941, the US President, Frank D. Roosevelt, proclaimed a vision of "the

⁶² Commission on Human Security, "San Jose Declaration", online, <http://www.humansecurity-chs.org/activities/outreach/sanjosedec.pdf> (accessed 14 December 2009).

⁶³ Kevin Boyle & Sigmund Simonsen, 'Human Security, Human Rights and Disarmament' (2004) *Disarmament Forum* 1 at 6.

⁶⁴ International Commission on Intervention and State Sovereignty (ICISS), 2001, *The Responsibility to Protect*, (2001) at www.dfait-maeci.gc/icciss-ciise/menu-en.asp, cited in Boyle & Sorensen, *ibid note 59* at 6.

world founded upon four essential freedoms – freedom of speech, freedom of religion, freedom from want and freedom from fear”.⁶⁵

It can be said that human security helps to identify the rights at stake in particular situations, with human rights helping to answer how human security issues can be promoted. While human development is unmistakably a broader concept connoting the process of widening the range of peoples’ choices, it is these very choices that constitute the essence of human security and the laudable standards that human rights seek to attain.

Although human security, human rights and human development are distinctive, human security has a unique feature which makes it desirable. The scope of human security is enormous and the ramifications of what threatens it are so pervasive that it encompass the entire range of human existence.

1.5 Tension between the Schools of Human Security

It has been highlighted above that human security is a deviation from the State-centric view as to the concept of security. It has also been highlighted above that there are different definitions of human security and that the meaning of security is highly contested by the proponents of the concept. While there is a consensus among the proponents that people are the reference point in the discourse, they are widely divided as

⁶⁵ Franklin Delano Roosevelt, *State of the Union Address*, 6 January 1941, cited in Boyle & Simonsen, *supra* note 63.

to the type of threat that should be prioritized.⁶⁶ The dispute has polarised the proponents into the narrow school and the broad school.

1.5.1 *The Narrow School*

A major proponent of the narrow school of thought is the Human Security Centre located at the Simon Fraser University.⁶⁷ The director of the centre, Prof. Andrew Mark, argues that the threat of political violence to people by the State or any other organised political actor is the proper focus of the concept of human security.⁶⁸ He restates support for the traditional meaning of human security as “the protection of individuals and communities from war and other forms of violence”.⁶⁹ He further acknowledges that there are many other threats to people apart from systematic violence.⁷⁰ However, he is of the opinion that many of these other threats are correlates of violence.⁷¹ For him, there is advocacy value in expanding the security agenda to include the broad school of thought but doing so also has analytical costs, such as determining what amounts to a security threat. This narrow school of thought has been simplified as ‘freedom from fear’ of threat

⁶⁶ Pauline Kerr, “Human Security” in Alan Collins, ed., *Contemporary Security Studies* (Oxford: Oxford University Press, 2007) at 95.

⁶⁷ The centre was initially located at the University of British Columbia before it was moved to Simon Fraser University in 2007.

⁶⁸ Human Security Centre, “What is Human Security”, online, http://www.humansecurityreport.info/HSR2005_PDF/What_is_HS.pdf (accessed 14 December 2009)

⁶⁹ *Ibid*

⁷⁰ *Ibid*.

⁷¹ *Ibid*, this was also restated by Pauline Kerr *supra* note 66.

or use of political power, as distinguished from the broad definition which is labelled ‘freedom from want.’⁷²

1.5.2 *The Broad School*

The major proponent of this school of thought is the much publicised UNDP report. According to the UNDP report, human security is not only freedom from fear but also freedom from want.⁷³ Several ideas have been bundled into this broad school of thought. According to this school of thought, “human security is concerned with the protection of people in critical life threatening dangers, regardless of whether the threats are rooted in anthropogenic activities or natural events, whether they lie within or outside states, whether they are direct or structural”.⁷⁴ Ramesh Thakur, former Vice Rector of the United Nations University argues that human security is “human centred” in that its principal focus is on people both as individuals and as communal groups.⁷⁵ It is “security oriented” in that the focus is on freedom from fear, danger and threat.⁷⁶

Another broad definition of human security is the one proposed by Sabina Alkiri. Sabina Alkiri, a member of the 2003 Commission on Human Security co-chaired by Amartya Sen and Sadako Ogata, argues that the objective of human security is “to protect the vital core of all human freedoms and human fulfilment”.⁷⁷ The broad school of thought has been criticised for its vagueness and lack of specifics. For example, Roland

⁷² *Ibid.*

⁷³ *Supra* note 24.

⁷⁴ Kerr *supra* note 66 at 95.

⁷⁵ See generally, Ramesh Thakur, *The United Nations, Peace and Security: From Collective Security to the Responsibility to Protect* (Cambridge: Cambridge University Press, 2006).

⁷⁶ *Ibid.*

⁷⁷ *Supra* note 41.

Paris argues that the broad school of human security “encompasses everything from drug abuse to genocide,’ and the number of causal hypothesis for human insecurity are so vast that frameworks for research and policy are difficult to formulate.⁷⁸ Therefore, Paris dismisses the whole concept as being “inscrutable.”⁷⁹

1.5.3 Meeting Point in the Two Schools

A common element of the two schools of thought is the agreement that human security centres totally on people. But the difference is the types of threats to be included in the definition of human security. The question remains: are we to include all form of threats to the human person in the human security discourse? Or should we regard politically motivated threats as the appropriate focus of the human security discourse?

It has been suggested that the two schools of thought can be reconciled by focusing on the nexus between the narrow school’s focus on political violence and the broad school’s focus on human development.⁸⁰ Pauline Kerr has suggested that the narrow school should be taken as the dependent variable and the broad school’s focus on human development as the independent variable which provides a policy framework for understanding causality and policies for crisis management.⁸¹ However, developing a coherent policy framework for the concept of human security will be of importance to the international community in appreciating that threats to the lives of people are multifarious. Engaging tools must be designed to prevent or ameliorate such threats. As it

⁷⁸ Roland Paris, “Human Security: Paradigm Shift or Hot Air?” (2001) 26:2 *International Security* 87 at 90.

⁷⁹ *Ibid* at 102.

⁸⁰ *Ibid* at 99.

⁸¹ *Ibid*.

stands now, human security is an ambiguous term. In fact, the Oxford Concise Dictionary indicates that the meaning of the concept is “impossible to understand or interpret.”⁸²

1.6 Framework for Health Security in West Africa

Human rights are the rights people enjoy in relation to their government. And health falls squarely under the economic, social and cultural rights which include rights to housing, food, and social security. The ‘right to health’ has been defined as the “‘right to the highest attainable standard of health’ as provided under Article 12 of the UN International Covenant on Economic, Social and Cultural Rights (ICESCR).⁸³ The preamble of the Constitution of the World Health Organisation provides that “the enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.⁸⁴ Furthermore, the right to health has also been identified as a firm feature of

⁸² The Oxford Concise Dictionary, 11th ed., “s.v”, “human security” 371.

⁸³ *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S.3, 1976 Can. T.S. No 46; the article provides that: 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

⁸⁴ The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org.*, **2**, 100), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and

international law⁸⁵ and it is recognised by other provisions in international treaties.⁸⁶ The right to health can also be gleaned from Article 16 of the African Charter of Human and

WHA51.23) came into force on 3 February 1977, 20 January 1984, 11 July 1994 and 15 September 2005 respectively.

⁸⁵ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Human Rights Guidelines to Pharmaceutical Companies in Relation to Access to Medicines, online, <http://www2.ohchr.org/english/issues/health/right/> (accessed 14 December, 2009)

⁸⁶ Article 25(1) of the United Nations Charter provides that: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Article 5(2) of the International Convention of All Forms of Racial Discrimination provides for “The right to public health, medical care, social security and social services.” Articles 11.1 and 12 of the Convention on the Elimination of All forms of Discrimination Against Women provides “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:... The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.” Article 12 provides: States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. (Ii) Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.” Article 24 of the Convention on the Rights of the Child (CRC) provides: “1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- (a) To diminish infant and child mortality;
- (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- (c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- (d) To ensure appropriate pre-natal and post-natal health care for mothers;

Peoples' Rights, which provides that: "Every individual shall have the right to enjoy the best attainable state of physical and mental health."⁸⁷ It further provides that "State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."⁸⁸

The right to health is an inclusive right. It does not merely extend to timely and appropriate health care services but it extends to other issues such as access to safe and potable water, adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information.⁸⁹

As can be seen from the above, the 'right to health' can be termed as 'right to life' and it is essential in achieving an optimal life. However, in a continent riddled with conflicts and poor governance, the right to health as enshrined in international treaties does not translate into access to good health in Africa. It is the contention of this author that the right to health and health security are synonymous and mutually inclusive. The

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services. 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. 4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries."

⁸⁷ Article 16(1).

⁸⁸ Article 16(2).

⁸⁹ Brigit Toebes, "The impact of acts of corruption on the enjoyment of the right to health" (A Report of the International Council on Human Rights Policy, 2007), online, www.abdn.ac.uk/law/documents/ReportRighttoHealthBTfinal.doc (accessed on 14 December 2009).

‘securitization’ of health will guarantee a concerted effort in achieving health security which is presently a mirage in West Africa.

West Africa is a highly diverse region in terms of language, culture, population size, politics and economics. However, this region shares the same health challenges, such as high fertility and mortality rates and the alarming increase in HIV/AIDS infection. These challenges are further worsened by poverty and armed conflicts.⁹⁰ It has been reported that 53.96 per cent of armed conflicts in the world occur in Africa.⁹¹

The impact of armed conflicts on the right to health cannot be underestimated. It has been estimated that conflicts caused more than 310,000 deaths in the year 2000 alone and more than half these deaths took place in sub-Saharan Africa.⁹² David Meddings, Douglas Bettcher and Roya Ghafele reported that, “violent death rates for low- to middle-income countries are more than twice those of high income countries, and over 90 percent of violent deaths occur in low- and middle-income countries.”⁹³

Armed conflicts not only cause deaths and injuries on the battlefield, but there are health consequences that follow the displacement of populations including the breakdown

⁹⁰ United States Agency for International Development, West Africa Health Context, online, <http://www.usaid.gov/westafrica/health/index.htm> (accessed on December 14, 2009).

⁹¹ World Health Organisation, “World Health Report 2001”, online, http://www.who.int/violence_injury_prevention/violence/collective/collective/en/index2.html (accessed on December 14 2009).

⁹² C. J. K. Murray, et al. “Armed Conflict as a Public Health Problem” (2002) 324 *British Medical Journal* 346 at 347.

⁹³ David R. Meddings, Douglas W. Bettcher & Roya Ghafele, “Violence and Human Security: Policy Linkages” in Lincoln Chen, Jennifer Leaning & Vasant Narasimhan, eds., *Global Health Challenges for Human Security* (Cambridge, USA: Harvard University Press, 2003) 161 at 167.

of health and social services, and the heightened risk of disease transmission.⁹⁴ Moreover, widespread violence which is often associated with armed conflict also degrades national resources including economic and natural resources. Armed conflicts dampen market economies, drive resources away from the social service sector, and decrease employment opportunities by destroying infrastructure and reducing capital.⁹⁵

Access to wealth and assets determine bargaining power in relation to the right to health in sub-Saharan Africa. At the intra household level, “intra-family decisions involving significant inequalities in the allotment of food, money, and health care have important implications for the welfare, health, and security of women.”⁹⁶ The World Health Organisation’s Commission on Social Determinants of Health states that “an estimated 2.6 billion people, half of the developing world, lack access to improved sanitation.”⁹⁷ In sub-Saharan Africa, this access is limited to only 36 percent.⁹⁸ Each year, 1.8 million people, 90 percent of which are children under 5 years, die from diarrhoea and cholera, mostly in developing countries.⁹⁹ In the current era of antibiotics and water purification techniques, close to 90 per cent of diarrhoea disease can be attributed to lack of access to safe water supply, inadequate sanitation and hygiene.¹⁰⁰

⁹⁴ Murray, *supra* note 92.

⁹⁵ David R. Meddings, Douglas W. Bettcher & Roya Ghafele, *supra* note 93 at 164.

⁹⁶ *Ibid* at 181.

⁹⁷ World Health Organization, (WHO) “Celebrating Water for Life: The International Decade for Action 2005-2015: *Resource Sheet 1*, online, <http://whqlibdoc.who.int/publications/2005/a85911.pdf> (accessed 14 December 2009).

⁹⁸ *Ibid*.

⁹⁹ *Ibid*.

¹⁰⁰ World Health Organization, “Facts and Figures: Water, Sanitation and Hygiene Links to Health”, Water

In addition, the Commission on Social Determinants of Health further stated that “almost half the people in the developing world have one or more of the main diseases or infections associated with inadequate water supply and sanitation: diarrhoea, intestinal helminth infections, dracunculiasis, schistosomiasis, and trachoma.”¹⁰¹ All these have made the right to health in Africa a mirage. Conflicts have also decimated the resources needed to provide better health facilities for the African people.

1.7.1 Human Security and Health

Human Security and health are closely knitted together. Good health is “intrinsic” to human security, since human survival and good health are at the core of “security.”¹⁰² Health is also “instrumental” to human security, because good health enables the full range of human functioning. Health permits human choices, freedom, and development¹⁰³ though there are many health problems, those considered most germane to human security are health crisis during armed conflicts and humanitarian emergencies, infectious diseases, and the health problems of poverty and inequity.¹⁰⁴

The average lifespan in Sierra Leone and Ethiopia is only about half that in Japan and Sweden, and fewer than half the newborns in Guinea-Bissau survive to their fifth

and Sanitation Department, March 2004, online, http://www.who.int/water_sanitation_health/publications/factsfigures04/en/ (accessed 14 December 2009).

¹⁰¹ *Supra* note 97.

¹⁰² Lincoln C. Chen, “Health as a Human Security Priority for the 21st Century”, online, <http://www.helsinki.fi/netcomm/ImgLib/24/89/LCHelsinkiPaper12%5B1%5D.6.04.pdf> (accessed 14 December 2009).

¹⁰³ *Ibid.*

¹⁰⁴ *Ibid.*

birthday.¹⁰⁵ Good health is both essential and instrumental to achieving human security. It is essential because the very heart of security is protecting human lives. Health security is at the vital core of human security and illness, disability and avoidable death are “critical pervasive threats” to human security.¹⁰⁶

Health is both objective physical wellness and subjective psychosocial wellbeing and confidence about the future. In this view, good health is instrumental to human dignity and human security.¹⁰⁷ It enables people to exercise choice, pursue social opportunities and plan for their futures.¹⁰⁸ Support for this can be found in the definition of health in the preamble of the WHO Constitution as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”¹⁰⁹

The absence of good health can result in enormous grief (for example, the loss of a newborn or young child) and can precipitate an economic catastrophe for the family (such as the sudden death of a working adult).¹¹⁰ Health’s instrumental role is collective as well as personal. Good health is a precondition for social stability. Sudden outbreaks of a contagious disease or other health crisis can destabilize an entire society.¹¹¹

¹⁰⁵ Commission for Human Security (CHS), “Better Health for Human Security” in *Human Security Now*, online, <http://www.humansecurity-chs.org/finalreport/English/chapter6.pdf> (accessed 14 December 2009).

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.*

¹⁰⁹ WHO, “Constitution of the World Health Organisation,” online, <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf> (accessed 14 December 2009).

¹¹⁰ *Supra* note 105.

¹¹¹ *Ibid.*

Poverty-related health threats are perhaps the greatest sources of human insecurity. Most preventable infectious diseases, nutritional deprivation and maternity-related risks are concentrated among the world's poor.¹¹² Poverty and disease set up a vicious spiral with negative economic and human consequences.¹¹³

The poor are at higher risk of infectious disease, and sickness can deepen poverty, creating a vicious cycle of illness and poverty. The risk and vulnerability to these poverty-related health threats are compounded by hunger, malnutrition and environmental threats, especially the lack of clean drinking water and sanitation.¹¹⁴ A significant share of the world's avoidable deaths and human insecurities is linked to poverty.¹¹⁵ Complications from childbirth are the leading cause of death among women in many developing countries. Over 515,000 women die yearly in pregnancy or childbirth, and 99 percent of these deaths occur in developing countries.¹¹⁶ The risk of dying from childbirth is 1 in 1,800 in developed countries but 1 in 48 in developing countries.¹¹⁷

This gap implies that countless pregnancy-related deaths in developing countries could be prevented with adequate resources and services. For every woman who dies in childbirth, 10–15 more women become incapacitated or disabled due to complications

¹¹² *Ibid.*

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

¹¹⁵ *Ibid.*

¹¹⁶ United Nations Population Fund (UNPFA), "Facts about Motherhood", online, <http://www.unfpa.org/mothers/facts.htm>, (accessed 14 December 200).

¹¹⁷ *Ibid.*

from childbirth.¹¹⁸ Over a quarter of women in the developing world, approximately 300 million women, suffer from short- or long-term complications arising from childbirth.¹¹⁹

1.8 Health as a Security Issue

The attempt to link health and security is not recent, as the impact of infectious diseases during war has been recognised for ages.¹²⁰ However, health became an important issue in foreign policy in the mid-to-late 19th century.¹²¹ At this time, there was an increase in the transmission of infectious diseases beyond the border of a State as a result of advances in trade and transportation brought about by the Industrial Revolution. Quarantine methods were used to stem the spread of diseases, but as they became expensive to the industries there was pressure on governments to set common international standards for the quarantines.¹²² It was this demand for a common standard that led to the 1851 International Sanitary Conference in Paris.¹²³

¹¹⁸ *Ibid.*

¹¹⁹ *Ibid.*

¹²⁰ N. B. King, "Security, Disease, Commerce: Ideologies of Postcolonial Global Health" (2002) 32 *Social Studies of Science* 763 at 764; G. H. Bruntland, "Global Health and International Security" (2003) 9 *Global Governance* at 417.

¹²¹ Sandra J. Maclean, "Microbe, Mad Cows and Militaries: Exploring the Links between Health and Security" (2008) 39 *Security Dialogue* 475 at 478.

¹²² Fraser Brockington, *The Health of the Developing World* (Lewes: Book Guild, 1985) at 56.

¹²³ World Health Organisation, "History of WHO and International Cooperation in Public Health", online, http://www.who.or.jp/GENERAL/history_wkc.html (accessed 14 December 2009). However, this attempt to produce an international sanitary convention failed. For a detailed historical evolution of the international sanitary conference, see generally, David Fidler, "The Globalisation of Public Health: the First 100 Years of International Health Diplomacy", (2001) 79:9 *International Journal of Public Health* (Bulletin of the WHO) 842-829.

In the recent past, the threat posed by infectious diseases and the impact of biological terrorist attack have renewed the discussion on the health security nexus within the traditional framework of National Security.¹²⁴ Resort to bio-weapons by terrorists to achieve political objectives is more likely in this global era, because of rapid, widespread movement of people and materials and because the ‘new’ wars of this modern times are characterised by non-state actors who are more likely to use non-conventional weapons of warfare.¹²⁵ Examples of bioterrorist attack abound. In 1995 the Iraqi government used biological weapons against its citizens, and a bioterrorist attack in a Japanese subway occurred in that same year.¹²⁶

Infectious diseases also gained a prominent place in the “securitisation of health” discourse. The outbreak of Ebola, a deadly and previously unknown disease, in Zaire (now Democratic Republic of Congo) in 1976, killing 88 percent of the people affected drew attention to the security threat infectious disease pose.¹²⁷ A second outbreak of Ebola in Zaire soon after the first outbreak and the identification of other similar ‘hemorrhagic fever’ viruses raised the alarm far beyond the locations of the infection, including alarm in western societies.¹²⁸ In fact, a leading African author on International Law and Public Health, Prof. Obijiofor Aginam, posited that the world is becoming a

¹²⁴ L. Garrett, “The Return of Infectious Disease’ (1006) 75 Foreign Affairs 66; National Intelligence Council, *The Global Diseases Threat and Its Implications for the United States* (National Intelligence Estimate NIE 99-17D, January 2000).

¹²⁵ Mary Kaldor, *New and Old Wars: Organised Violence in a Global Era*, 2nd ed. (Cambridge, Polity 2006) at 7.

¹²⁶ D.A. Henderson, “Bioterrorism as a Public Health Threat” (1998) 4:3 Emerging Infectious Diseases 488.

¹²⁷ Sandra Maclean, *supra* note 121.

¹²⁸ Sandra Maclean, *ibid.*

single germ pool in which there are no health sanctuaries or safe havens from pathogenic microbes.¹²⁹

Health professionals further heightened the call for a rapid response to the adverse effects of infectious diseases on nations. This clarion call produced the 2005 Revision of International Health Regulations, the main international health response to emerging infectious diseases.¹³⁰ It also led the United Nations to include infectious diseases in the Report of the High-Level Panel on Threats, Challenges and Changes, which drew attention to the security threat of infectious diseases.¹³¹

Infectious diseases also have direct links with military security, because of their potential to limit the effectiveness of the military.¹³² The high incidence of disease in some nations may contribute to a shortage of new recruits for the armed forces.¹³³ Disease has always been a leading cause of disability and death among military personnel, with hospitalisations and deaths from disease outnumbering those from combat by a significant margin.¹³⁴

There are several possible links between HIV/AIDS and national security. The impact of HIV/AIDS on national security lies in the ability of the disease to deplete

¹²⁹ Obijiofor Aginam, *Global Health Governance: International Law and Public Health in a Divided World* (Toronto: University of Toronto Press, 2005) at 6.

¹³⁰ World Health Assembly (WHA), 2005 Revision of the International Health Regulations, WHA 58.3, 23 May; online, http://www.who.int/csr/ihr/IHRWHA58_3-en.pdf (accessed 14 December 2009).

¹³¹ United Nations, *A More Secure World: Our Shared Responsibility, Report of the Secretary-General's High Panel on Threats, Challenges and Changes* (New York: United Nations, 2004).

¹³² Sandra Maclean, *supra* note 121.

¹³³ *Ibid.*

¹³⁴ Nation Intelligence Council, *supra* note 124.

military forces; its propensity to destabilize nations and contribute to state failure especially in sub-Saharan Africa.¹³⁵ It has also been suggested that HIV/AIDS is spread effectively and sometimes consciously as a weapon of war, by military personnel.¹³⁶

It has been argued that the rates of HIV/AIDS infection are typically higher in the military than among the general population, and in some national militaries, the rate of infection exceeds 50 per cent.¹³⁷ However, according to some recent studies, the link between HIV/AIDS and National Security is not firmly supported.¹³⁸ A study by Whiteside, de Waal & Gebre-Tensae shows that HIV rates in sub-Saharan militaries are not as high as have been widely reported, and in fact are actually lower than in the general populations of some countries with high rates of infection.¹³⁹

There is an extensive study on the impact of infectious diseases on national and international security, including the capacity and stability of States.¹⁴⁰ Countries with

¹³⁵Harley Feldbaum & Patel Preeti, "Global Health and National Security; The Need for Critical Engagement" (2006) 22:3 *Medicine, Conflict and Survival* 192.

¹³⁶L. Garrett, "The Lessons of HIV/AIDS", 84.4 *Foreign Affairs* 54 -61; Thoraya Ahmed Obaid, 'Introduction' to edition on "Sexual Violence: Weapon of War, Impediment to Peace" 27 *Forced Migration Review* 5- 6.

¹³⁷ R. L. Ostergard, "Politics in the Hot Zone: AIDS and National Security in Africa" (2002) 23 *Third World Quarterly* at 333; International Crisis Group, "HIV/AIDS as a Security Issue" (ICG Report June 2001), online, http://www.crisisgroup.org/library/documents/report_archive/A400321_19062001.pdf (accessed 14 December 2009).

¹³⁸ Alex de Waal, 2005 "Issue Paper 1: HIV/AIDS and the Military", paper presented at Expert Seminar and Policy Conference on 'AIDS, Security and Democracy', Clingendael Institute, The Hague, 2-4 May, http://asci.ssrc.org/doclibrary/issue_paper1.pdf (accessed 14 December 2009).

¹³⁹ Alan Whiteside, Alex de Waal & Tsadkan Gebre-Tensae, "AIDS, Security and the Military in Africa: A Sober Appraisal", (2006) 105:419 *African Affairs* 210 - 218.

¹⁴⁰ An extensive study was done by A. T. Price-Smith, *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development* (Cambridge, MA: MIT

high HIV/AIDS prevalence rates are deprived of a large proportion of their productive workforce and providers of essential services like education, health care, policing and government.¹⁴¹ There is also the concern about the social and political impact of demographic changes, in particular the increasing proportion of children and older adults in national populations, and the growing number of orphans.¹⁴²

The health care costs associated with HIV/AIDS place a large and increasing burden on developing countries' economies, which is exacerbated by lost productivity.¹⁴³ Various studies have estimated significant decreases in national GDP for countries seriously affected by HIV/AIDS and other diseases.¹⁴⁴ The economic impacts of infectious diseases are not equally distributed, and are likely to increase inequality within national populations.¹⁴⁵

Although there is a link between security and health, the attempt to broaden the concept of security to include health threats has not gone without controversy. There has been resistance to the expansion of security to include non-military threats such as health

Press 2002) see also A. T. Price-Smith, *Contagion and Chaos: Disease, Ecology, and National Security in the Era of Globalisation* (Cambridge, MA: MIT Press, 2009); M. E. Wilson, 'Health and Security: Globalisation of Infectious Diseases' in L Chen, J Leaning and V Narasimhan ed., *Global Health Challenges for Human Security* (Cambridge, MA, Harvard University Press, 2003).

¹⁴¹ UNGA, 'Special Session of the General Assembly on HIV/AIDS: Report of the Secretary-General' (16 February 2001) UN Doc A/55/779 [Special Session Report] paragraphs 26–38.

¹⁴² UNGA Special Report *Ibid* at paragraph 41

¹⁴³ UNGA *Ibid*.

¹⁴⁴ Alex de Waal, 'HIV/AIDS: The Security Issue of a Lifetime' in L Chen, J Leaning and V Narasimhan ed., *Global Health Challenges for Human Security* (Cambridge, MA, Harvard University Press, 2003) at 130; International Crisis Group, *supra* note 137.

¹⁴⁵ C. McInnes, "HIV/AIDS and Security" (2006) 82 *International Affairs* 315 at 316.

and environmental threat. A little space is created for health threats in the expansion of security only if it affects defence and stability.¹⁴⁶

In fact, some authors have questioned the link between health and security. For example, Barnett and Prins argue that there is paucity of strong fieldwork studies to prove the connection between HIV/AIDS and security.¹⁴⁷ They also argue that the discourse is plagued with factoids – viruses of opinion that have hardened through repetition into assumed fact.¹⁴⁸ Another study also found that to date there seems to be no correlation (much less causal relationship) between HIV infection rates and conflict.¹⁴⁹ At the very least, it appears that the relationship between HIV/AIDS prevalence and the risk of conflict or ‘failed states’ is more complex than early analyses seem to suggest.¹⁵⁰

1.9 Challenges to Health Security in West Africa

The present disparity in the global world order between the affluent North and the impoverished South is inequitable and this is reflected not only in economic development but also in the health sector. While life expectancy in the industrialised countries is above 80 years, the opposite is the case in sub-Saharan Africa of which West Africa is an integral part. Life expectancy in sub-Saharan Africa is lower than 46 years.¹⁵¹

¹⁴⁶ Von Tigerstrom, *Human Security and International Law* (Oxford: Hart Publishing, 2007) 175.

¹⁴⁷ T. Barnett & G Prins, “HIV/AIDS and Security: Fact, Fiction and Evidence – A report to UNAIDS” (2006) 82 *International Affairs* 359 at 360.

¹⁴⁸ T. Barnett, *Ibid.*

¹⁴⁹ Human Security Centre, *Human Security Report 2005: War and Peace in the 21st Century* (New York: Oxford University Press, 2005) at 139; also McInnes, *supra* note 137, at 317.

¹⁵⁰ Human Security Centre, *ibid.*, at 140; McInnes, *ibid.* at 318, 326.

¹⁵¹ UNDP, “Beyond scarcity: Power, poverty and the global water crisis”, online, <http://hdr.undp.org/en/media/HDR06-complete.pdf> (accessed 14 December 2009); WHO, “World Health

However, attempts have been made to bridge this divide through declarations such as the Alma Ata Declaration,¹⁵² the Bamako Declaration,¹⁵³ and the 2000 Millennium Development Goals.¹⁵⁴ At the regional level, there have been some initiatives such as the New Partnership for Africa's Development (NEPAD), the creation of the West African Health Organisation and the international financial support in combating Africa's health challenges.

One of the objectives of the World Health Organisation (WHO) is to provide an opportunity for concerted action to improve global health and to place health at the heart of development by establishing a new global compact, linking developed and developing countries through clear, reciprocal obligations that each entity would undertake to respect.¹⁵⁵

Report 2005: Make Every Mother and Child Count", online, http://www.who.int/whr/2005/whr2005_en.pdf (accessed 14 December, 2009); World Bank, "World Development Report 1993: Investing in Health: World Development Indicators", online, <http://files.dcp2.org/pdf/WorldDevelopmentReport1993.pdf> (accessed 14 December 2009).

¹⁵² The 1978 Alma Ata Declaration challenged the world "to respect the principles of primary health systems in order to remedy glaring disparities in the health sector between countries and within nations." This system was therefore based on primary health care.

¹⁵³ The 1987 Bamako Initiative underlined the necessity of community participation for the development of health.

¹⁵⁴ The MDG declaration stated the principles and values that should underlie international relations in the 21st century and identified seven areas in which national leaders had to make specific commitments:

1 – Peace, security and disarmament, 2 – Development and poverty eradication, 3 – Protection of our common environment, 4 – Human rights, democracy and good governance, 5 – Protection of vulnerable groups, 6 - Measures aimed at meeting Africa's special needs, 7 – Strengthening the United Nations Organisation.

¹⁵⁵ WHO, "World Health Report 2003: Chapter Two: Millienium Health Goals: Paths to the Future", online, <http://www.who.int/whr/2003/chapter2/en/index.html> (accessed 14 December, 2009); Organisation for Economic Co-operation and Development (OECD) 2006 Meeting, Human Security in West Africa:

Furthermore, the “Strategy for Health for All in the 21st century” or “Health for All by the Year 2000” was adopted by WHO’s Regional Committee for Africa’s 49th session. The Strategy for Health for All in the 21st century aims at considerably improving the African population’s health by promoting healthier lifestyles, preventing diseases, increasing life expectancy and reducing mortality rates. It also aims at reducing the growing malaria, tuberculosis and HIV related mortality rates. People’s health is indeed a vital aspect of economic and social development.¹⁵⁶

However, the situation on ground is completely different. The disparities between the North and the South continue to widen. For instance, there has been an increase in the average life expectancy in the past fifty years by 20 years in the world as a whole. It grew from 46.5 years in 1950 – 1955 to 65.2 in 2002. But life expectancy has dropped to below 46 years for men in sub-Saharan Africa, largely due to the HIV/AIDS pandemic in adult and in children below 5 years of age and other infectious diseases.¹⁵⁷

Another challenge to health security in West Africa is the mortality rate. The mortality rate, which is the death rate, is used in accessing a nation’s health status. Research shows that in 2002, there were 57 million deaths of which 10.5 million (20 percent) were children below the age of five, 98 percent of whom lived in the developing world and 50 percent in Africa.¹⁵⁸ Among those above 70 years of age, 60 percent of deaths occurred in developed nations and 30 percent in developing countries. In the 15-59

Challenges, Synergies and Action for a Regional Agenda, Vol 2., online, <http://www.oecd.org/dataoecd/57/31/38522363.pdf> (accessed 14 December 2009).

¹⁵⁶ UNDP *supra* note 151.

¹⁵⁷ OECD, *supra* note 155 at 68.

¹⁵⁸ *Ibid.*

year age group, 20 percent of deaths occurred in developed nations and 30 percent in developing countries.¹⁵⁹

Thus, in certain sub-Saharan countries, the adult mortality rate is higher today than it was 30 years ago. Deaths due to intentional or accidental injuries or “occult epidemics” among the youth (armed conflicts, road accidents, acts of violence or voluntary, self-inflicted injuries) have almost caught up with deaths due to HIV/AIDS in sub-Saharan Africa.¹⁶⁰

Another health challenge is infant and juvenile mortality. Research shows that infant and juvenile mortality remains high in Africa and has increased than in previous years.¹⁶¹ About 35 percent of African children are exposed to death risk and the causes of the risk are preventable diseases such as per natal conditions, diarrhoea and malaria, each aggravated by malnutrition.¹⁶² In many African countries, acute respiratory infections account for up to 20 percent of the mortality in children under five years, as compared to 5 percent in industrialized nations.¹⁶³ These are risks that have been wiped out in other regions, but they still pose a serious problem in Africa.

Deeply embedded in the health challenges of sub-Saharan Africa is poverty. Poverty is usually defined in monetary terms based on either income or consumption

¹⁵⁹ *Ibid.*

¹⁶⁰ *Ibid.*

¹⁶¹ *Ibid.*

¹⁶² *Ibid.*

¹⁶³ See M. Wilson, “Health and Security: Globalization of Infectious Diseases” in *Global Health Challenges for Human Security*, *supra* note 140 at 88.

levels.¹⁶⁴ These monetary approaches often use poverty lines, calculated from estimates of the income required to purchase a minimum set of goods and services.¹⁶⁵ Usually, this list of goods and services encompasses basic food, clothing, shelter, education and health needs.¹⁶⁶ People with incomes less than the poverty line are deemed to be living in poverty.¹⁶⁷ Using the above poverty framework, more than 45 per cent of Africans live below the poverty line,¹⁶⁸ and poverty is more endemic in rural areas. Poverty in Africa is also accentuated by mismanagement of government resources, corruption and nepotism.

Poverty and health are intertwined. Ill health contributes to poverty by, for instance, consuming household resources to pay for care and medicines, by lowering educational achievement through absences or disrupting concentration, reducing time or productivity at work or limiting the possibility of working at all.¹⁶⁹ Ill health also creates economic insecurity. Furthermore, poverty causes ill health by reducing access to health care while increasing the likelihood of malnutrition, inadequate housing and exposure to environmental and other health risks.¹⁷⁰ Ill health is both a cause and a consequence of

¹⁶⁴ Roger Riddell, "Approaches to Poverty: A Note from the 'Development' Perspective" (2004), International Council on Human Rights Policy, Researcher's Meeting on Poverty, Development, Rights (Geneva, 24-25 November 2004) 3.

¹⁶⁵ Riddell, *ibid.*

¹⁶⁶ *Ibid* at 4.

¹⁶⁷ *Ibid* at 3. The first Millennium Development Goal, for example, is to reduce by half the number of people living in extreme poverty, which is defined as living on less than a dollar a day. See Millennium Development Goals, available at <http://www.un.org/millenniumgoals/> (accessed 14 December 2009).

¹⁶⁸ OECD, *supra* note 155.

¹⁶⁹ OHCHR, Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies (2002), online, <http://www.ohchr.org/english/issues/poverty/guidelines.htm112> (accessed 14 December 2009).

¹⁷⁰ *Ibid.*

poverty: sick people are more likely to become poor and poor people are more vulnerable to disease and disability.¹⁷¹

Another major challenge to health security in West Africa is skill drain. There is a shortage of health personnel in West Africa and this hinders the achievement of the MDG health target for the year 2015. Africa produces health personnel who are lured away by private recruitment agencies to the developed countries, further widening the gap between the North and the South. Skill drain has impacted negatively on the right to health and the health security of the African countries.

1.10 CONCLUSION

This chapter has explored the concept of human security by tracing its origin from the concept of security itself. Attempt has also been made to explore the framework of health security by examining the “securitization” of health and the challenges of health security in West Africa.

Despite its incoherence, the concept of human security is important because it compels governments to view security beyond maintaining the territorial integrity of States and the stability of governments in power at a given point in time. Therefore, attention should be on the people within the borders of a State whose security is equally as important as the security of the State from external aggression. However, human security cannot be guaranteed if the State is not secured from external aggression. Therefore, there should be a convergence between State security and human security.

¹⁷¹*Ibid.*

The next chapter will examine the impacts of HIV/AIDS on three groups: Peacekeepers, Women and Children. An attempt will be made to explore how the disease furthers the human insecurity of these groups.

CHAPTER TWO

THE IMPACTS OF HIV/AIDS ON HUMAN SECURITY IN WEST AFRICA: THREE CASE STUDIES

2.1 INTRODUCTION

HIV/AIDS has disproportionate effects on peacekeepers, women and children due to their vulnerability to the disease during and after combat. The high mobility of peacekeepers during conflicts exposes them to the HIV/AIDS virus. Conflicts also increase the vulnerabilities of women and children to the HIV/AIDS virus even though most of them are not directly engaged in combat.

This chapter will explore peacekeepers, women and children as case studies and critically examine the far reaching effects of HIV/AIDS on them. The impact of HIV/AIDS on the ability of peacekeepers to participate in peacekeeping missions in West Africa will be considered. This chapter will also examine existing social and cultural inequalities in West Africa that expose women and children to the HIV/AIDS virus.

2.2 CASE STUDY ONE: PEACEKEEPERS

Peacekeeping has been a central issue in the maintenance of peace and security in Africa. Following the failure of western interventions in Somalia and Rwanda which led in part to genocide, western powers reconsidered their effort in peace support operations (PSOs) on the continent and concentrated on developing Africa's capacity to address complex political situations. It culminated in the involvement of the US, France and UK in training African peacekeepers to be more effective in handling conflicts in the last decade.

The responsibility for maintaining regional peace and security falls on African governments, the African Union (AU) and the Regional Economic Communities such as the Economic Community of West African States (ECOWAS). For example, ECOWAS became involved in the maintenance of peace and security in the West African region with the establishment of the Economic Community of West African States Monitoring Group (ECOMOG) when some States in the region were engulfed in civil wars. Of importance is the ECOWAS intervention in Liberia and Sierra Leone.¹ In a desire to develop an effective regional security mechanism to respond to emergencies in the African region, the AU intends to establish an African Standby Force (ASF)² in 2010 for the maintenance of peace and security in the region.

However the greatest challenge to the success of regional peace and security initiatives in Africa (and in West Africa in particular) is not the operational preparedness of the military but the ability of HIV/AIDS to decimate African military forces and therefore compromise their peacekeeping capabilities. In light of the potential adverse consequences the pandemic poses to regional security in West Africa, this section will critically examine the effects of the pandemic on institutional peacekeeping in West Africa.

¹ See Ikechi Mgbeoji, *Collective Insecurity: The Liberian Crisis, Unilateralism and Global Order* (Vancouver: UBC Press, 2003).

² Since African governments are expected to bear the burden of troop deployment for future peacekeeping operations, the African Union (AU) decided to set up the African Standby Force to be operational in 2010. The African Standby Force consists of standby brigades in Central, Southern, Eastern, North, and West Africa. It is expected that the African Standby Force will undertake traditional peacekeeping operations, as well as observer missions and peacebuilding activities. See generally, Jakkie Cilliers, *The African Standby Force: An Update on Progress* (Pretoria: Institute for Security Studies, 2008).

2.2.1 Linking AIDS to African Military Security

James Wolfenson, erstwhile President of the World Bank, reasoned at the start of 2000 that:³

Many of us used to think of AIDS as a health issue. We were wrong. AIDS can no longer be confined to the health or social sector portfolios. Across Africa, AIDS is turning back the clock on development. ...Nothing we have seen is a greater challenge to the peace and stability of African societies than the epidemic of AIDS. ...We face a major development crisis, and more than that, a security crisis. For without economic and social hope we will not have peace, and AIDS surely undermines both. We need to break that vicious circle of AIDS, poverty, conflict, AIDS. Not only do AIDS threaten stability, but when peace breaks down it fuels AIDS. Of the countries in Africa with the highest prevalence of AIDS, half are engaged in conflict of one kind or another. ...AIDS spreads through the military. It spreads even when conflict ends and when populations move. It spreads rapidly among refugees – 75 percent of whom are women and children, making them especially vulnerable. There are too many refugees in Africa. Too many refugees and too many conflicts and AIDS is their handmaiden.

The link between HIV/AIDS and security was debated at a UN session in 2000, marking the first time the Security Council addressed a health issue. The Security Council noted that HIV/AIDS is killing more people than any other preventable cause of death, destabilising countries politically, reversing decades of economic progress, reducing numbers and expertise within conscript army, and destroying the social glue that binds communities together.⁴ This move led to the adoption of Resolutions 1308 and 1325,

³ Speech given to the UN Security Council meeting on HIV/AIDS in Africa, 10 January 2000 cited in Greg Mills, “AIDS and the South African Military: Timeworn Cliché or Time Bomb?” in Michael Lang, ed., *HIV/AIDS: A Threat to the African Renaissance*, online, <http://www.lib.uct.ac.za/asl/info/renaissance.pdf> (accessed 23 March 2010).

⁴ UNAIDS, “Statement to the UN Security Council, 10 January 2000,” online, <http://www.un.org/News/dh/latest/piotuids.htm> (accessed 23 March 2010).

which specifically identified the HIV/AIDS pandemic as a threat to international security.⁵

According to a January 2000 report of the United States National Intelligence Council, diseases such as HIV/AIDS “will add to political instability and slow democratic development in sub-Saharan Africa”.⁶ The report notes that “the severe social and economic impact of infectious diseases, particularly HIV/AIDS, and the infiltration of these diseases into the ruling political and military elites and middle classes of developing countries are likely to intensify the struggle for political power to control scarce resources.”⁷

⁵ *HIV/AIDS and International Peacekeeping Operations*, SC Res. 1308(2000), UN SCOR, 2000, UN Doc S/Res 1380: The resolution encouraged Member States and the international community, including UNAIDS to develop long-term strategies for HIV/AIDS education, prevention, confidential voluntary counselling and test (VCT) and for the treatment of uniformed personnel, as part of the overall preparation for participation in peacekeeping operations. The Security Council asked the UN Secretary to ensure that training was provided to peacekeeping personnel on issues related to HIV prevention. It also asked the UN Secretary General to provide both pre-deployment orientation and ongoing training for peacekeepers on issues pertaining to HIV/AIDS. At the national level, the Security Council encouraged Member States to increase cooperation among their relevant national bodies to assist in the creation and execution of policies for HIV prevention, VCT and treatment in the deployment of international peacekeeping operations.

⁶ National Intelligence Council, *The Global Infectious Disease Threat and Its Implications for the United States* (Washington: NIC, January 2000) 46.

⁷ *Ibid*; for a wider discussion on the issue of AIDS in the military, see J.A Anderson, K. J. Kramer & K. A. Shambley, “AIDS Issues in the Military,” (1990) 32 *Air Force Law Review* 353-375; W. H. Lyerly Jr., S. Barry & N. Miller, “HIV Transmission and the Military”, (1993) 1:1 *AIDS and Society: International Research and Policy Bulletin* 8-10; M. R. Smallman- Raynor, et al, “Civil War and the Spread of AIDS in Central Africa”, (1990)107 *Epidemiol Infect* 69-80; Michael Fleshman, “AIDS Prevention between the Rank: UN targets peacekeepers, combatants in war against the disease” (2001) 15:1 *African Recovery* 16-19.

The impact of HIV/AIDS on the military in the African continent has catapulted beyond imagination and in most southern African countries, it has become the leading cause of death among the military and police forces.⁸

It has been argued that “AIDS is becoming a far greater threat to human existence than armed conflict; in the next decade alone, the pandemic is expected to kill more human beings than all the combatants killed in the First World War, the Second World War, the Korean War and the Vietnam War combined.”⁹ It is apparent that the disease is raging a silent war and little empirical research has been carried out on the impact of this disease on societies and, in particular, on fragile states such as Liberia and Sierra Leone in West Africa. This has made scholars to call for “further empirical analysis” and “a sustained and focused research on individual countries” in order to be able to determine how serious the impact of HIV/AIDS is on a country-by-country basis.¹⁰ It is highly important to clarify the security dimensions of the HIV/AIDS pandemic on the military capabilities of a country because actions taken to confront the disease as a matter of domestic policy or foreign aid may markedly differ from those taken to address threats to security.¹¹

⁸ L. Heinecken, “Living in Terror: The Looming Security Threat to Southern Africa” (2001) 10:4 African Security Review 1.

⁹ Stefan Elbe, *Strategic Implications of HIV/AIDS* (New York: Oxford University Press 2003) at 7.

¹⁰ Andrew Price-Smith, *The Health of Nations, Infectious Disease, Environmental Change, and Their Effects on National Security and Development* (Cambridge/London: MIT Press, 2002) at 174; Elbe, *ibid* 60.

¹¹ Laurie Garrett, *HIV and National Security: Where are the Links?* (New York: Council on Foreign Relations, 2005) at 9.

HIV/AIDS affects the institutions that guarantee national security and safeguard the international system as a whole. HIV/AIDS can be so pervasive that it assaults the essence of the nation state: to secure families, communities, economics and political institutions, military and police forces.¹² First, through the pandemic's effects on the economy, politics and, more broadly, society, HIV/AIDS poses a threat to both future stability and democratic governance.¹³ Second, conditions of conflict have been shown to exacerbate the vulnerability of both civilian and military populations to HIV/AIDS.¹⁴

It is of course clear that African militaries are vulnerable to contracting HIV and transmitting it. African militaries are also potential agents in the fight against HIV/AIDS. And this has significant implications for individuals within the militaries as well as the communities where they are deployed for peacekeeping duties. The recognition given to the threats posed by the HIV pandemic to international and national security led to the adoption of Resolution 1380 by the United Nations Security Council referred to above.

The Resolution was reinforced in June 2001, when the United Nations General Assembly Special Session on HIV/AIDS unanimously adopted the Declaration of Commitment on HIV/AIDS. Through this Declaration, Member States committed themselves to "...developing national strategies to address HIV/AIDS prevention, care

¹² M. Schneider and M. Moodie, *The destabilizing impacts of HIV/AIDS* (Washington DC: Center for Strategic and International Studies, 2002) at 3.

¹³ *Report of the UN Secretary General, In Larger Freedom: Towards Development, Security and Human Rights For All*, UN GAOR, 59th Sess., UN Doc. A/59/2005 (2005).

¹⁴ *Ibid.*

and awareness among national uniformed services, as well as guidelines to be used by personnel involved in international peacekeeping operations.”¹⁵

HIV/AIDS and armed conflicts go together. Armed conflicts can influence the dynamics of AIDS in societies and it has been argued vehemently that AIDS can influence armed conflict in Africa.¹⁶ The past two decades has witnessed an increase in the number of armed conflicts in Africa, yet HIV/AIDS is expected to kill ten times more people in the coming years and experts have predicted the spread of AIDS in the camps of internally displaced people.¹⁷

Military personnel are at a high risk of contracting and transmitting HIV/AIDS in and out of conflict settings. HIV/AIDS rates among soldiers are generally higher than in comparable civilian population.¹⁸ However, the prevalence rate can be described as inconsistent because UNAIDS in 2005 admitted that ‘little reliable information is available on levels of HIV infection among uniformed services and few countries conduct systematic screening and public health surveillance systems are often weak.’¹⁹ Nonetheless, it has been observed that the military personnel are key vectors for the transmission of the virus because soldiers are frequently deployed on long tours of duty

¹⁵ *Declaration on Commitment on HIV/AIDS*, UN GAOR, 26th Sess., UN Doc. A/Res/S-26/2 (2001).

¹⁶ See Stefan Elbe, *supra* note 9.

¹⁷ Pollard R., “UN forces more at risk from HIV than war”, online, <http://www.smh.com.au/articles/2002/07/10/1026185066992.html> (accessed 23 March 2010).

¹⁸ Paolo Tripodi & Preeti Patel, “HIV/AIDS, Peacekeeping and Conflict Crises in Africa” (2004) 20.3 *Journal of Medicine, Conflict and Survival* 195 at 199.

¹⁹ See UNAIDS/WHO, “On the front line: A review of Policies and programmes to address HIV/AIDS among peacekeepers and uniformed services”, online, http://data.unaids.org/publications/IRC-pub05/jc950-frontline_en.pdf (accessed 23 March 2010).

and are imbued with a risk-taking ethos which exacerbates the pandemic.²⁰ Prevalence of HIV/AIDS in the armed forces appears to depend on a variety of factors including demography, structure, recruitment patterns, military ethos and training, delivery of awareness programmes, access to condoms, alcohol and drug abuse, and the stage and nature of the epidemic.²¹

The prevalence rate of the HIV/AIDS in African militaries is estimated to be as high as 40 percent to 60 percent.²² This brings to the fore military preparedness in case of an outbreak of conflict in Africa. Some of these militaries also participate in international peacekeeping and there is a likelihood of the soldiers contributing to the spread of HIV in regions where they are deployed. The epidemic can also serve as a politically destabilising force in countries that have high prevalence rate. It has been argued that HIV infections through rape can be used as a weapon of war. For example, survivors of the Rwandan genocide claimed that HIV was used as a weapon of war through rape aimed at subjecting victims to economic hardship, psychological stress, illness, and ultimately, death.²³

²⁰ Paolo Tripodi & Preeti Patel, *supra* note 18.

²¹ AIDS, Security and Conflict Initiative (ASCI), *HIV/AIDS, Security and Conflict: New Realities, New Responses*, online, http://asci.researchhub.ssrc.org/working-papers/HIV_AIDS%20Security%20and%20Conflict.pdf (accessed 23 March 2010).

²² See Armed Forces Medical Intelligence Centre, *Impact of HIV/AIDS on Military Forces: Sub-Saharan Africa*, (Washington, DC: Defence Intelligence Agency, 2000); but it has been argued to be highly imprecise. See generally Alen Whiteside, Alex De Waal & Tsadkan Gerre-Tenae, "AIDS, Security and the Military in Africa, A Sober Appraisal" (2006) *105 African Affairs* 201- 218.

²³ Elbe, *supra* note 9 at 9.

2.2.2 Strategic Impacts of HIV/AIDS on Militaries in West Africa

The current knowledge on the prevalence rate of HIV in militaries in Africa is conflicting and hazy. This is not unconnected with the difficulty in getting accurate data from militaries where the prevalence rate is high because of the strategic importance of such disclosure and the potential vulnerabilities it signifies. However, it is an established fact that AIDS is a threat to national security in West Africa.

HIV within the military is predominantly transferred through risky and unsafe sexual behaviour. Members of the uniformed services usually live and work in environments where the circumstance of their recruitment, their rank and their posting may predispose them to contracting HIV.²⁴ The Uniformed Services Task Force on HIV/AIDS held a meeting in Ghana in 2001 and identified the following factors, which predispose members of the uniformed services to contracting HIV. First, members of the uniformed services are predominantly young men and women who see themselves as invulnerable and are very sexually active.²⁵ Second, duty schedules and periods of deployment result in separation from families.²⁶ With a steady income, service men and women are often considerably better off than those in surrounding communities and the host populations depend on the military for food, since uniformed service personnel are

²⁴ UNAIDS/WHO, *supra* note 19.

²⁵ *Ibid*; However, this point has been debated. Most of the young men recruited into the militaries are in the 17 to 22 age range which has been identified as a demographic group (contrary to popular wisdom) to have low levels of HIV prevalence. See generally, Alan Whiteside, Alex De Waal and Tsadkan Gebre-Tensae, "AIDS, Security and the Military in Africa: A Sober Appraisal", *supra* note 201 – 208.

²⁶ *Ibid*.

often perceived by civilians as being privileged and in positions of power or authority.²⁷ All these provide the incentive to engage in risky sexual behaviours.

The strategic implication of AIDS in West Africa is expected to manifest in terms of the decimation of resources within the militaries. High HIV prevalence rates are likely to entail the training and recruiting of more soldiers to replace personnel who have succumbed to the illness, increasing the amount of human and financial resources expended, particularly if the need is to replace personnel in specialised or technically demanding roles, such as information technology or communications.²⁸ As Major James Samba of the Sierra Leone Army puts it, “there will have to be a continuous high level of army recruitment because of this disease.”²⁹

HIV also will affect the staffing of personnel in the militaries of West Africa. HIV/AIDS will decimate the pool of “would be” recruits for military duties. This will in turn reduce the combat effectiveness, readiness and deployment of troops, which will be worsened by increased absenteeism, sick leave, early retirement, bereavement, funeral leave and leave to care for dependants.³⁰

HIV/AIDS affects the moral cohesion and discipline of military forces, leading to the disruption of schedules, loss of respected personnel and the merging of units in

²⁷ *Ibid.*

²⁸ Elbe, *supra* note 9 at 24.

²⁹ James Astill, “War Injects AIDS into the tragedy of Sierra Leone’: Armies Spread AIDS in Africa” (2001) *Atlanta Journal of Constitution*, cited in Elbe, *ibid.*

³⁰ A de Waal and T Gebre-Tinsae, “HIV and Conflict in Africa”, Report prepared for DFID, February 2003, cited in UNAIDS/WHO *supra* note 18.

response to such personnel losses.³¹ It is expected that HIV/AIDS will reduce the quality of human resources and training, owing to reductions in performance, level of skills, institutional memory and experience of military personnel, which may result in a leadership vacuum, with young and inexperienced personnel brought in to replace the sick and dying.³²

It is safe to conclude that militaries will be less likely to be able to maintain stability and security within States due to the impact of the epidemic. It has been argued that in weak States with divided societies, opposition groups may exploit the situation by instigating civil unrest or toppling the ruling elite.³³ It has further been argued that there is a link between HIV/AIDS and State fragility in Africa due to the adverse effect the pandemic has on skilled workers such as civil servants, teachers, police, and health workers and this threatens the institutions that make a State run effectively.³⁴ This led a scholar to argue that the disease will hollow out military capabilities and weaken armed forces to the point of failure and collapse.³⁵ However, this argument appears speculative

³¹ *Ibid.*

³² *Ibid.*

³³ *Ibid.*

³⁴ See UN Secretariat, *The impact of AIDS*, report by the Population Division, Department of Economic and Social Affairs, (New York: United Nations, 2003) pp. xiii, xiv, chs 4, 8; International Crisis Group, *HIV/AIDS as a security issue* (Brussels: International Crisis Group, 2003) 9–13; Ostergard, "Politics in the Hot Zone: AIDS and the Threat to Africa's Security" (2002) 23:2 *Third World Quarterly* 344; Mark Schneider and Michael Moodie, *The Destabilising Impact of HIV/AIDS* (Washington DC: Center for Strategic and International Studies, 2002) 5 – 6.

³⁵ Peter W. Singer, "AIDS and International Security", (2002) 44:1 *Survival* 145 - 146.

because there is no example of a State failing as a result of high HIV prevalence.³⁶ In fact, there is a noticeable lack of correlation between those States with the highest levels of HIV in Africa and those that are most fragile.³⁷ Moreover, the AIDS, Security and Conflict Initiative has found that there is no direct causal linkage between HIV and State fragility.³⁸ It argues that the use of the concept ‘state fragility’ may actually undermine the effectiveness of international responses: “fragile states” are not all fragile in the same way, or for the same reasons. Therefore attempts to address HIV/AIDS must recognize this diversity.³⁹ However, the impacts of HIV/AIDS do not play out in the simple arithmetic of cause and effect. These impacts may be far deeper than studies have shown. Thus, there is need for a sustained study on how its multidimensional effects will play out in each specific context, as the variables are not the same in each African State.

The AIDS epidemic may also complicate attempts at post-conflict reconstruction and recovery in countries with high HIV-prevalence rates. Efforts at demobilizing and reintegrating combatants may be threatened by combatants returning to villages and families heavily affected by the virus, and by the breakdown of government, police and civil society.⁴⁰ The US based Center for Strategic and International Studies has argued that should powerhouses such as South Africa and Nigeria be unable to furnish

³⁶ Colin McInnes & Simon Rushton, “HIV/AIDS and Security: Where are we now?” (2010) 86:1 *International Affairs* 225 at 236.

³⁷ ASCI, *supra* note 21.

³⁸ *Ibid*

³⁹ Tony Barnett, “HIV/AIDS and State Fragility”, (2009) ASCI synthesis paper, online, <http://asci.researchhub.ssrc.org/workingpapers/ASCI%20Synthesis%20Paper%20State%20Fragility.pdf> (accessed 23 March 2010).

⁴⁰ Schneider *supra* note 12.

peacekeepers, contribute to growth and stability in the region and/or guarantee their own stability, the security of the continent, or at least that of the entire sub regions, could be threatened.⁴¹

2.2.3 Impacts of HIV/AIDS on International Peacekeeping in West Africa

Since the involvement of ECOMOG in the armed conflicts in Sierra Leone and Liberia, international peacekeeping has taken another dimension in the West African region. The ECOMOG force consists of troops from West African Countries with Nigeria contributing the greater percentage of peacekeepers.

However, HIV has the potential to decimate regional capacity of the ECOMOG and West African militaries to respond to emergencies in the region. HIV also poses new challenges to international peacekeeping in West Africa because, as noted earlier, peacekeeping operations may contribute to the spread of HIV/AIDS in the conflict zone. For example, Richard Holbrooke has observed that one of the ugliest truths about AIDS in conflict zones is that it is spread by UN Peacekeepers.⁴² The irony is that the spread of HIV/AIDS through peacekeeping kills more people than the war itself.⁴³ It has been reported that 32 percent of peacekeepers in Sierra Leone originated from countries with HIV prevalence rates greater than 5 percent.⁴⁴

⁴¹ *Ibid.*

⁴² Richard Holbrooke, comments on *Voice of America*, 8 June 2000, cited in Stefan Elbe *supra* note 9 at 40.

⁴³ *Ibid.*

⁴⁴ United States General Accounting Office, *UN Peacekeeping: United Nations Faces Challenges in Responding to the Impact of HIV/AIDS on Peacekeeping Operations* (Washington DC: US General

Peacekeepers can also acquire the virus from civilians where they are deployed. Peacekeepers are posted away from home for a long period of time and they always attract sex workers to where they are posted, thus bringing two high risk groups together. They can also be victims of the virus if they are posted to a country that has a high prevalence rate. It was reported that some Nigerian peacekeepers were on field duty without rotation up to three years as part of the turbulent *Operation Sandstorm* in Sierra Leone.⁴⁵ In this particular instance, the HIV incidence rate correlated with the length of duty, increasing from 7 percent after one year to 10 percent after two years and to 15 percent after three years of operation.⁴⁶

This incidence can make countries to be unwilling to contribute troops for peacekeeping missions.⁴⁷ It is on record that of the 10,000 troops Nigeria sent to Sierra Leone in 1997, 11 percent of those that returned tested HIV-positive.⁴⁸ The Nigerian government admitted in December 1999 that there was an extremely high prevalence rate amongst its troops participating in ECOMOG operations in neighbouring West African

Accounting Office, December 2001) at 8. Five percent is widely believed to be the point at which the epidemic is out of control.

⁴⁵ A. Adefolalu, "HIV/AIDS as an Occupational Hazard to Soldiers – ECOMOG Experience" Unpublished paper presented at the Third All African Congress of Armed Forces and Police Medical Services, Pretoria, 24-28 October 1999, cited in Stuart Kingma and Rodger Yeager, "A Civil-Military Alliance Response to the HIV/AIDS Epidemic in Nigeria", concept paper presented to the US Agency for International Development, February 2000, online, http://www.certi.org/cma/publications/Los_Alamos_Paper_6.pdf (accessed 23 March 2010).

⁴⁶ *Ibid*

⁴⁷ United States Department of State, "US International Strategy on HIV/AIDS", online, <http://dosfan.lib.uic.edu/ERC/environment/releases/9507.html> (accessed 23 March 2010).

⁴⁸ *Agence France Presse*, "Obasanjo warns Soldiers against Unprotected Sex," online, <http://www.aegis.com/NEWS/AFP/2000/AF000584.html> (accessed 23 March 2010).

States.⁴⁹ The fragile peace in West Africa will be truncated if Nigeria decides to stop contributing troops for peacekeeping missions for fear that its troops will contract the HIV/AIDS virus. This will also affect the West African Brigade of the African Standby Force to be constituted in 2010. This shows that HIV/AIDS has a multidimensional impact on securing peace in the West African Region.

HIV/AIDS also constitutes a potential threat to international peacekeeping in West African Region because it decimates the capacity of West African States to deploy troops to international peace keeping operations on short notice due to shortage of combat ready soldiers. It has been argued that peacekeeping operations may come under intense staffing pressure as HIV prevalence rate rise in national armies which may make peacekeeping operations to be extremely difficult to staff.⁵⁰ This particular vulnerability is apparent in the Southern Africa Development Community (SADC). During the SADC Blue Crane peacekeeping exercise in South Africa in April 1999, nearly 50 percent of the 4,500 participating troops were HIV-positive and 30 percent of the South African contingents were not medically fit for deployment.⁵¹ Greg Mills argues that:

The high rate of infection in SADC armies also calls into question the nature and size of their potential contribution to Congo mission. In more general terms, it presents problems and questions the appropriateness of the current Western strategy to devolve the responsibility for peacekeeping missions down to the sub-regional level in Africa. Preliminary studies of an SANDF peacekeeping operation in the Democratic Republic of Congo (DRC)

⁴⁹ Omololu Falobi, "Nigerian Government admits HIV Infection among ECOMOG Soldiers", AF-AIDS, 4 July 2000 cited in Stefan Elbe, *supra* note 9 at 41.

⁵⁰ Elbe, *supra* note 9 at 42.

⁵¹ Greg Mills, "AIDS and the South African Military: Timeworn Cliché or Time bomb?" in Michael Lang, ed., HIV/AIDS: A Threat to the African Renaissance, online, <http://www.lib.uct.ac.za/asl/info/renaissance.pdf> (accessed 23 March 2010).

suggest that the military contingent will be far more at risk from disease than bullets.⁵²

In fact the South Africa National Defence Force has expressed grave concerns about its ability to find enough volunteers for its international peacekeeping commitments, particularly given the UN recommendations to test all peacekeepers for HIV/AIDS prior to deployment.⁵³

HIV/AIDS can also limit the cooperation of the countries hosting peacekeeping missions. For instance, in March 2001 the Eritrean government insisted that peacekeepers deployed to the country should be screened for HIV, and demanded a guarantee from the UN that no HIV-positive soldiers will be deployed.⁵⁴ This fear was echoed in Sierra Leone where the United Nations HIV/AIDS coordinator, Hirut Befecadu, had insisted that “the population should be protected from the soldiers as well, because most of the troops come from places where AIDS is a problem.”⁵⁵ Similarly, officials in Zagreb sought to ensure that no African peacekeepers served in Croatia during the Balkans conflict because of the fear of HIV transmission.⁵⁶ The International Crisis Group suggested that the ‘concern that foreign peacekeeping troops may carry the virus may prompt populations to reject cooperation with such forces, contributing to the

⁵² *Ibid.*

⁵³ Lyndy Heinecken, “Strategic Implications of HIV/AIDS” (2001) 1:1 Conflict Security and Development 111.

⁵⁴ Roxanne Bazergan, “UN Peacekeepers and HIV/AIDS” (2001) 57:5 World Today 6.

⁵⁵ Simon Robinson, “Battle Ahead”, Time, 16 July 2001 cited in Stefan Elbe *supra* note 9 at 43.

⁵⁶ Forman & Carballo, “A Policy Critique of HIV/AIDS and Demobilisation” (2001)1:2 Conflict, Security and Development 73 at 77. See an in depth analysis in Massimo Lowicki-Zucca, Sarah Karmin & Karl-Lorenz Dehne, “HIV among Peacekeepers and its Likely Impact on Prevalence on Host Countries' HIV Epidemics” (2009)16:3 International Peacekeeping 352 – 363.

continuation of conflict.’⁵⁷ This dilemma prompted the UN Security Council to address the situation by urging member States to screen their soldiers.⁵⁸

2.3 CASE STUDY TWO: WOMEN

Globally, HIV/AIDS is the leading cause of death among women of reproductive age.⁵⁹ UNAIDS estimates that out of the 31.3 million adults worldwide living with HIV/AIDS, approximately half were women at the end of 2008.⁶⁰ About 98 percent of these women live in developing countries,⁶¹ and around three quarters of all women with HIV live in sub-Saharan Africa.⁶²

The AIDS pandemic has a unique impact on women due to their sexuality and their submissive role in the society which further makes them vulnerable to HIV infection. In many societies, women have a lower social and economic status simply because they are women. Generally women are at a greater risk of heterosexual transmission of HIV.

⁵⁷ International Crisis Group, *supra* note 34.

⁵⁸ *HIV/AIDS and International Peacekeeping Operations*, SC Res. 1308(2000), UN SCOR, 2000, UN Doc S/Res 1380.

⁵⁹ World Health Organisation, “Women & health: today's evidence tomorrow's agenda”, online, http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf (accessed 17 May 2010).

⁶⁰ UNAIDS, “2009 Report on the global AIDS epidemic”, online, http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf (accessed 17 May 2010).

⁶¹ UNAIDS/UNFPA/UNIFEM “Women and HIV/AIDS: Confronting the crisis”, online, <http://www.unfpa.org/hiv/women/report/index.htm> (accessed 17 May 2010).

⁶² UNAIDS, “2008 Report on the Global AIDS Epidemic”, online, http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp (accessed 17 May 2010).

From a biological point of view, women are twice more likely to become infected with HIV through unprotected heterosexual intercourse than men. Viral concentration in semen is higher than that in vaginal fluids, and women have a larger mucous surface, which is exposed to the virus for longer durations.⁶³ However this biological reason alone does not explain the high prevalence of HIV in African women.

The rate of male to female transmission of HIV is between two and four times higher than the rate of female to male transmission.⁶⁴ Sub-Saharan Africa is one region of the world where the majority of HIV transmissions occur during heterosexual contact. As women are twice as likely to acquire HIV from an infected partner during unprotected heterosexual intercourse as men; women are disproportionately infected in this region based on the data provided by UNAIDS. Also, in many countries women are less likely to be able to negotiate condom use and are more likely to be subjected to non-consensual sex.⁶⁵

Furthermore, millions of women are indirectly affected by the HIV/AIDS epidemic because of the domestic roles of women in traditional African societies. For example, women's childbearing role means that they have to contend with issues such as

⁶³ *Supra* note 59.

⁶⁴ United Nations Population Fund (UNFPA). "Addressing Gender Perspectives in HIV Prevention, HIV Prevention Now, programme briefs, no.4, online, <http://www.unfpa.org/hiv/prevention/documents/hivprev4.pdf> (accessed May 14, 2010).

⁶⁵ UNAIDS, "A Strategic Approach: HIV & AIDS and Education", http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090615_UNESCO.asp (accessed May 17, 2010); UNAIDS, "Women and Girls", <http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/WomenGirls/default.asp> (accessed May 17, 2010).

mother-to-child transmission of HIV. Women also have responsibility of caring for AIDS patients and orphans which is also an issue that has an adverse effect on them.

Generally, in societies with few palliative care facilities, it is usually the woman's responsibility to care for persons living with HIV/AIDS. In Africa for example, two thirds of all caregivers for persons living with HIV/AIDS are women.⁶⁶ This palliative-care giving is usually done in conjunction with other tasks that women perform within the household, such as cooking, cleaning, and caring for the children and the elderly.

The AIDS epidemic has great impact on young girls and elderly women. Responsibilities in households where both parents are ill from AIDS are given to the daughter even if it is to her detriment and even if she misses school. When both parents die from AIDS, the domestic responsibility is shifted to the grandmothers, aunts or cousins who then look after the AIDS orphans.

Mother-to-child transmission is also an urgent issue that directly affects women and concurrently increases the spread of HIV. Incidence of mother-to-child transmission happens when an HIV positive woman passes the virus to the unborn child during pregnancy, labour and delivery, or through breastfeeding.⁶⁷ UNAIDS reported that at the end of 2007 there was an estimated 2 million children (under 15 years) living with HIV,

⁶⁶ UNAIDS, "2008 Report on the global AIDS epidemic", online, http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp (accessed May 17, 2010).

⁶⁷ C.K. Burr, S. Taylor & D. Bartelli, *Reduction of Perinatal HIV Transmission: A Guide for Providers* (Newark, NJ: National Pediatric and Family HIV Resource Center, 1997).

most of whom were infected by their mothers.⁶⁸ Tragically, a great number of these children will not live to adulthood.

Although drugs have been manufactured that reduce the chances of a child acquiring HIV from its mother from about 40 percent to less than 2 percent, these drugs are unavailable in many parts of the world, especially Africa. This constitutes a human security threat to women in West Africa. Recent years have witnessed drug companies reducing significantly the prices of drugs such as nevirapine and Azidothymidine (AZT), which help in preventing mother to child transmission of HIV. However, because of limited financial resources and poor infrastructure and poverty, many women cannot access these drugs in Africa.

2.3.1 The Vulnerability of Women to HIV/AIDS in West Africa

A number of factors account for the prevalence of HIV/AIDS among women in West Africa. These factors include the social and cultural inequalities within families, poverty, lack of education, sexual violence against women amongst others.

The social and economic status and cultural expectations of both women and men in West Africa can increase the risk of HIV infection. A woman's lower status usually leaves her more exposed to infection.⁶⁹ In some African societies, women have few rights within sexual relationships and within the family. Usually, men make majority of the decision regarding women, such as who to date and marry. This power imbalance makes

⁶⁸ UNAIDS *op.cit.*

⁶⁹ R. Jewkes, J. Levin & L. Penn-Kekana, "Gender Inequalities, Intimate Partner Violence and HIV Preventive Practices: Findings of a South African Cross-sectional Study" (2003) 56 *Social Science & Medicine* 125.

it more difficult for women to protect themselves from HIV infection. For instance, a woman may not be able to insist on the use of condoms because the husband, as the head of the home, makes all the decisions.

Also, young women in Africa tend to have older, more experienced partners who are more likely to have sexually transmitted diseases from previous sexual activity.⁷⁰ Girls and young women may willingly initiate sexual relationships with older men for material benefits, especially if they are languishing in poverty.⁷¹ A study conducted in Malawi revealed that two-thirds of 168 sexually active women reported having sex for money or gifts.⁷²

Deeply linked to the vulnerability of women and young girls is poverty. HIV and poverty are inextricably linked. Poverty contributes to HIV transmission and HIV creates an enabling environment for poverty. Women and girls are greatly affected both ways as they are among the poorest in society.⁷³ A study conducted in Ghana examined the context of disease transmission and identified factors that influenced women's ability to protect themselves from infection.⁷⁴ The study revealed that the poverty experienced by many of the women during their childhood years, as well as society's habit of favouring

⁷⁰ T. Turmen, "Gender and HIV", (2003) 82 *International Journal of Gynaecology and Obstetrics* 411 at 412.

⁷¹ T. Turmen, *ibid.*

⁷² UNAIDS, "Gender and HIV/AIDS: UNAIDS technical update", online, http://whqlibdoc.who.int/unaid/1998/gender_HIV_eng.pdf (access May 17, 2010).

⁷³ World Health Organisation (WHO), "Integrating gender into HIV/AIDS Programmes, review paper for Expert Consultation", online, http://www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf (accessed May 17, 2010).

⁷⁴ J.E. Mill & J.K. Anarfi, "HIV Risk Environment for Ghanaian Women: Challenges to Prevention", (2002) 54 *Social Science & Medicine* 325 – 337.

the education of males, restricted the participants' educational and vocational opportunities. As a result of limited education and skills, many women took boyfriends to assist them with the purchase of food and shelter, as a survival strategy.⁷⁵ For most of these women, the use of condoms with sexual partners was restricted by the high value placed on fertility, the negative (albeit erroneous) association of condoms with prostitution, and the women's limited ability to influence their partners.⁷⁶

Poverty among women also affects their access to information. Men and women of high economic status know more about HIV prevention than those who are economically worse-off in almost every country where data is available.⁷⁷ A study conducted in Maputo, Mozambique, among 182 schoolgirls in two secondary schools, suggests that while gender dynamics work against women overall, middle-class young women had fewer sexual partners, used condoms more often, seemed willing to challenge gender norms and were more assertive than their working class counterparts.⁷⁸

These factors mean that middle-class women also have a potential advantage in sexual negotiation. Working class women may not question gender power differentials, are less assertive and tend to be more dependent on their partners for material needs. This weakens their negotiating power in relation to safe sexual behaviour and makes them more vulnerable.⁷⁹

⁷⁵ J. E. Mill, *ibid.*

⁷⁶ J. E. Mill, *ibid.*

⁷⁷ WHO, *supra* note 59.

⁷⁸ J. Z. Machel, "Unsafe Sexual Behaviour among Schoolgirls in Mozambique: A Matter of Gender and Class", (2001) 9.17 *Reproductive Health Matters* 82 – 90.

⁷⁹ *Ibid.*

These inequalities led to the adoption of The Convention on the Elimination of All Forms of Discrimination against Women⁸⁰ by the United Nations in 1979. The Convention, described as the International Bill of Rights of Women, defines what constitutes discrimination against women and it sets up an agenda for national action to end such discrimination. Specifically, Article 16 requires States parties to eliminate discrimination against women in the context of marriage and family relations. State parties are directed to ensure that women and men have equal right to enter into marriage; equal right to freely choose a spouse and to enter into marriage only with their free and full consent; and equal rights and responsibility during its dissolution.⁸¹ Strict adherence to this Convention will help to challenge and change the social and cultural inequalities within the family as identified in this chapter.

However, the reality is that State Parties to the Convention are not enforcing the provisions of the Convention. Furthermore, the cultural veil that covers women in African societies is so deeply embedded that the provisions of a convention cannot be expected to challenge or change it. Rather, grassroots mobilisation is needed if cultural attitudes towards women`s right in Africa are to be changed.

In many countries around the world, women do not have the same property rights as men. For example, in sub-Saharan Africa, property is typically owned by men and even when married, women still do not have the same property rights as their husbands.

⁸⁰ *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, 1249 UN.T.S. 13, Can T.S. 1982 No 31.

⁸¹ *Ibid.*

Inheritance rights are discriminatory; when a husband dies, his property often goes to his side of the family and not to his wife.⁸²

The denial of a woman's inheritance and property rights can increase her vulnerability to HIV. Not being able to own property means that women have limited economic stability. This can lead to an increased risk of sexual exploitation and violence, as women may have to endure abusive relationships or resort to informal sex work for economic survival.⁸³

Furthermore, women traditionally play the role of care-givers in Africa. Caring for the sick, as well as for orphans, increases the already overwhelming burden of care placed on women.⁸⁴ Female-headed households are not only likely to be poor; they are also more likely to take in orphans than male-headed households. Female-headed households affected by HIV/AIDS are therefore more likely to enter an irreversible

⁸² See generally, Janet Walsh, LaShawn R. Jefferson & Joseph Saunders, *Kenya Double Standards: Women Property Rights Violations in Kenya*, (New York: Human Right Watch, 2003); J.L. Andreff, "The Power Imbalance Between Men and Women and Its Effects on the Rampant Spread of HIV/AIDS among Women", (2001) 9:1 Human Rights Brief 24.

⁸³ United Nations Development Program (UNDP), "HIV and Women's Inheritance and Property Rights", online, <http://content.undp.org/go/newsroom/updates/hiv-www-news/womens-inheritance-and-property-rights-are-essential-to-effective-aids-response.en?src=print> (accessed May 17, 2010); UNAIDS, "2004 Report on the global Aids epidemic", online, http://www.unaids.org/bangkok2004/GAR2004_pdf/UNAIDSGlobalReport2004_en.pdf (accessed May 17, 2010).

⁸⁴ UNAIDS/UNFPA/UNIFEM, "Women and HIV/AIDS: Confronting the Crisis", online, <http://www.unfpa.org/hiv/women/report/chapter4.html> (accessed May 17, 2010).

downward spiral of increasing expenses, contributing to the present feminisation of poverty.⁸⁵

Also women's control of their own bodies and sexuality is important to HIV/AIDS prevention. This principle is also enshrined in UN Conventions and declarations to which African countries have committed to, including the Declaration of Commitment from the 2001 UN Special Session on HIV/AIDS.⁸⁶ Placing the issue in the context of upholding human rights obligations, African governments have committed to "empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection."⁸⁷

In addition to the factors highlighted above, the high infection rates among women in sub-Saharan Africa are intricately linked to the problems of gender-based violence. There is growing evidence that the vulnerability of women and girls to HIV/AIDS is partly rooted in intimate partner violence which is the commonest form of violence against women.⁸⁸ In Rwanda, Nigeria, Tanzania and South Africa, the risk of

⁸⁵ Economic Commission for Africa, "Commission on HIV/AIDS and Governance in Africa: Impact of HIV/AIDS on gender, orphan and vulnerable children", online, http://www.uneca.org/CHGA/Cameroon/cameroon_orphans.pdf (accessed May 17, 2010)

⁸⁶ UNAIDS, "United Nations General Assembly Special Session on HIV/AIDS: Declaration of Commitment on AIDS", online, http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf (accessed May 17, 2010).

⁸⁷ *Ibid.*

⁸⁸ S. Maman, J. Campbell, M. D. Sweat & A. Gielen, "The Intersections of HIV and Violence in West Africa: Directions for Future Research and Interventions" (2002) 50 *Social Science and Medicine* 456 -478.

HIV among women who have experienced sexual violence is three times higher than those that have not experienced such violence.⁸⁹

Violence against women by intimate partners is recognised as a violation of human rights, criminal law and public health.⁹⁰ The Declaration on the Elimination of Violence against Women adopted by the United Nations General Assembly in 1993 defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”⁹¹ Gender-based violence is not limited to rape. There are many forms of violence against women, including sexual, physical, or emotional abuse by an intimate partner; physical or sexual abuse by family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers or employers); trafficking for forced labour or sex; and such traditional practices as forced or child marriages, dowry-related violence; and honour killings, when women are

⁸⁹ S. Maman, J. K. Mbwambo & N. M. Hogan, “HIV Positive Women Report More Lifetime Partner Violence: Findings From a Voluntary Counselling And Testing Clinic in Dar es Salaam, Tanzania” (2002) 92.8 American Journal of Public Health 1967 – 1972.

⁹⁰ A. Van der Straten, R. King & O. Grinstead, “Sexual Coercion, Physical Violence and HIV Infection Among Women in Steady Relationships in Kigali, Rwanda” (1998) 2.1 AIDS and Behaviour 61-73

⁹¹ *Declaration on the Elimination of Violence against Women* GA Res. UN GAOR, UN Doc. A48/104 (1993).

murdered in the name of family honour. Systematic sexual abuse in conflict situations is another form of violence against women.⁹²

Violence against women is a manifestation of historically unequal power relations between men and women. It is complex and diverse in its manifestations, with far-reaching and long-lasting consequences and costs that impoverish women, their families, communities and nations.⁹³ Many girls and young women in Africa had their first sexual encounter by coercion and young girls are more likely to experience sexual coercion than older ones. Violence is not only committed by strangers. In some countries, up to one in five women have experienced violence from an intimate partner and up to a third of girls reported that their sexual initiation was forced.⁹⁴ The World Health Organisation conducted a research in 2002, and it was revealed that globally, between 10 percent and 69 percent of women report physical abuse by an intimate partner at least once in their lives.⁹⁵

The existing social tolerance for violence against women and children increases their vulnerability to HIV infection, and forms part of the dynamics that underpin the spread of HIV in Africa.

⁹² World Health Organisation, “WHO Multi-country Study on Women’s Health and Domestic Violence against Women: Initial Results on prevalence, health outcomes, and women responses”, online, http://www.who.int/gender/violence/who_multicountry_study/en/index.html (accessed May 17, 2010); also N.I. Aniekwu & Ayo Atsenuwa, *Sexual Violence and HIV/AIDS in Sub-Saharan Africa: An intimate Link*, (June 2007) 12:3 *Local Environment* 313 at 314.

⁹³ United Nations, “Fact Sheet – Violence against Women: Forms, Consequences and Costs”, online, <http://www.un.org/womenwatch/daw/vaw> (accessed May 17, 2010).

⁹⁴ UNAIDS, *supra* note 85.

⁹⁵ Gracias Moreno & C. Watts, “Violence Against Women: Its Importance for HIV/AIDS”, (2000) 14 *AIDS*, 14 (Suppl.3) 253 -265.

Sexual violence often results in sexually transmitted infections (STIs), including HIV infections; especially since coerced sex may lead to the tearing of sensitive vaginal tissues and increase the risk of contracting the HIV virus.⁹⁶ When sexual violence occurs in girls and women, the risk of transmission is higher because girls' vaginal tracts traumatize easily during violent sexual intercourse.⁹⁷ For example, 31 percent of Nigerian women who were raped in 2003 tested HIV positive compared with 11 percent among those who were not raped.⁹⁸

The lack of condom use and the forced nature of rape mean that women are immediately more vulnerable to HIV infection.⁹⁹ A South African study concluded that women who were beaten or dominated by their partners were much more likely to become infected with HIV than women who were not.¹⁰⁰ Another study of 20,425 couples in India found not only that HIV transmission was much greater in abusive

⁹⁶ C. Jenny, T. Hooton & A. Bowers "Sexually Transmitted Diseases in Victims of Rape", (1990) 322:11 New England Journal of Medicine 713.

⁹⁷ *Ibid.*

⁹⁸ World Health Organisation, "Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes", online, <http://www.who.int/gender/documents/en/genderdimensions.pdf> (accessed May 17, 2010).

⁹⁹ UNIFEM & Action Aid, "Together We Must End Violence Against Women and Girls and HIV & AIDS", online, http://www.unifem.org/attachments/products/TogetherWeMust_en.pdf (accessed May 17, 2010); K. Sarkar "Sex-trafficking, Violence, Negotiating Skill, and HIV infection in Brothel-based Sex Workers of eastern India, adjoining Nepal, Bhutan, and Bangladesh" (2008) 26:2 Journal of Health, Population and nutrition 223 – 231.

¹⁰⁰ D. L. Dunkle, "Gender-based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa" (2004) 363:9419 The Lancet 1415.

relationships, but also that abusive husbands were more likely to be infected with HIV than non-abusive husbands.¹⁰¹

2.4 CASE STUDY THREE: CHILDREN

Orphanhood is high in sub-Saharan Africa as a result of high rate of mortality in the region. The AIDS pandemic disproportionately affects sexually active people and parents, thereby increasing the number of orphans in sub-Saharan Africa to unprecedented levels. UNICEF estimates that there are 143 million orphans in Africa due largely to AIDS.¹⁰² The number of children orphaned by HIV/AIDS is expected to increase by an additional 25 million and in 12 African countries, projections show that orphans will comprise at least 15 per cent of all children younger than 15 years in 2010.¹⁰³ Because these orphans are robbed of their parents' care and support, they therefore represent a 'skipped generation' on the African continent.¹⁰⁴

At the household level, the orphan crisis leads to changes in the household composition, as well as to the present rise in the number of child-headed households, child caregivers, and elderly caregivers. At the national level, it raises a number of issues such as increased mortality, fall in life expectancy, changing age structures, increased

¹⁰¹ M. Decker, "Intimate Partner Violence Functions As Both A Risk Marker and Risk Factor for Women's HIV Infection: Findings from Indian Husband-Wife Dyads" (2009) 51:5 Journal of Acquired Immune Deficiency Syndromes.

¹⁰² UNICEF, "Child Protection From Violence, Exploitation and Abuse", online, http://www.unicef.org/protection/index_orphans.html (accessed May 17, 2010).

¹⁰³ *Ibid.*

¹⁰⁴ Economic Commission for Africa, "Commission on HIV/AIDS and Governance in Africa: Impact of HIV/AIDS on gender, orphan and vulnerable children", online, http://www.uneca.org/CHGA/Cameroon/cameroon_orphans.pdf (accessed May 17, 2010)

food insecurity, and reduced household saving. Orphanhood also exacerbates gender inequalities. Girl orphans are overworked and often sexually exploited by their caregivers, they are most likely to drop out of school, and they are more often dispossessed of their parents' property.¹⁰⁵

Gender discrimination and the crisis of orphanhood reinforce each other in a number of ways. First, girl orphans, being both girls and orphans, are doubly vulnerable, and particularly exposed to sexual abuse and other forms of exploitation. They also have lower access to education and health services. All orphans are at a greater risk of marginalisation in their households and in the community, and they are at a greater risk of poverty. Taken together this increases the vulnerability of orphans to HIV infection.

Second is the issue of stigma and the ensuing discrimination. Both women and orphans face more AIDS-related stigma, discrimination and marginalisation than men. This exacerbates their already disadvantaged position and lower access to HIV testing, treatment and care. Because the struggles for equality begin in the family, it is also the primary site for stigmatization, discrimination, violence and abuse against women and children, especially orphans. Research demonstrates that key to the household's response when struck by HIV is not the women's but their spouse's reaction to the new crisis in the family.¹⁰⁶

¹⁰⁵ Hilda Tandria, "The Gender Dimensions of HIV/AIDS in Africa", online, http://www.uneca.org/chga/gender_hiv_aids.pdf (accessed May 17, 2010); UNICEF, "Children on the Brink: A Report of the New Orphan Estimates and a Framework for Action", online, http://www.unicef.org/publications/files/cob_layout6-013.pdf (accessd May 17, 2010).

¹⁰⁶ *Ibid.*

The HIV epidemic has drastically changed the lives of many children in Africa. Millions of children have been infected with HIV and have died of AIDS each year without treatment. The epidemic has a tremendous impact on adolescents as well as younger children and it has increased the marginalisation of millions of children living in difficult circumstances in Africa.

Everyday all around the world, sixteen hundred children are born with prenatally transmitted HIV infection;¹⁰⁷ and 95 percent of these children live in the developing world.¹⁰⁸ Also an unknown number of children acquire the virus through unsafe blood and blood products, unsterile needles, and through sex, including sexual abuse.¹⁰⁹ UNAIDS estimates that 2.1 million children were living with HIV around the world at the end of 2008,¹¹⁰ and that every hour 31 children die as a result of AIDS.¹¹¹

Most children living with HIV – around 9 out of 10 – live in sub-Saharan Africa, the region of the world where AIDS has taken its greatest toll.¹¹² Girls and boys living

¹⁰⁷ Global Strategies for HIV Prevention, “A Call to Action to Prevent HIV Infections of Newborns: Global Strategies for HIV/Prevention”, online, http://globalstrategies.org/resources/call_to_action_newborns.html (accessed May 17, 2010).

¹⁰⁸ United States Agency for International Development (USAID), UNICEF and UNAIDS (Joint United Nations Programme on HIV/AIDS), *Children on the Brink: A Joint Report on Orphan Estimates and Program Strategies*, online, http://data.unaids.org/Topics/Young-People/childrenonthebrink_en.pdf (accessed May 17, 2010).

¹⁰⁹ Sofia Gruskin & Daniel Tarantola, “Human Rights and Children Affected by HIV/AIDS”, in Geoff Foster, Carol Levine & John Williamson, ed., *A Generation at Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children* (New York: Cambridge University Press, 2006) 136.

¹¹⁰ UNAIDS, “2009 Report on The Global AIDS Epidemic”, online, http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf (accessed May 17, 2010).

¹¹¹ *Ibid.*

¹¹² *Ibid.*

with HIV suffer the physical consequences of infection through stunted growth, disability, increased morbidity, and premature death. Furthermore, their condition creates psychological stress and exposes them to stigma and discrimination. Discrimination on the ground of HIV status can impact on children's families and the communities and on the services available to them, including entitlements to education, health, and social services. Children with HIV/AIDS are often discriminated against in the formal and informal educational systems,¹¹³ and in some countries where the overall capacity of the health system is already strained, children with HIV are routinely denied access to basic health care.¹¹⁴

Furthermore, children are drastically affected when their close or extended family, their community, and, more broadly, the structures and services that exist for their benefit are strained by the consequences of the HIV/AIDS pandemic. The most devastating impact of the pandemic occurs when children lose their immediate family environment and their support system is weakened by the sickness, disability, or premature death from AIDS of one or both of their parents. The emotional impact of trauma, including living through the deprivation of parental support and loss of childhood, can create serious obstacles to a child's development. For example, children may have to leave their homes, drop out of school, find jobs, or seek a life on the street. Moreover, the disclosure of the HIV status of one of the child's parents may result in discrimination or the marginalisation of the child's wellbeing in the society.

¹¹³ R. Carr-Hill, K.J. Katabaro & A.R. Katahoire, *The Impact of HIV/AIDS on Education and Institutionalizing Preventive Education*. (Paris: International Institute for Education Planning and UNESCO, 2002).

¹¹⁴ *Ibid.*

In Africa, studies reveal that one in three newborns infected with HIV die before the age of one, over half die before reaching their second birthday, and most are dead before they are five years old.¹¹⁵

HIV damages the life of children in Africa by its negative impacts on the child, the child's family and the community where the child lives. For example, because many children have lost one or both parents to AIDS, many households in Africa are headed by children. Thus, there is a generational gap as AIDS erodes traditional community support systems for these children and some children have to live with their grandparents. Also, children end up being the principal wage earners for their family as AIDS prevents infected adults from working. AIDS also ravages African communities by leading to the loss of teachers which impacts negatively on the access of African children to education and this leads to high illiteracy among vulnerable children.

One of the major problems of children in Africa is Mother-to-child transmission of HIV which accounts for the majority of HIV infections in children. Children are exposed to HIV in hospitals and clinics across Africa through unsterilized needles and unsafe blood transfusion. In some African countries, children are becoming sexually active at an early age, which further makes them vulnerable to HIV. Studies reveal that in sub-Saharan Africa, 16 percent of young females and 12 percent of males are having sex

¹¹⁵ M. L. Newell, "Mortality of Infected and Uninfected Infants Born to HIV-Infected Mothers in Africa: A Pooled Analysis," (Oct 2004) 364.9441 The Lancet.

before they are 15. In Lesotho, these figures are 16 percent and 30 percent, respectively, while in Kenya, the figures are 15 percent and 31 percent respectively.¹¹⁶

It is important that effective strategies be put in place to prevent mother-to-child-transmission of HIV. In 2008, around 45 percent of HIV-infected pregnant women in low- and middle-income countries received drugs to protect their babies from infection.¹¹⁷ This shows that a low percentage of women in developing countries have access to interventions that can reduce the chances of a baby being born with HIV. In addition, the effective use of sterile medical equipments and screened blood products will help in preventing children being infected through medical transmission. However, the reality in Africa is that access to antiretroviral drugs is extremely limited, demand for such drugs overshadows the availability of the drugs and many children who could benefit from this therapy are not receiving it.¹¹⁸

2.5 Conclusion

The adoption of resolution 1308 by the United Nations Security Council changed the way AIDS is perceived in the international arena. The resolution securitized the pandemic by committing States to develop effective strategies to combat AIDS. AIDS is a threat to national security by effectively weakening the capacity of the security sector to respond to emergencies. The pandemic does not only affect national security, but international security by limiting the combat readiness of military forces. This

¹¹⁶ UNAIDS, UNICEF & WHO “Children and AIDS: Third Stocktaking Report”, online, http://www.unicef.org/publications/files/CATSR_EN_11202008.pdf (accessed May 17, 2010).

¹¹⁷ WHO/UNAIDS/UNICEF “Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector”, online, http://www.who.int/hiv/pub/tuapr_2009_en.pdf (accessed May 17, 2010).

¹¹⁸ *Ibid.*

compromises the fragile peace and security in West Africa. Thus, urgent measures ought to be taken to change the tide of things within the militaries in West Africa.

There is also an urgent need for more empirical research on how HIV/AIDS will play out in different settings. The data available so far on the HIV dynamics has been weak and shaky in its foundations. Nevertheless, HIV/AIDS appears to be a major variable in African peace support operations and concrete policy tools need to be designed by African institutions to respond to the challenges posed by HIV/AIDS.

CHAPTER THREE

WEST AFRICAN REGIONAL STRATEGIES ON HIV/AIDS

3.1 Regional Approach to HIV/AIDS in West Africa

Stopping the spread of HIV/AIDS constitutes the greatest developmental challenge facing African countries and failure to address the epidemic can compromise the future of the continent. The major step towards addressing the pandemic came in the 2001 African Summit on HIV/AIDS, Tuberculosis, and other related diseases,¹ which was held in Abuja, Nigeria and led to a document here referred to as *Abuja Declaration*.

African leaders declared HIV/AIDS to be a state of emergency and committed themselves to “placing the fight against HIV/AIDS at the forefront and as the highest priority issue in our respective national development plans... for the first quarter of the 21st century.”² African leaders also pledged in the Abuja Declaration to “set a target of allocating at least 15 percent of our annual budget to the improvement of the health sector.”³ Unfortunately, African governments have failed to meet this target. Rather, Africa has relied on donor support for the advancement of HIV treatment and prevention.

Ironically, at the African Union’s annual Conference of Ministers of Finance, Planning and Economic Development in March 2010, a decision was taken to omit budgetary targets – including the Abuja Declaration’s 15 percent target – from the official meeting resolutions, on the ground that Heads of State had made a “colossal

¹ African Union, “African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases”, online, http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (accessed July 6, 2010).

² *Ibid.*

³ *Ibid.*

mistake” in setting these targets.⁴ Apparently, this shows a lack of clarity as to the essence of targets in government declarations such as the Abuja Declaration. The absence of targets in declarations leads to an unguided effort in reaching goals and this will in turn lead to incoherent decisions with no measuring guidelines. Presently, African governments on average allocate 6 percent of their budgets to health.⁵ Only 6 African governments have met the 15 percent allocation to health after 9 years of signing the Abuja declaration.⁶ Also, one of the shortcomings of the Abuja plan of action is that, while it commits African States to devoting at least 15 percent of national budgets to the health sector, the initiative did not explicitly address HIV/AIDS in the continent’s military and defence forces.

Nevertheless, the signing of the Abuja Declaration has witnessed some milestones. There has been an improvement in HIV/AIDS diagnostics, care, support, prevention, as well as higher coverage of antiretroviral therapy. For instance, in 2002, only 2 percent of patients in need of treatment were receiving treatment but the number increased to 44 percent in 2008.⁷ HIV prevalence has dropped from 5.8 percent to 5.2 percent, and the rate of new infections has declined by 25 percent in that timeframe. And

⁴ Pambazuka News, “African Finance Ministers Dismiss Development Declarations”, online, <http://www.pambazuka.org/en/category/comment/63894> (accessed July 6, 2010).

⁵ AU Monitor, “Summit to focus on maternal and child health”, online, <http://www.pambazuka.org/aumonitor/comments/2699/> (accessed July 6, 2010).

⁶ *Ibid.*

⁷ Center for Global Health Policy, “WHO Regional Director for Africa Discusses Abuja Declarations”, online, <http://sciencespeaks.wordpress.com/2010/05/08/who-regional-director-for-africa-discusses-abuja-declarations/> (accessed July 6, 2010).

since 2004, the annual number of HIV-related deaths has fallen by 18 percent.⁸ Despite all these, it is essential that more funds are devoted to the fight against AIDS in Africa and West African governments must take more responsibilities for HIV programs in the region.

The African Union developed an HIV/AIDS Continental Strategic Plan which covered the period of 2004 to 2007.⁹ Its 2007 implementation activities sought to strengthen existing national, sub-regional and continental responses to HIV/AIDS in Africa, and to mainstream HIV/AIDS into all the African Union's departments – including the Peace and Security department.¹⁰

African States have also been mobilised against HIV/AIDS, and there have been significant achievements at the country level. Several countries have established coordinating mechanisms in the form of National AIDS Councils/Commissions. West African countries such as Nigeria, Ghana and Sierra Leone have National Strategic Frameworks and Plans, which are being implemented. Resources have been mobilised at each country level and these resources are targeted towards prevention, care and support. Partnership has also fostered and strengthened between government, the private sector, religious groups, youth, people living with HIV/AIDS (PLHWA), and civil society organisations (CSOs) among others in the region.

⁸ *Ibid.*

⁹ African Union (AU), “Strategic Plan of the Commission of African Union”, online, <http://www.africa-union.org/AU%20summit%202004/volume%202%20final%20-%20English%20-%20June%202004.pdf> (accessed July 6, 2010).

¹⁰ *Ibid.*

3.2 Ghana

The first incidence of HIV/AIDS in Ghana was diagnosed in 1986 but attempts to track prevalence of HIV/AIDS in the country were instituted in 1990 when the Ministry of Health implemented the national HIV Sentinel Surveillance (HSS) system.¹¹ The annual HIV sentinel surveys conducted among antenatal attendants revealed that the HIV prevalence in the country was on a downward trend from 3.6 percent in 2003 to 2.7 percent in 2005. However, it increased to 3.2 percent in 2006, reduced to 2.2 percent in 2008 and increased to 2.9 percent in 2009.¹²

The main mode of transmission of the virus in Ghana is through heterosexual intercourse, which accounts for 75 to 80 percent of all HIV/AIDS infections. Vertical transmission from mother to child (mother-to-child transmission) accounts for 15 percent, and transmission through blood and blood products accounts for 5 percent.¹³ HIV-1 is the predominant infecting agent (94.4percent); 5.1 percent of cases are dual infections with HIV-1 and HIV-2; and only 0.5 percent of all infections in 2003 were HIV-2 alone.¹⁴

¹¹ Priscilla A. Akwara, Gabriel B. Fosu, Pav Govindasamy, Silvia Alayón, and Ani Hyslop, *An In- Depth Analysis of HIV Prevalence in Ghana: Further Analysis of Demographic and Health Surveys Data* (Calverton, Maryland, USA: ORC Macro, 2005).

¹² National AIDS/ STI Control Programme, *2008 HIV Sentinel Survey Report* (Accra: Ghana Health Service, Ministry of Health, 2009) National AIDS/ STI Control Programme, *2007 HIV Sentinel Survey Report* (Accra: Ghana Health Service, Ghana AIDS Commission, World Health Organisation, Department of International Development; 2008) National AIDS / STI Control Programme, *2009 HIV Sentinel Survey Report* (Accra: National AIDS/STI Control Programme, Ghana Health Service, Ministry of Health, Accra Ghana, 2010).

¹³ Ghana AIDS Commission, *Ghana HIV/AIDS Strategic Framework: 2001-2005* (Accra: Ghana AIDS Commission, 2001).

¹⁴ Ghana Health Service, *HIV Sentinel Survey Report 2003* (Accra, Ghana: Ghana Health Service, 2004).

No doubt, HIV/AIDS has deep social, economic and developmental effects and if it is not curtailed, it could have a devastating effect on the human security of the people of Ghana. The large number of people with HIV will overwhelm the health care sector, overburden the social system, inhibit educational development and hinder agricultural production.

3.2.1 Ghana's Response to HIV/AIDS

Ghana's first attempt to combat the HIV/AIDS pandemic was characterised by medical approach where the disease was viewed as an individual health issue. However, as the disease spread, a public health approach was adopted. This culminated in the formation of a technical committee in 1985 to advise the government. The committee, working with the World Health Organisation, was charged with the task of developing a short term plan for HIV prevention and control.¹⁵

In 1987, the National AIDS/STI Control Program (NACP) was established within the Disease Control Unit of the Ministry of Health for the prevention, management, and control of HIV in the country. Basically, the functions of the NACP was the organisation of educational campaigns through the mass media, workshops, video shows, and other channels to inform the public on how to prevent HIV-related risky behaviours, particularly through the use of condoms.¹⁶

Condom promotion was a major focus of the advocacy activities of the Ghanaian government. The Ministry of Health in Accra, in collaboration with Family Health

¹⁵ *Supra* note 11 at 10.

¹⁶ *Ibid.*

International embarked on AIDS prevention with condom promotion among sex workers as it's main goal.¹⁷ This program was initiated barely a year after the first AIDS case was reported in Ghana. This was followed by HIV antibody testing and blood screening facilities, which were introduced in 1987.

The beginning of the 21st century witnessed a major HIV campaign by the Government of Ghana and it adopted a multisectoral approach to HIV/AIDS programming. The Ghana AIDS/STI Commission (GAC)¹⁸ was established as a supraministerial and multisectoral body under the leadership of the President to direct and coordinate all HIV/AIDS activities in the country. GAC was given the mandate to formulate national policies and strategies; to provide high-level advocacy for HIV/AIDS prevention and control; to provide effective leadership in the national planning of programs; to expand and coordinate the national response; to mobilize, manage, and monitor resource allocation and utilization; and to foster linkages and networks among stakeholders.¹⁹

The GAC published the *Ghana HIV/AIDS Strategic Framework: 2001-2005* to guide the national response. Five key interventions were identified: prevention of new infections; care and support for people living with HIV/AIDS; creation of an enabling environment for the national response; decentralized implementation and institutional

¹⁷ *Ibid.*

¹⁸ *Ibid.*

¹⁹ *Ibid.*

arrangements; and research, monitoring, and evaluation.²⁰ Ghana also published the second strategic Framework, *Ghana HIV/AIDS Strategic Framework: 2006 – 2010* with the goal of reducing new infections among vulnerable groups and the general population; mitigating the impact of the epidemic on the health and socio-economic systems as well as infected and affected persons; and promoting healthy life-styles, especially in the area of sexual and reproductive health.²¹

Some achievements were recorded in scaling up of antiretroviral drugs for people living with AIDS in Ghana. For instance, due to availability of funds and the efforts by the implementers of some of the policies in place, the care, treatment, and support for HIV/AIDS patients were scaled-up and the number of people accessing these services increased. About 28 percent of HIV positive pregnant women and 40 percent of adults and children with advanced HIV received Antiretroviral Therapy (ART) services.²²

Also interventions are being promoted to limit the transmission of HIV through heterosexual contacts. Such interventions involve promoting abstinence and faithfulness; promoting reductions in the number of sexual partners; encouraging delays in the onset of sexual activity among adolescents; promoting the correct use of and consistent

²⁰ Ghana AIDS Commission, *Ghana HIV/AIDS Strategic Framework: 2001-2005*. (Accra: Ghana AIDS Commission, 2001).

²¹ Ghana AIDS Commission, *Ghana HIV/AIDS Strategic Framework: 2006 – 2010*. (Accra: Ghana AIDS Commission, 2006).

²² UNAIDS, Ghana's Progress Report on the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS, online, http://data.unaids.org/pub/Report/2010/ghana_2010_country_progress_report_en.pdf (accessed July 6, 2010).

availability of condoms; strengthening programmes for the control of STD; and encouraging voluntary counselling and testing.²³

Behavioural adjustment is necessary to combat HIV in Ghana. However, existing findings reveal that although there is high HIV/AIDS awareness in Ghana, this has not translated to behavioural changes as most Ghanaians believe that they are not personally at risk of contacting the HIV virus.²⁴ This shows the failure of the behavioural adjustment model of HIV/AIDS intervention in Ghana.

3.2.2 Challenges

No doubt, Ghana has many policies and strategies²⁵ in place to tackle the AIDS epidemic, but these policies and strategies are confronted by challenges that undermine

²³ Ghana Ministry of Health, “HIV/AIDS in Ghana: Background, Projections, Impacts, Interventions and Policy”, online, http://www.policyproject.com/pubs/countryreports/GHA_AIM3rdEd.pdf (accessed July 6, 2010).

²⁴ *Ibid.* See also, Akwara, Priscilla A., Gabriel B. Fosu, Pav Govindasamy, Silvia Alayón, and Ani Hyslop, *An In-Depth Analysis of HIV Prevalence in Ghana: Further Analysis of Demographic and Health Surveys Data* (Calverton, Maryland, USA: ORC Macro, 2005).

²⁵ The Government of Ghana through institutions such as GAC, National Development Planning Commission (NDPC), Ministries, Departments and Agencies (MDAs), in collaboration with Civil Society including the private sector, UN Agencies, Multi-lateral and Bi-lateral Development Partners developed a number of Policies, Guidelines, Strategic frameworks, Acts and related legal instruments to create an enabling environment to fight the HIV/AIDS epidemic in Ghana. Significant among these were: *Guidelines for management of Opportunistic Infections and Other Related HIV Diseases: Ministry of Health* October 2008; *Guidelines for Antiretroviral Therapy: Ministry of Health* September 2008; *National Guidelines for Prevention of Mother to Child transmission of HIV (PMTCT): Ministry of Health*, September 2008; *National Guidelines for the Development and the Implementation of HIV counselling and Testing: Ministry of Health*, September 2008; *Guidelines for Management of Sexually Transmitted Infections: Ministry of Health*, September 2008; *National Policy Guidelines on Orphans and Other Children made Vulnerable by HIV/AIDS: GAC*. January 2005; *Early childhood Care and Development Policy: Ministry of Women and*

their effectiveness. However, one has to be careful in drawing conclusions on the effectiveness of the many interventions in Ghana due to the lack of quantitative empirical evidence as regards their impacts on the general population.

The effectiveness of intervention programmes and government strategies have not been formally evaluated. This creates a lacuna and makes it difficult to determine the real impacts of HIV/AIDS prevention and control programmes in Ghana.²⁶ This lack of empirical evidence greatly restricts any analysis of the impacts of programme interventions on the reduction of HIV/AIDS in the country.

From the above, it can be gleaned that Ghana has HIV/AIDS policies and strategies that appear to be well-designed and robust. However, many of the policies lack implementation clarity which may have led to implementation conflicts among implementing agencies. For instance, the Ghana HIV/AIDS Strategic Framework mandates all sector ministries to incorporate HIV/AIDS activities into their programmes and to draw a budget line for such activities. However, as a result of lack of clarity, definition of roles among the implementing agencies remains largely ambiguous.

Children's Affairs; National Social Protection Strategy (NSPS) 2007; National Gender and Children's Policy: Ministry of Women and Children's Affairs; National Domestic Violence Policy: MOWAC, 2008; HIV/TB Workplace Policy for the Revenue Agencies of Ghana: December 2007; HIV/TB Workplace Policy for Serious Fraud office of Ghana, November 2007; HIV/TB Workplace Policy Ministry of Justice December 2008, Growth and Poverty Reduction Strategy (GPRS II) (2006 – 2009), November 2005 (NDPC).

²⁶ See generally P. Bennell, K. Hyde, & N. Swanson, *The Impact of the HIV/AIDS Epidemic On The Education Sector in Sub-Saharan Africa – A Synthesis of the Findings and Recommendations of Three Country Studies*. (Centre for International Education, University of Sussex Institute of Education, 2002).

Also, there is a thin line of division between the functions performed by the NACP and GAC and this might lead to power struggle between the agencies. For instance, the objectives of the NACP are to reduce new infections among the 15 – 49 year age group, improve service delivery and reduce individual and societal vulnerability, as well as establish a multisector and multidisciplinary institutional framework to coordinate programme implementation. However, the GAC, which is seen as the highest policy-making body on HIV/AIDS in Ghana, is mandated to direct and coordinate all activities in the fight against the disease. Apparently, when two bodies are mandated to coordinate the same activity, this will lead to waste of resources and create implementation conflicts between the two bodies.

Also, while the Ghanaian government has shown strong interest in HIV prevention, the political commitment has remained low. There exists a large gap between government policies on HIV/AIDS and the political commitment to implement these policies. This constitutes a major setback to efforts to lower HIV prevalence. Political commitment to the fight against AIDS has been at a rhetorical level and has reduced the momentum in the allocation of adequate funding to support AIDS control activities. The central government has focussed largely on developing policy strategies while ceding funding of activities relating to the policies to external donors.²⁷

Furthermore, the data used in the analysis, estimation and projection of HIV/AIDS are obtained from the sentinel system, built on selected antenatal clinics in the country. Prevalence estimated from such antenatal attendance may not represent

²⁷ See J. N. Fobil & I. N. Soyiri, “An Assessment of Government Policy Response to HIV/AIDS in Ghana”, (2006) 3:2 *Journal of Social Aspect of AIDS* 457 at 464.

prevalence in the general population.²⁸ The antenatal sentinel system is based on an assumption of generalised epidemic conditions and high antenatal attendance. But this cannot serve as an accurate estimate of HIV prevalence rate in the country because the number of pregnant women attending antenatal clinics constitutes a small proportion of women of reproductive age.²⁹ This number excludes sexually active women outside the reproductive age and men who do not attend antenatal clinics. Hence HIV prevalence rate calculated from the sentinel system may be an underrepresentation of the prevalence rate in the general population.

Finally, government policies and strategies on the HIV/AIDS disease in Ghana do not contain provisions that address the factors promoting high-risk behaviours, especially among youth and other vulnerable groups. For instance, it is common knowledge that economic determinants override all factors that promote high-risk behaviours among youth and adolescents but the Ghanaian government efforts in addressing unemployment among youth has remained at a very low ebb. The lack of policy provisions that address both direct and indirect drivers of the rapid spread and transmission of HIV/AIDS has left most control programmes and strategies largely ineffective.³⁰

²⁸ See B. Zaba, T. Boerma, & R. White, “Monitoring the AIDS Epidemic Using HIV Prevalence Data Among Young Women Attending Antenatal Clinics: Prospects and Problems” (2000) 14 *AIDS* 1633-1645.

²⁹ *Supra* note 26.

³⁰ *Ibid* at 464.

3.3 Nigeria

The first two incidences of HIV in Nigeria were identified in Lagos State in 1986.³¹ At the onset of the epidemic, there was lethargy on the part of the Nigerian government in its response to the increasing rates of HIV transmission and it was a case of denial and little action.³² It was only in 1991 that the Federal Ministry of Health assessed the AIDS situation in Nigeria and the result showed that around 1.8 percent of Nigerians are HIV positive.³³ A subsequent surveillance report revealed that during the 1990s, HIV prevalence rose from 3.8 percent in 1993 to 4.5 in 1998.³⁴

Currently, the prevalence rate is estimated at 3.6 percent according to a population based survey.³⁵ Antenatal sentinel survey has also been used to monitor the trend of the epidemic. The prevalence rate among pregnant women in 2008 was 4.6 percent and this can be seen as a sign of progress given the 5.8 percent recorded in 2001.³⁶

³¹ Abdulsalami Nasidi & Tekena O. Harry, "The Epidemiology of HIV/AIDS in Nigeria" in Olusoji Adeyi, *AIDS in Nigeria: A Nation on the Threshold* (Cambridge: Harvard Center for Population and Development Studies, 2006) at 18.

³² P. J. Kanki & O. Adeyi, "Introduction" *Ibid* at 7.

³³ See C.A Sofo, Ali-Akpajiak & Toni Pyke, "Social Development and Poverty in Nigeria", Chapter 3 in *Measuring Poverty in Nigeria*, (Oxfam Working Paper, 2003).

³⁴ *Ibid*.

³⁵ Federal Ministry of Health Nigeria, "National HIV/AIDS and Reproductive Health Survey" (Abuja: NARHS, 2007).

³⁶ UNAIDS, "Nigeria's Progress Report on the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS," online, http://data.unaids.org/pub/Report/2010/nigeria_2010_country_progress_report_en.pdf (accessed July 6, 2010).

In Africa, Nigeria has the second highest number of people living with HIV after South Africa. At the end of 2008, Nigeria had 2.98 million people living with HIV and this makes about 9 percent of the global HIV burden.³⁷ There is gender inequality in the prevalence rate of the virus. HIV estimations and projections in 2008 reveal that 1.23 million males are infected while 1.72 million females are infected with HIV.³⁸ This finding shows Nigerian women are still heavily overburdened by the infection just like other African women. The high prevalence rate among women has a broad range of implications which have been identified in Chapter Two. It is crucial that this gender inequality is addressed if there is to be any meaning check on the epidemic.

3.3.1 Nigeria's Response to HIV/AIDS

The discovery of the HIV virus in Nigeria in 1986 led to the creation of National Expert Advisory Committee on AIDS (NEACA) with the assistance of World Health Organisation.³⁹ This led to the establishment of nine testing centres in the country. Following the increased infection rate in the country, NEACA recommended the development of a short-term plan to combat the spread of the virus. With the assistance of the World Bank and under the guidance of the NEACA, the Federal Ministry of Health (FMH) implemented the comprehensive Medium-Term Plan for the nation's battle against HIV/AIDS.⁴⁰

³⁷ *Ibid.*

³⁸ Adeyi, *supra* note 31.

³⁹ *Supra* note 35.

⁴⁰ *Supra* note 33.

In 1988, the National AIDS Control Program replaced NEACA but still under the auspices of the FMH. The program was expanded in 1991 to include sexually transmitted infections (STIs) and renamed the National AIDS and STDs Control Program (NASCP).⁴¹ This shifted the focus of the NASCP from a multi-sectoral approach to health sector oriented responses to HIV and other STIs. It further developed guidelines on key interventions, which included syndromic management of STIs, voluntary counselling and testing (VCT), prevention of mother-to-child transmission of HIV (PMTCT), and the management of HIV/AIDS, including treatment of opportunistic infection, administration of antiretroviral (ARVs), and home-based care.⁴²

The advent of democratic rule in 1999 led to a change of approach on HIV issue from a medical approach to a multisectoral approach. Drastic measures were taken to curb the rising HIV prevalence rate which peaked at 5.8 percent.

The then President of Nigeria – Olusegun Obasanjo - launched a serious approach to tackle HIV. He placed high priority on HIV prevention, as well as the treatment, care, and support for HIV/AIDS patients. The NASCP was replaced with a broader AIDS control program, which comprises of the Presidential Committee on AIDS and the multisectoral National Action Committee on AIDS (NACA) to coordinate HIV/AIDS programmes at the federal level. At the State and local level, the coordination was done by the State Action Committee on AIDS (SACA) and the Local Government action committee on AIDS (LACA) respectively.

⁴¹ *Ibid.*

⁴² *Ibid.*

The NACA developed the first multisectoral medium-term plan of action, the HIV/AIDS Emergency Action Plan (HEAP). NACA was charged with the responsibility of executing and implementing the HEAP action plan. The HEAP action plan has three main components: to create an enabling environment through the removal of socio-cultural, informational and systemic barriers to community-based responses; to promote prevention; and provide care and support intervention directly.⁴³

The implementation of the HEAP led to increased HIV-related activities in the country with networks formed for Civil Society Organisations (CSOs), People living with HIV/AIDS and HIV/AIDS researchers. Nigeria was also able to attract funding from the World Bank, USAID, DFID, the Bill & Melinda Gates Foundation and the Ford Foundation. Several AIDS projects were implemented all around the country.⁴⁴

Despite progress toward achieving HEAP goals, there remained huge gaps in HIV prevention, treatment, and care services at the community levels. This led to an agitation for a more comprehensive response. Some of the criticisms of HEAP were that states were not effectively mobilised to action, coordination was weak at the centre, and access to services such as PMTCT and antiretroviral treatments was limited.⁴⁵ In 2004, the

⁴³ Federal Ministry of Health of Nigeria, *HIV/AIDS Emergency Action Plan* (Abuja: Federal Ministry of Health, 2001).

⁴⁴ *Supra* note 36.

⁴⁵ Oluwole Odutolu *et.al*, “The National Response to HIV/AIDS” in Adeyi, ed., *supra* note 31 at 249.

National HIV/AIDS Strategic Framework (NSF 2005-2009) was developed.⁴⁶ This replaced the HEAP.

The goal of the NSF was to reduce the HIV incidence and prevalence rate by 25 percent, and to provide equitable prevention, care and treatment, and support while mitigating HIV impact among women, children and other vulnerable groups and the general public by 2009.⁴⁷ However, the NSF is not the only policy document on HIV/AIDS in Nigeria. Other documents include the National Policy on HIV/AIDS, the National Health Policy and Strategy, the National Reproductive Health Policy, the National Youth Development Policy on Women, the National Policy on Population for Sustainable Development, the National Policy on HIV/AIDS in the Workplace, and the National Curriculum on Sexuality Education. Other action plans include the National Health Sector Strategic Plan, and the National Behaviour Change Communication Strategy.

An interesting aspect of these policy documents is the process that led to their adoption. The plans were critically accessed at different stages by various stakeholders, including ten key ministries at different levels of government (health, education, defence, internal affairs, information, women and youth, labour, agriculture and rural development, police affairs, and culture and tourism); the organized private sector; nongovernmental organizations; community-based organisations; donor agencies; the

⁴⁶ See National Action Committee on AIDS, *HIV/AIDS Strategic Framework 2005 – 2009* (Abuja: National Action Committee on AIDS, 2005).

⁴⁷ *Ibid.*

academic community; faith-based organisations; and women and youth organisations.⁴⁸ The involvement of many organisations in the formulation of these documents gave them the multisectoral approach necessary for effective HIV/AIDS programming in Nigeria and it is laudable.

However, one major weakness of these policies is the lack of effective communication of the policies from the federal level to the lower tiers of government, which are expected to implement the policies.⁴⁹ For instance, few of the SACAs and LACAs that are charged with translating the multisectoral approach to HIV prevention and impact mitigation into reality on the ground are engaged in such transformation activities.⁵⁰ In addition, a dominant feature of these policies is the total reliance on external donor agencies and their implementing partners to fund the plans.

3.3.2 Private Sector Participation

The Nigerian government established the public-private sector forum to harness the vast private sector resources and expertise to further improve the federal government initiatives on AIDS. Currently, there exists the Nigerian Business Coalition against HIV/AIDS which comprises of thirty-nine multinational companies such as MTN, Coca-

⁴⁸ See Action Aid/Nigeria, *Mapping Civil Society's Involvement in HIV/AIDS Programmes in Nigeria* (Abuja: Action Aid, 2001).

⁴⁹ See generally, Ahanihu E, *Closing Ranks: An Account of Nigeria's Response to HIV/AIDS, 1986–2003* (Ibadan: Spectrum Books, 2005); ActionAid/Nigeria, *Mapping Civil Society's Involvement in HIV/AIDS Programmes in Nigeria* (Abuja: ActionAid, 2001); National Action Committee on AIDS. *National HIV/AIDS Behavior Change Communication Strategy (2004–2008)* (Abuja: National Action Committee on AIDS, 2004).

⁵⁰ Ahanihu *ibid* at 250.

Cola, Julius Berger, Nigerian Breweries, Cadbury, Guinness, and Chevron among others. This coalition supports workplace programs on HIV/AIDS including prevention and treatment.⁵¹

Multinational companies in Nigeria also support outreach programmes as part of their Corporate Social Responsibility either directly or through partnerships with local organisations. For instance, NACA partnered with ECOBANK to establish youth friendly reproductive health centres at seven universities with the goal of providing AIDS information, counselling services, and training of youth peer educators.⁵² There is also partnership between NACA, Liquefied Natural Gas Company, Shell and Exxon-Mobil to provide comprehensive prevention, treatment and care and support worth over 500 million Naira in communities in the Niger Delta of Nigeria through the IBANISE Art program.⁵³

However, the public-private partnership initiatives on HIV/AIDS suffer some shortcomings. First, the scope and the engagement of the initiatives are limited to multinationals, thereby denying the participation of small scale and medium scale enterprises in HIV/AIDS activities. Second, there is an active discrimination and stigma against people living with HIV/AIDS in the private sector workplace and this constitutes a major shortcoming of private sector settings.

⁵¹ *Supra* note 36.

⁵² *Ibid.* These universities are Universities of Abuja, University of Uyo, University of Jos, University of Nigeria Nsukka, University of Port Harcourt, Obafemi Awolowo University Ile –Ife, and Ladoke Akintola University of Technology Ogbomosho.

⁵³ *Ibid.*

3.3.3 Civil Society Participation

Civil Society Organisations in HIV/AIDS intervention in Nigeria are primarily community-based and faith-based organisations with small scale welfare services.⁵⁴ The first instance of civil society participation in HIV/AIDS activities dates back to 1985 when the Society for Family Health (SFH), a national NGO based in Abuja, Nigeria established an HIV prevention programme that focused primarily on the social marketing of condoms.⁵⁵

Another example of HIV/AIDS interventions by CSOs can be found in the work of the national chapter of the Society for Women and AIDS in Africa (SWAAN). The SWAAN has provided prevention education, voluntary HIV counselling, and community home-based HIV care services among low-income women across Nigeria, including sex workers since, 1990.⁵⁶ SWAAN was founded in 1989 as a national volunteer organisation of professional and community women. Its membership has grown tremendously and it has branches in 22 states.⁵⁷

⁵⁴ See generally, E. Ahanihu, *Closing Ranks: An Account of Nigeria's Response to HIV/AIDS, 1986–2003* (Ibadan: Spectrum Books, 2005); K. S. Touray, *Mapping of Support Groups for People Living with HIV/AIDS (PLWHAs) in Nigeria: National Report* (Abuja: National Action Committee on AIDS, 2005).

⁵⁵ Society for Family Health, “*SFH News*, January – June 1997” cited in “A Nation on the Brink, *supra* note 31; Population Services International, *SFH: first Nigerian NGO to get direct U.S. funding. Profile: Social Marketing and Communications for Health*, June 2005.

⁵⁶ See N.D. Mba, *Youth-for-Youth Health, Gender and Development NGOs: Report of a Mapping Exercise Prepared for the Ford Foundation* (Lagos: Ford Foundation, 2004).

⁵⁷ Life Link Organisation (Nigeria), LLO Newsletter (10th anniversary issue), 2004; 1:1-3, cited in *Nigeria: A Nation on the Threshold* (Cambridge: Harvard Center for Population and Development Studies, 2006).

SWAAN used culturally sensitive information materials, community outreach, and participatory activities to mobilize nearly 3,500 peer health educators for HIV prevention education in schools across Nigeria between 1996 and 2000; provided income and safer sex negotiating skills training to more than 500 sex workers between 1996 and 2001; and provided home visits, care, and psychosocial support to PLWHAs in nine states through more than 90 members and more than 200 community health workers it trained for this purpose.⁵⁸ Due to the culturally sensitive nature of HIV prevention in Nigeria, it can be reasonably presumed that the HIV prevention efforts of SWAAN will positively impact the prevention initiatives by the number of people they have trained and reached through their many outreach programs.

CSOs have also been involved in piercing the stigmatization of HIV patients in Nigeria. Overcoming stigmatization represents one of the most challenging community-based projects. Nigerians living with HIV often experience discrimination, abandonment and neglect due to the disease. Stigmatizations in Nigeria vary based on class. Upper-class families tend to hide or deny the fact that a family member is HIV positive due to the fear of losing social standing. They tend to reject a family member and withdraw financial support to avoid society's censure.⁵⁹ Those in lower socioeconomic classes also shield their HIV positive status due to the fear of losing their jobs or suffering reprisal from the privileged.⁶⁰

⁵⁸ *Supra* note 51 at 257.

⁵⁹ FHI Nigeria, "Nigerian NGOs Foster a Caring Community," online, <http://www.fhi.org/en/HIVAIDS/pub/Archive/articles/IOH/ioh11/ioh112.htm> (accessed July 6, 2010).

⁶⁰ *Ibid.*

3.3.4 Challenges

Despite the proliferation of policy documents on HIV/AIDS in Nigeria, there are still some shortcomings that undermine the national response to the AID epidemic. First, there is lack of adequate HIV testing programming. In 2007, only 3 percent of health facilities had testing and counselling services,⁶¹ and only 11.7 percent of women and men aged 15 – 49 had done HIV test and were aware of the result.⁶² It has been suggested that some health facilities in Nigeria do not follow international standards about confidentiality and ethics.⁶³ In one particular study, over half of people living with HIV reported that they did not know they were being tested for the virus and around one in seven health care professionals admitted to never receiving informed consent for HIV tests.⁶⁴

Furthermore, sex is still viewed as a private subject in Nigeria and attempts to provide sex education to teenagers has been hindered by cultural and religious barriers.⁶⁵ In 2009, only 23 percent of schools were providing life skills based HIV education, and just 25 percent of men and women between the ages of 15 and 24 correctly identified ways to prevent sexual transmission of HIV and rejected major misconceptions about

⁶¹ WHO, UNAIDS & UNICEF ‘Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions In The Health Sector’, WHO online, http://www.who.int/hiv/pub/towards_universal_access_report_2008.pdf (accessed July 6, 2010).

⁶² *Supra* note 36.

⁶³ Physicians for Human Rights (2006) “Nigeria: Access to Health Care for People Living with HIV and AIDS,” online, <http://physiciansforhumanrights.org/library/documents/reports/nigeria-access.pdf> (accessed July 6, 2010).

⁶⁴ *Ibid.*

⁶⁵ O. Odotolu, *et.al* in Adeyi, ed., *supra* note 31 at 249.

HIV transmission.⁶⁶ In some regions of Nigeria girls marry relatively young, often to much older men. In North Western Nigeria around half of girls are married by age 15 and four out of five girls are married by the time they are 18.⁶⁷ Studies have found those who are married at a younger age have less knowledge about HIV and AIDS than unmarried women, and are more likely to believe they are low-risk for becoming infected with HIV.⁶⁸ HIV and AIDS education initiatives need to focus on young married women, especially as these women are less likely to have access to health information than other women.⁶⁹

Nigeria's programme to prevent the transmission of HIV from mother to child (PMTCT) started in July 2002.⁷⁰ Despite 'considerable efforts' to strengthen PMTCT interventions, by 2007 only 5.3 percent of HIV positive women were receiving antiretroviral drugs to reduce the risk of mother-to-child transmission. This figure has risen to almost 19 percent by 2010, but still remains far short of universal access targets.⁷¹

⁶⁶ *Supra* note 36.

⁶⁷ The Population Council, Inc., "The Experience of Married Adolescent Girls in Northern Nigeria", online, http://www.popcouncil.org/pdfs/Nigeria_MarriedAdol.pdf (accessed July 6, 2010).

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

⁷⁰ National Agency for the Control of AIDS (2010) "National HIV/AIDS response review 2005-09", Abuja Nigeria.

⁷¹ *Supra* note 36.

Nigeria instituted the national AIDS treatment program in 2002 geared towards expanding access to antiretroviral drugs.⁷² The programme aimed to supply 10,000 adults and 5,000 children with antiretroviral drugs within one year. An initial \$3.5 million worth of ARVs were to be imported from India and delivered at a subsidized monthly cost of \$7 per person.⁷³ The program was described as as 'Africa's largest antiretroviral treatment programme'.⁷⁴

However, in 2004, the programme suffered a major setback as too many patients were being recruited without enough supply of drugs to administer. This resulted in an expanding waiting list and shortage of drugs due to the high demand. The patients who had already started the treatment then had to wait for up to three months for more drugs, which can not only reverse the progress the drugs have already made, but can also increase the risk of HIV becoming resistant to the ARVs. Eventually, another \$3.8 million worth of drugs were ordered and the programme resumed.⁷⁵ ARVs were being administered in only 25 treatment centres across the country which was far from adequate attempt at helping the estimated 550,000 people requiring antiretroviral therapy. As a

⁷² See Abantu for Development, *Empowering Youth Through Comprehensive Reproductive Health Programs*. London (Accra: Abantu for Development, 2004); Action Aid/Nigeria *Mapping Civil Society's Involvement in HIV/AIDS Programmes in Nigeria* (Abuja: Action Aid, 2001).

⁷³ *Supra* note 59.

⁷⁴ See generally, O. Falobi & O. Akanni, ed., *Slow Progress: An Analysis of Implementation of Policies and Action on HIV/AIDS Care and Treatment in Nigeria* (Lagos: Journalists Against AIDS, 2004).

⁷⁵ Avert, "HIV/AIDS in Nigeria", online, <http://www.avert.org/aids-nigeria.htm> (accessed July 6, 2010).

result, in 2006 Nigeria opened up 41 new AIDS treatment centres and started handing out free ARVs to those who needed them.⁷⁶

Resources needed to provide sufficient treatment and care for those living with HIV in Nigeria are seriously lacking. A study of health care providers found many had not received sufficient training on HIV prevention and treatment and many of the health facilities had a shortage of medications, equipment and materials.⁷⁷

The National HIV/AIDS Strategic Framework for 2005-2009 set a target of providing ARVs to 80 percent of adults and children with advanced HIV infection and to 80 percent of HIV-positive pregnant women by 2010.⁷⁸ However, only 34 percent of people with advanced HIV infection were receiving ARVs in 2010.⁷⁹ In the revised framework (from 2010-2015), the date for achieving the treatment goals was pushed to 2015.⁸⁰

3.4 West Africa's Regional Response to HIV/AIDS in the Military

As mentioned earlier, some regional initiatives on HIV/AIDS have been put into place in Africa. For example, in 2001, the AU adopted the Abuja Declaration and Plan of

⁷⁶ Reuters Limited, "Nigeria Opens 41 New AIDS Treatment Centres", online, <http://www.aegis.com/news/re/2006/RE060316.html> (accessed July 6, 2010).

⁷⁷ Physicians for Human Rights, *supra* note 63.

⁷⁸ WHO, UNAIDS & UNICEF, *supra* note 61.

⁷⁹ *Supra* note 36.

⁸⁰ National Agency for the Control of AIDS (NACA) (2009, December) "National HIV/AIDS Strategic Framework (NSF) 2010-15", online, http://www.naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=58&Itemid=268 (accessed July 6, 2010).

Action for HIV/AIDS, Malaria and Tuberculosis.⁸¹ The Abuja declaration was reaffirmed by the AU in May 2006, through an African Common Position on HIV/AIDS, which was submitted to the June 2006 UN General Assembly Special Session on AIDS. The Common Position calls on African leaders to integrate measures to address the HIV/AIDS pandemic with other efforts to fight poverty and food insecurity; treat essential medicines and other basic services as a human right; provide prevention, treatment and care for people affected by conflicts, such as refugees and internally displaced persons, increase the percentage of the continent's health workforce from its global number of 25 percent; exempt healthcare from the spending ceilings imposed by African finance ministers and ensure that officials mandated to respond to HIV/AIDS are accountable to parliaments and civil society through parliamentary review of policies and other measures.⁸²

However, one of the shortcomings of the Abuja plan of action is that while it commits African States to devoting at least 15 percent of national budgets to the health sector, the initiative did not explicitly address HIV/AIDS in the continent's defence force.

⁸¹ African Union, "Abuja Declaration and Framework Plan of Action on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases", online, http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (accessed 23 March 2010).

⁸² African Union, "Common Position on HIV/AIDS," Sp/Assembly/ATM/3 (I) Rev.2, online, http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/UNGASS_Common_Position.pdf (accessed 23 March 2010).

ECOWAS as a regional organisation developed a Plan of Action for 2004 – 2006 for the control of sexually transmitted infections and HIV/AIDS within the armed forces sector. However, there is nothing on ground to show how ECOWAS will incorporate HIV/AIDS into the training of the West African brigade (ECOWASBRIG) of the ASF to be set up in 2010. This shows that West African countries are yet to respond to HIV/AIDS as a strategic issue that could compromise their effectiveness. A shortcoming of existing measures in West African Military programming of HIV/AIDS initiatives in terms of prevention, voluntary counselling, testing, care and support is that there are little initiatives to tackle the possible loss of military personnel to the pandemic.⁸³

Sierra Leone has established an HIV/AIDS work-place policy.⁸⁴ This policy protects military personnel from being dismissed from service because of their HIV status, and makes an urgent call for antiretroviral drugs to be made available free of charge to military personnel through grants from the World Bank and the Global Aids Fund.⁸⁵

The Sierra Leonean military programme on HIV/AIDS involves education activities such as the integration of HIV/AIDS activities into the military training curriculum, and sensitising trainers to the importance of HIV/AIDS and regular workshops with battalion commanders; training soldiers' wives, female soldiers and the

⁸³ Centre for Conflict Resolution, "HIV/AIDS and Militaries in Africa," online, http://www.ccr.org.za/images/stories/Vol_28_hivaidis_militaries.pdf (accessed 23 March 2010).

⁸⁴ Dr James Samba, "HIV Prevention and Mitigation: the Republic of Sierra Leone Armed Forces", presentation made at the HIV/AIDS and Militaries and Peacekeeping in North and West Africa Workshop in Cairo, Egypt, 8 and 9 September 2007, cited in "HIV/AIDS and Militaries in Africa," *ibid.*

⁸⁵ *Ibid.*

leaders of women groups – “mammy queens” - to act as peer educators and counsellors; training counsellors in each brigade and battalion; establishing voluntary counselling and testing centres in each brigade; establishing a programme to improve knowledge of reproductive health; the distribution of condoms and the provision of ARVs to soldiers living with HIV/AIDS and their families.⁸⁶

Furthermore, the Sierra Leonean government also explores the media for HIV/AIDS programming. Annual concerts are conducted to raise awareness about HIV and about how military personnel can protect themselves and their families from the disease.⁸⁷ It also records short audio-visual dramas for distributions to all brigades, battalion and garrisons.⁸⁸

Likewise in Ghana, the military established a Technical Committee on AIDS which was mandated with implementing HIV/AIDS activities and setting up an effective mechanism for HIV/AIDS surveillance.⁸⁹ The Ghanaian army first responded to the HIV/AIDS pandemic in 1989 with the establishment of the Ghana Armed Forces AIDS Control Programme (GARACP) mandated to design HIV/AIDS programmes to reduce the spread of STIs and HIV/AIDS within its ranks. During this period, a policy was formulated to promote the health of troops and their families, as well as address HIV/AIDS.

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*

⁸⁹ Dr Jane Ansah, “HIV/AIDS and Militaries in West Africa: The Ghanaian Experience”, presentation made at the HIV/AIDS and Militaries and Peacekeeping in North and West Africa workshop in Cairo, Egypt, 8 and 9 September 2007, cited in “HIV/AIDS and Militaries in Africa,” *ibid.*

The policy provides for awareness-raising and advocacy within the military command; ongoing HIV/AIDS education, including incorporating an HIV/AIDS component into the training curricula for young recruits and ongoing awareness-raising among in-service personnel, as well as refresher and upgrade courses; the provision of voluntary testing and counselling facilities for both troops and their families; and the training and deployment of STI/HIV/AIDS counsellors and peer educators.⁹⁰

Furthermore, the policy precludes HIV-positive potential recruits from joining the Ghana Armed Forces; while in-service personnel are tested prior to deployment. Those found to be HIV-positive are not allowed on peacekeeping missions or other local deployments, but are allowed to remain within the Ghana Armed Forces and to continue to work for as long as they are able to.⁹¹ The soldiers and their families are guaranteed access to full medical facilities and treatment for opportunistic infections, as well as ARVs. The policy also stipulates that all Ghanaian troops going on overseas courses must be HIV-negative.⁹² However, this policy negates the Voluntary, Counselling and Testing (VCT) principle advanced by the UN Department of Peacekeeping Operations (DPKO). It is also a breach of the principles of human rights provisions that no one shall be subjected to medical test without her/his consent. This is a contentious issue, physical fitness is an essential feature of military service and HIV/AIDS without treatment erodes the physical fitness that military personnel are expected to possess. As will be discussed

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² *Ibid.*

in Chapter four of this thesis, access to essential medicines is greatly limited in West Africa and antiretroviral drugs are not accessible by all including military personnel.

No doubt, many African states have been mobilised to develop strategies on HIV/AIDS and this has led to the creation of national commissions on HIV/AIDS in most African nations. However, what is lacking is the harmonisation of national policies within the West African region to form an effective regional mechanism on HIV/AIDS.

3.4.1 Shortcomings of Existing Measures on HIV/AIDS within the Military

Certain shortcomings bedevil the existing regional measures on HIV/AIDS. First, existing data on infection rates within the military is soft and not conclusive. This is due to the fact that few African countries have the capacity to collect and analyse the data required to generate accurate estimates. Even then, the existing estimates do not include the infection rate among rebel groups and other paramilitary groups. Second, West African countries as well as other African countries are struggling with lack of manufacturing capacity in the pharmaceutical industry, which is crucial in tackling the HIV/AIDS epidemic.

Third, West African countries are burdened by the incapacity to provide adequate food security for the diverse nutritional needs of their citizens who are infected with AIDS. Fourth, West Africa lacks the ability to train and retain skilled medical and other human resources that will support research and administer new regimes of drugs as well as care and treatment. Furthermore, the ability to develop a health system that includes both public and private entities as well as research and developmental capacity is lacking.

Fifth, there are currently weak social and economic structures within West African countries thus hinders the political leadership needed to tackle the epidemic. The absence of a strong leadership in the fight against AIDS on the continent constitutes an albatross on any regional mechanism on AIDS in the continent.

Finally, HIV/AIDS initiatives in West Africa are uncoordinated, hence their inability to improve HIV/AIDS prevention and treatment. Efforts to curb the spread of HIV/AIDS in West Africa can benefit from a well coordinated integration process. Integration will provide a platform to harness the region's huge capital, human, material and scientific resources to improve the lives of people in the region. While various aspects such as transport, commerce, telecommunication, finance have benefited greatly from integration efforts in the West African Region, the health sector has not benefited from such integration.

The benefits of regional integration are countless. Regional integration will eliminate political, social and economic restrictions to mobility and resource flows. This will further facilitate increase in exchanges and movements of people across borders within West Africa. Integration further provides an opportunity for promoting synergies and the harmonisation of HIV/AIDS policies within the region. It also offers an opportunity to synchronise HIV/AIDS interventions and collectively mobilise resources in the region and it will facilitate access to global resources such as Global Fund to fight AIDS, Tuberculosis, and Malaria.

Also, national health policies can be co-ordinated to increase the effectiveness of health systems. The supply and production of medicines, as well as vaccine research, may

not be efficient unless undertaken at the West African regional level. However, one disadvantage of integration is that it can further spread HIV/AIDS within the region due to free mobility. Therefore, mainstreaming of HIV/AIDS policies within the region require a strong political support.

3.5 Conclusion

This chapter has examined the regional responses to HIV/AIDS in West Africa using Nigeria and Ghana as case studies. I have explored the military approach to HIV/AIDS in West Africa. No doubt, there are many policies on the pandemic in the West African region. What is needed is a solid roadmap that will benefit from regional integration in West Africa.

The next chapter will examine the provisions of the Trade Related Aspect of Intellectual Property Rights (TRIPS) as barrier to access to essential medications while suggesting ways in which West African countries can utilise the provisions of TRIPS to provide essential medications to HIV-positive people in the region.

CHAPTER FOUR

TRADE-RELATED ASPECTS OF INTELLECTUAL PROPERTY RIGHTS (TRIPS) AS A BARRIER TO ACCESS TO ESSENTIAL MEDICATIONS

4.1 Introduction

The scale of the HIV/AIDS epidemic and its devastating implications for the socio-economic development of West Africa has made the issue of access to essential medicines an urgent one. The dire need for HIV medications is particularly urgent in Africa because of the high rate of HIV/AIDS-related deaths. This problem is succinctly summarised by Edwin Cameron, an openly HIV-positive South African Appellate Court judge in the following words:

Nearly 34 million people in our world are at this moment dying [of AIDS]. And they are dying because they don't have the privilege that I have, of purchasing my health and life... Now why should I have the privilege of purchasing my life and health when 34 million people in resource-poor world are falling ill, feeling sick to death, and dying? That to me...seems a moral inequity of such fundamental proportions that no one can look at and fail to be spurred to thought and action about it. That is something which we in Africa cannot accept. It is something that the developed world cannot accept.¹

In South Africa, only 25 percent of the estimated four million HIV-infected people are able at current prices to afford access to life-sustaining AIDS medication. In Malawi the reported figure is 30 out of one million infected Malawians. In Uganda, about 1.2

¹ E. Cameron, Press conference, XII International AIDS Conference, Durban, South Africa, July 10, 2000, cited in M. Harrington, "Brazil: What Went Right? The Global Challenge of Access to Treatment and The Issue of Compulsory Licensing," Address to the 10th National Brazilian Meeting of People Living With HIV and AIDS, online, <http://www.aidsinfonyc.org/tag/activism.brazil.html> (accessed July 6, 2010).

percent of the people living with AIDS can afford any of the drugs used to treat the illness.² This picture is replicated all over the African region.

Attempts will be made in this chapter to critically consider the World Trade Organisation's (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) as regards access to essential medications. In addition, the chapter examines some of the rationale for the exorbitant prices of essential medications by pharmaceutical companies and concludes by advancing some perspectives on solving the problem of access to essential medications in Africa.

4.2 TRIPS

The TRIPS has some restrictive provisions which many developing countries see as impediments to their effort to address public health emergencies.³ These provisions appear to restrict drug availability in developing countries through high prices of drugs.⁴ It has have argued that the introduction of patents into the developing world restricts sustainable development and perpetuates their dependence upon developed nations.⁵

² AFP Report, "Price Cuts Have Little Impact on Access to AIDS Drugs in Uganda," March 23rd, 2001 cited in Udo Schuklenk & Richard Ashcroft, "Affordable Access to Essential Medication in Developing Countries: Conflicts Between Ethical and Economic Imperatives," in Anton A. Van Niekerk & Loretta M. Kopelman, ed., *Ethics and AIDS in Africa* (South Africa: David Philip Publishers, 2005).

³ A detailed analysis of the provisions of the TRIPS can be found in Ellen t' Hoen, *The Global Politics of Pharmaceutical Monopoly Power: Drug Patents, Access, Innovation and the Application of the WTO Doha Declaration on TRIPS and Public Health* (Netherlands: AMB Publishers, 2009).

⁴ *Integrating Intellectual Property and Development Policy*, UK Commission on Intellectual Property (CIPR), September 2002, 41.

⁵ Samuel A. Oddi, "TRIPS- Natural Rights and a 'Polite Form of Economic Imperialism'" (1996) 29 Vand. J. Transnat'l L. 415.

Pharmaceutical manufacturers in developed countries view the TRIPS agreement as essential to innovation in the pharmaceutical sector by assuring international compensation for their intellectual property.⁶ It is also firmly believed that the introduction of full-fledged patent system around the globe will provide needed incentives for investment and innovation.⁷ The pharmaceutical industry claims that without the intellectual property rights guaranteed under the TRIPS, it could not recoup the high cost of developing medicines because developing countries are hubs for piracy activities, having not introduced legal mechanisms to deal with piracy.⁸

A patent can be defined as “a statutory grant which confers on an inventor or his legal successor, in return for the disclosure of the invention to the public, the right to exclude others from using the invention for a limited period of time.”⁹ To qualify as a patentable subject matter under the TRIPS, an invention (which may be a product or a process) must be “...new, involve an inventive step and (be) ... capable of industrial application.”¹⁰ The TRIPS further provides that, the terms ‘inventive step’ and ‘capable of industrial application’ may be deemed by a Member to be synonymous with the terms ‘non-obvious’ and ‘useful’ respectively.¹¹ Therefore under Article 27.1 of the TRIPS, a

⁶ Pharmaceutical Research and Manufacturers of America, *Intellectual Property*, Online, PhRMA, <http://www.phrma.org/issues/intprop> (accessed July 6, 2010).

⁷ Evelyn Su, “The Winners and The Losers: The Agreement on Trade-Related Aspects of Intellectual Property Rights and Its Effects on Developing Countries” (2000) 23 *Hous. J. Int’l L.* 169.

⁸ United States International Trade Commission, *Foreign Protection of Intellectual Property Rights and the Effects on the US industry and trade*, 1988. Publication No. 2065.

⁹ Ernst Jucker, *Patents and Pharmaceuticals* (Basle: Buchdruckerei Gasser & Cie AG, 1980) 16.

¹⁰ TRIPS, Article 27.1

¹¹ Article 27.1 of TRIPS.

patent will be granted if an invention conforms to the requirements of novelty, inventive step, and industrial applicability.

Specifically in the pharmaceutical industry, patents give inventors a temporary monopoly for a twenty-year period over patented pharmaceuticals, thereby permitting the patent-holder to charge whatever price it deems fit on patented drugs.¹² The patent protection on a drug may extend to any other improved version or process of the same drug.¹³

The TRIPS allows all WTO member countries to adopt “certain minimum standards for protection of private intellectual property rights”, including pharmaceutical inventions.¹⁴ Generally, pharmaceutical companies rely on Article 27.1 of TRIPS to obtain patents, in countries different from their home countries, since the provision imposes on all members of the WTO an obligation by which “patents shall be available for any inventions, whether products or processes, in all fields of technology, provided they are new, involve an inventive step and are capable of industrial application”. The TRIPS therefore guarantees patent protection for all inventions for twenty years, beginning from the date of first filing.¹⁵ The rationale for the twenty year period is to

¹² Pascale Boulet, Christopher Garrison & Ellen ‘t Hoen, *Drug Patents under the Spotlight: Sharing Practical Knowledge about Pharmaceutical Patents* (Geneva: Medecins Sans Frontieres, 2004) at 2.

¹³ The Rt. Hon. Sir Robin Jacob, Daniel Alexander & Lindsay Lane, *A Guidebook to Intellectual Property: Patents, Trade Marks, Copyright and Designs*, 5th ed. (London: Sweet & Maxwell, 2004) at 18.

¹⁴ See TRIPS, paras (a), (b) and (c).

¹⁵ TRIPS, Article 33.

compensate for the delays usually experienced by drug and other products producers when securing regulatory approval before the domestic sale of such products.¹⁶

Different types of pharmaceutical patents are operational in developing countries.¹⁷ These are: *Product patents* (covering the pharmacologically active chemical or formulation), *Process patents* (covering a manufacturing process for the same) and *Use patents* (covering the use of a drug for a medical indication).¹⁸ All these types of patents give the patent holder an exclusive right to manufacture and sell the patented product.

4.3 Rationale for Patent Protection

There are two schools of thought on the rationale for granting patents. These can be categorized into the ‘incentive theory’ and the ‘natural right’ schools of thought. The incentive theory has two fronts. There is the incentive to invent and innovate and the incentive to disclose trade secrets. In the context of pharmaceutical patents, the incentive to invent and innovate rather than the incentive to disclose trade secrets seems to be the overriding justification for the granting of patents. Under the incentive to invent theory, proponents view the patent system and its dominant feature of monopoly as providing incentives for individuals to engage in innovative ventures.¹⁹ It has been argued that “without the prospect of an exclusive right to use the invention (and a possibility of recouping the money invested in the development of the invention), investments in

¹⁶ Trevor Cook, *A User's Guide to Patents* (London: Butterworths Lexis' Nexis, 2002) at 272.

¹⁷ Amir Attaran & Lee Gillespie-White, “Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa?” (2001) 286 JAMA 1886 at 1887.

¹⁸ *Ibid.*

¹⁹ Roger E. Schechter & John R. Thomas, *Principles of Patent Law* (Minnesota: Thomson West, 2004) at 9.

research and development would not be attractive enough and too little inventing would be done.”²⁰ The proponents of the incentive to invent theory contend that without a patent system, inventions could be easily duplicated or exploited by other people- also known as free riders- who would have incurred no cost to develop and perfect the idea involved, and who could thus undersell the inventor.²¹

The pharmaceutical industry argues that prices of medicines are necessarily high because medical innovation is expensive²² and that research and development (‘R&D’) enterprise must be nurtured by high prices to yield the next generation of breakthrough therapies. The chief proponent of this view, the Pharmaceutical Research and Manufacturers of America (‘PhRMA’)²³, argues that it takes 10-15 years and cost \$800 million on average to bring a new medicine to the market.²⁴ This argument has however been challenged. It has been stated that much of the profits going to pharmaceutical companies are used for marketing and other expenses rather than for R&D.²⁵

²⁰ Sigrid Sterckx, “The Ethics of Patenting- Uneasy Justifications” in Peter Drahos, ed., *Death of Patents* (London: Lawtext Publishing Limited, 2005) at 193.

²¹ See Rebecca Eisenberg, “Patents and the Progress of Science: Exclusive Rights and Experimental Use” (1989) 56 U. Chi. L. Rev. 1017.

²² Kevin Outterson, “Pharmaceutical Arbitrage: Balancing Access and Innovation in International Prescription Drug Markets” (2005) 5 Yale J. Health Pol’y, L & Ethics 193-194.

²³ The PhRMA is the U.S Trade Association for Research Pharmaceutical and Biotechnology Companies. http://www.phrma.org/about_phrma.

²⁴ Pharmaceutical Research and Manufacturers of America, *Intellectual Property*, online, PhRMA, <http://www.phrma.org/index.php?option=com> (access July 6, 2010).

²⁵ Ellen ‘t Hoen, “TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha” (2002) 3 Chicago J. Int’l L. 29.

The second ground of the ‘incentive theory’ is the incentive to disclose which is based on the desirability for public disclosure of an invention. The patent system encourages inventors to disclose their inventions instead of keeping them secret. Inventors have to disclose sufficient information about their invention in order to obtain patent protection. Advocates of the incentive to disclose argument describe the granting of patents as a social contract between the society and the inventor: “society gives the inventor a temporary monopoly in return for which the inventor discloses his secrets.”²⁶ But the incentive to disclose has been criticized as discouraging instead of encouraging inventions and innovations. For example, Sigrid Sterckx argues that patent granting authorities do not often take seriously the requirement of sufficiency of disclosure, hence “patents with unduly broad claims are granted.”²⁷

However, in contrast to the incentive theory, the natural rights school argues that persons have a natural right of property in their labour. The famous proponent of this theory is the philosopher, John Locke. Locke asserts that individuals should enjoy a property entitlement to the products of their labour, and innovators too should be entitled to enjoy the fruits of their labour by being granted an exclusive right to their inventions.²⁸

²⁶ Sigrid Sterckx, “The Ethics of Patenting- Uneasy Justifications” in Peter Drahos, ed., *Death of Patents* (London: Lawtext Publishing Limited, 2005) 198-199.

²⁷ Sigrid Sterckx, “European Patent Law and Biotechnological Inventions” in Sigrid Sterckx (ed.) *Biotechnology, Patents and Morality*, 2nd Ed. (Aldershot: Ashgate, 2000) at 21 - 25.

²⁸ Peter Laslett, ed., *John Locke’s Two Treatises of Government*, 2d ed, 1967; Wendy Lim, “Towards Developing a Natural Law Jurisprudence in the US Patent System” (2003) 19 Santa Clara Computer & High Tech. L. J. 559.

The effects of patent protection in respect to essential medication is that ARVs are unaffordable by those who desperately need them in Africa as well as other developing countries.²⁹ Availability of ARVs is crucial for the treatment of HIV positive people but the cost of the drugs has made the treatment inaccessible to most of those infected.³⁰ Most African countries cannot purchase these needed drugs from brand name manufacturers in developed countries because of the high cost of the drugs. This is the crux of the treatment intervention in Africa. The lack of access to essential medication due to the exorbitant prices charged on these essential medications constitutes a threat to the human security of the people of Africa.

However, a contrary position has been advanced by the Center for International Development at Harvard University and the World Intellectual Property Organization (WIPO) that “it is doubtful that patents are to blame for the lack of access to antiretroviral drug treatment in most African countries...other factors, and especially the ubiquitous poverty of Africa countries, must be more to blame.”³¹ Industry-supported American think tanks such as the American Enterprise Institute, the International Intellectual

²⁹ Michael Selgelid & Eline Sepers, “Patents, Profits, and the Price of Pills: Implications for Access and Availability” in Jillian Cohen, Patricia Illingworth & Udo Schuklenk, eds, *The Power of Pills: Social, Ethical and Legal Issues in Drug Development, Marketing and Pricing* (London: Pluto Press, 2006) at 156.

³⁰ On this point, see Robert Hogg & Amy Weber, et al., “One World, One Hope: The Cost of Providing Antiretrovirals to all Nations” (1998) 12:16 AIDS 2203- 2209.

³¹ Attaran & Gillespie- White 2001, *supra* note 14 at 1890.

Property Institute (IPI) and the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) have also advanced this view.³²

Amir Attaran supports this position by arguing that patents for essential medicines are uncommon in poor countries and cannot readily explain why access to those medicines are often lacking, suggesting that poverty, not patents, imposes the greater limitation on access.³³ In fact, Attaran & Gillespie-White argue that “because geographic patent coverage do not appear to correlate with anti-retroviral treatment access in Africa, patents and patent law are not a major barrier to treatment access in and of themselves.”³⁴ However, Attaran & Gillespie-White have been criticised for failing to consider the drug combination required for effective therapy in the particular context of Africa.³⁵

Also, Attaran and Gillespie-White did not take into cognizance the extent to which patents on drugs in one country could have adverse access implications for other countries within the same region.³⁶ South Africa, for instance, has the largest number of

³² Eric Noehrenberg, *Report of the Commission on Intellectual Property Rights, Innovation and Public and Public Health: An industry Perspective* (2006) 84 Bull. World Health Org. 419; IFPMA, *WHO Commission Report on Biomedical Innovation, Patents and Public Health Contains many Sound Proposals but Mistakenly Underestimates the Vital Role of Patents*, April 3, 2006, Online, <http://www.ifpma.org/News/NewsReleaseDetail.aspx?nID=4628> (accessed 6 July, 2010).

³³ Amir Attaran, *How do Patents and Economic Policies Affect Access to Essential Medicines in Developing Countries?* (2004) 23 Health Affairs 155-166.

³⁴ Amir Attaran & Lee Gillespie-White, *Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa?* (2001) 286 JAMA 1886 at 1887.

³⁵ Marleen Boelaert, Lut Lynen, Wim Van Damme & Robert Colebunders, “Do Patents Prevent Access to Drugs for HIV in Developing Countries?” (2002) 287:7 JAMA 840-841.

³⁶ *Ibid.*

HIV-positive persons worldwide³⁷ and possesses production capacity for generic medicines. But patent protection for the essential antiretroviral drugs in that country means that other African countries like Botswana and Zimbabwe that depend on South Africa for cheap drugs cannot access those cheap drugs.³⁸

For the developing countries, the TRIPS sets the general compliance date as January 1, 2000.³⁹ However, there is one exception to this general date. If on January 1, 2000, a developing country did not extend patent protection to all areas of technology within the meaning of Article 27 of the TRIPS, that developing country is permitted to delay implementation of these provisions for an additional five years.⁴⁰

Prior to the onset of the TRIPS, many developing countries did not issue patents for pharmaceutical products. The implication of this is that following the timelines set by WTO, developing countries did not have to grant patents for pharmaceutical products

³⁷ The figure is currently put at 5.5 million. See UNAIDS, *Uniting the World against AIDS*, online: UNAIDS http://www.unaids.org/en/Regions_Countries/Countries/south_africa.asp (accessed July 6, 2010).

³⁸ For instance, owing to the high cost of ARVs in resource-poor countries, some analysts have suggested distribution of free ARVs. See Donald Berwick, "We all have AIDS: Case for reducing the cost of HIV Drugs to zero" (2002) 324:7331 *BMJ* 214 -218; Ken Bluestone, "Safeguarding Developing Countries' Rights to Affordable Medicines for HIV/AIDS: How Effective are International Trade Rules?" (2001) 6:3 *Trop Med Int Health* 161-162; Gavin Yamey & William Rankin, "AIDS and Global Justice" (2002) 324:7331 *BMJ* 181- 82.

³⁹ TRIPS, Article 65.2.

⁴⁰ TRIPS, Article 65.4 provides that: "To the extent that a developing country member is obliged by this Agreement to extend product patent protection to areas of technology not so protectable in its territory on the general date of application of this Agreement for that member, as defined in paragraph 2, it may delay the application of the provisions on product patents of section 5 of Part II to such areas of technology for an additional period of five years."

until January 1, 2005.⁴¹ But, starting from that date, developing countries must implement every aspect of the TRIPS including granting product, process and use patents on pharmaceuticals and other goods in their domestic markets.

Although the TRIPS gives the least developed country members until January 1, 2016 to fully implement the TRIPS, the granting of pharmaceutical patents in these countries is likely to have wide-ranging implications. Leading generic manufacturing nations such as India and South Africa will become fully subject to the TRIPS since they are self-designated as developing countries.⁴² For instance, India is the primary exporter of affordable generic ARVs to other developing countries and compliance with Article 65 of the TRIPS will present a huge challenge to other developing countries.⁴³ By Article 65, India and other developing countries have to grant domestic intellectual property protection for products and processes, including pharmaceutical products. In fact, India has amended its Patent Act, 1990 by enacting the Patents (Amendment) Act, No. 15, 2005, to allow patenting of medicines in India.⁴⁴ This Act became operational on January 1, 2006.

⁴¹ Schechter & Thomas, *supra* note 16 at 401.

⁴² See Maria Oliveira & Jorge Bermudez, *et al.*, “Has the Implementation of the TRIPS Agreement in Latin America and the Caribbean Produced Intellectual Property Legislation that favours Public Health?” (2004) 81:11 Bull. World Health Org. 815-821 at 815.

⁴³ For example, of the 700,000 people in developing countries estimated to be on ARV treatment, 50 percent are taking generics manufactured in India. See Ellen t’ Hoen, *TRIPS*, “Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha” (2002) 3 Chicago J. Int’l L. 29 at 55.

⁴⁴ The Gazette of India, Ministry of Law and Justice, *Patents (Amendment) Act, No. 15 of 2005*, online, http://www.patentoffice.nic.in/iprpatent/patent_2005.pdf (accessed July 6, 2010).

4.4 HOW CAN TRIPS BE USED TO IMPROVE ACCESS TO ESSENTIAL MEDICATIONS?

Some of the provisions of the TRIPS that hinder access to affordable medicine in African countries have been examined in this chapter. However, the TRIPS contains some flexibilities designed to foster access to drugs.⁴⁵ These flexibilities are the provisions relating to compulsory licensing and parallel importing.

A compulsory license can be defined as a situation “where the government requires that (intellectual property) right owners make their works available to users at a fixed price.”⁴⁶ At the onset of the TRIPS, western pharmaceutical companies opined that compulsory licensing represented a TRIPS-legitimized public health option to improve access by increasing the supply of lower cost drugs.⁴⁷ However, the effectiveness of compulsory licensing as provided under the TRIPS has been doubted by developing countries.⁴⁸

Particularly contentious is Article 31 (f) that requires that “any such use shall be authorized predominantly for the supply of the domestic market of the member authorizing such use.”⁴⁹ Because many developing countries lack the manufacturing and

⁴⁵ Article 31 of TRIPs provides for compulsory licenses.

⁴⁶ S.J. Liebowitz, “Alternative Copyright Systems: The Problems with a Compulsory License,” (Unpublished paper) School of Management, University of Texas at Dallas. Online at <http://www.serci.org/2003/liebowitz2.pdf> (accessed July 6, 2010).

⁴⁷ David P. Fidler, *International Law and Public Health: Materials on and Analysis of Global Health Jurisprudence* (New York: Transnational Publishers, Inc., 2000) at 152.

⁴⁸ See M.A Oliveira, *et al.*, “Has the Implementation of the TRIPS Agreement in Latin America and the Caribbean produced Intellectual Property Legislation that Favours Public Health?” (2004) 82:11Bull. World Health Org. 815.

⁴⁹ See Article 31(f) of TRIPS.

financial capabilities needed to fully utilize the potentials of compulsory licensing⁵⁰, it has been argued that the “entire compulsory licensing mechanism is rendered practically worthless.”⁵¹

The WTO recognized this concern in 2001 and attempted to revise its strict intellectual property regime with a view to facilitating access to pharmaceutical products to address public health problems affecting developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics. Thus, the WTO declared that:

We stress the importance we attach to implementation and interpretation of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) in a manner supportive of public health, by promoting both access to existing medicines and research and development into new medicines and, in this connection, are adopting a separate declaration.⁵²

This ‘separate declaration’ is the *Doha Ministerial Declaration on the TRIPS Agreement and Public Health* (‘Doha Declaration’).⁵³ The *Doha Declaration* states that:

We recognise that WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPs Agreement. We instruct

⁵⁰ Cameron Hutchison, *Over 5 Billion Not Served: The TRIPs Compulsory Licensing Export Restriction*. Available online at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1012625 (accessed July 6, 2010).

⁵¹ Roger E. Schechter & John R. Thomas, *Principles of Patent Law* (Minnesota: Thomson West, 2004) at 399.

⁵² Doha WTO Ministerial 2001: *Ministerial Declaration*, Art.17. WT/MIN(01)/DEC/1, online: <http://docsonline.wto.org/DDFDocuments/t/WT/Min01/DEC2.doc> [hereinafter referred to as the “Doha Declaration.”]

⁵³ Doha WTO Ministerial 2001: TRIPS; WT/MIN(01)/DEC/2, online: http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm (accessed July 6, 2010)

the Council on TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002.⁵⁴

Subsequently, on December 6, 2005 the WTO General Council adopted a Protocol aimed at amending Article 31 (f). This Protocol amended the TRIPS “by inserting Article 31*bis* after Article 31 and inserting the Annex to the TRIPs Agreement after Article 73.”⁵⁵ Article 31*bis* creates a global mechanism for issuance of compulsory licenses by wealthy nations with the goal of supplying generic versions of patented antiretrovirals to developing and least developed countries with no manufacturing capacity and facing a serious problem of public health.⁵⁶

The significance of this amendment is that it removes some of the hindrances inherent in Article 31 of the TRIPS. Paragraph 1 of Article 31*bis* provides that the obligations of an exporting member under Article 31 (f) “shall not apply with respect to the grant by it of a compulsory license to the extent necessary for the production of a pharmaceutical product(s) and its export to an eligible importing member(s) in accordance with the terms set out in paragraph 2 of the annex⁵⁷ to the (TRIPs) Agreement.”⁵⁸ This provision laid the ground for the waiver of the predominant domestic

⁵⁴ See Paragraph 6 of the Doha Declaration.

⁵⁵ See para. 1 of the *Protocol Amending the TRIPs Agreement*, WT/L/641, 6 December 2005. This Protocol was adopted and submitted to WTO Members for acceptance on December 6, 2005; the Protocol is open for acceptance by Members until 1 December, 2007.

⁵⁶ Frederick M. Abbott & Rudolf V. Van Puymbroeck, *Compulsory Licensing for Public Health: A Guide and Model Documents for Implementation of the Doha Declaration Paragraph 6 Decision* (Washington, DC: World Bank, 2005) at 2.

⁵⁷ The *Annex* in question is the *Annex to the TRIPs Agreement*, which is actually the new definition section of the amendment of the TRIPs Agreement.

⁵⁸ See generally, Chitra Akileswaran, Mark Lurie, Timothy Flanagan & Kenneth Mayer, “Lessons from use of Highly Active Antiretroviral Therapy in Africa” (2005) 41.3 *Clin. Infect. Dis.* 376 – 385.

supply requirement with regards to a compulsory license granted by the exporting country if certain conditions set out in paragraph 2 of the annex to the TRIPS Agreement are met.

The conditions that have to be met before a compulsory license is issued are clearly stated. First, the eligible importing country has to notify the Council for TRIPS confirming the name and expected quantity of the exact pharmaceutical product it seeks to import.⁵⁹ Second, the compulsory license issued by the exporting country must contain the exact amount of the pharmaceutical product to be produced under the compulsory license, including specific information on labelling and packaging of the pharmaceutical product sought to be exported.⁶⁰ Thirdly, the exporting country shall inform the Council for TRIPS of the grant of a compulsory license and the conditions attached to it.⁶¹ The essence of the provision on specific information on labeling and packaging is to stem the diversion of the products into unofficial markets where exorbitant prices are charged on the legitimate drugs.

Article 31 (h) of the TRIPS provides that where the patent law of a member nation of the WTO permits it to use a patented product without the authorization of the patent holder, that member nation shall pay an ‘adequate remuneration’ to the patent holder, taking into account the economic value of the authorization. Succinctly put, this provides for the payment of ‘adequate remuneration’ to compensate a patent holder for

⁵⁹ Para. 2 (a) (i), *Annex to the TRIPs Agreement*.

⁶⁰ Para. 2 (b) (i) and (ii), *Annex to the TRIPs Agreement*.

⁶¹ Para. 2 (c), *Annex to the TRIPs Agreement*.

the breach of his patent right in a product. The TRIPS Amendment modified this adequate remuneration requirement thus:

Where a compulsory licence is granted by an exporting Member under the system set out in this Article and the Annex to this Agreement, adequate remuneration pursuant to Article 31 (h) shall be paid in that Member taking into account the economic value to the importing Member of the use that has been authorized in the exporting Member. Where a compulsory license is granted for the same products in the eligible importing Member, the obligation of that Member under Article 31 (h) shall not apply in respect of those products for which remuneration in accordance with the first sentence of this paragraph is paid in the exporting Member.⁶²

The last paragraph of this provision essentially seeks to avoid incidences of double compensation by waiving the obligation to pay adequate remuneration to the pharmaceutical company that produced the needed drugs in the importing country once adequate remuneration had been paid in the exporting country.⁶³ The full import of paragraph two is that when an eligible importing country issues a compulsory license for the production and importation, from an exporting country, of the same antiretroviral drug for which the former had previously paid adequate remuneration to the patent holder, there will be no further payment of remuneration by the exporting country.

Furthermore, where an exporting country who is a member of WTO seeks to export essential medicines to an eligible importing country for humanitarian reasons, certain conditions have to be met under the TRIPS amendment. Paragraph 2 of the *Annex to the TRIPs Agreement* provides that the government of the exporting country:

⁶² Para. 2, *Annex to the Protocol Amending the TRIPs Amendment*.

⁶³ Frederick M. Abbott & Rudolf V. Van Puymbroeck, *Compulsory Licensing for Public Health: A Guide and Model Documents for Implementation of the Doha Declaration Paragraph 6 Decision* (Washington, DC: World Bank, 2005) 10.

1. Shall notify the Council for TRIPS of the grant of a compulsory license;⁶⁴
2. Satisfy itself that the importing country has made a notification⁶⁵ to the Council for TRIPS that it needs the product.⁶⁶
3. Ensure that the compulsory license it intends to issue states the name and address of the licensee, the product for which the license has been granted, the quantities for which it has been granted, the country to which the product is to be supplied and, the duration of the license.⁶⁷

The TRIPS Amendment also contains provisions encouraging technology transfer and capacity building⁶⁸ in developing countries as well as a framework for the assessment of manufacturing capacities in the pharmaceutical sector of developing countries.⁶⁹

4.5 Implementation of TRIPS flexibilities in Africa

There have been instances where the utilization of TRIPS flexibilities by African countries has led to the reduction of ARV prices. For example, the Rwandan government passed a law requiring that generic medicines be used for all HIV/AIDS treatment

⁶⁴ Para. 2 (c) of the *Annex to the TRIPs Agreement*.

⁶⁵ TRIPs require eligible importing countries to specify to the WTO, the name and expected quantities of the product needed, to establish its lack of manufacturing capability etc. See Para. 2 (a) & (b) of the *Annex to the TRIPs Agreement*.

⁶⁶ Footnote 5 in the *Annex to the TRIPs Agreement* states that any notification from an eligible importing country will be made available publicly by the WTO Secretariat through a page on its website.

⁶⁷ Para. 2 (c) of the *Annex to the TRIPs Agreement*.

⁶⁸ Para. 6 of the *Annex to the TRIPs Agreement*.

⁶⁹ *Appendix to the Annex to the TRIPs Agreement*.

programs, when available.⁷⁰ In July 2007, Rwanda became the first country to announce its intention to use the WTO 30 August 2003 mechanism to import a generic fixed-dose combination of Zidovudine, Lamivudine, and Nevirapine from a generic manufacturing company, Apotex. The compulsory licence issued under Canadian Access to Medicines Regime (CAMR) authorized the delivery of Apo-TriAvir to treat approximately 21,000 people living with AIDS for 1 year at the most affordable price globally of just US\$ 0.19 per dose. Similar examples exist in Mozambique, Zambia and Zimbabwe where compulsory licences have been issued for the local manufacture or importation of generic medicines in recent years.⁷¹

Despite these successes, most African countries have not amended their laws to take full advantage of TRIPS flexibilities. A 2007 study found that only six sub-Saharan African countries have incorporated a provision on the international exhaustion of

⁷⁰ V. B. Kerry & K. Lee “TRIPS, the Doha Declaration and Paragraph 6 Decision: What Are The Remaining Steps For Protecting Access to Medicines?” (2007) 3:3 *Globalization and Health*.

⁷¹ Hoover, *Playing by the Rules: Using Intellectual Property and Policy to Improve Access to Essential Medicines*, Open Society Institute, Access to Medicines Initiative, New York, online, http://www.soros.org/initiatives/health/focus/access/articles_publications/publications/playing_20080731/playing_20080818.pdf . See also WHO, *Improving access to Medicines in Thailand: the use of TRIPS flexibilities: Report of a WHO Mission*, Bangkok, 31 January to 6 February 2008’, online, <http://www.moph.go.th/hot/THAIMissionReport%20FINAL15feb08.pdf>; Martin G, Sorenson C and Faunce T “Balancing Intellectual monopoly privileges and the need for essential medicines” (2007) 3.4 *Globalization and Health*; Ford N et al “Sustaining access to antiretroviral therapy in the less developed world: lessons from Brazil and Thailand” (2007) *AIDS* 21 (suppl 4).

intellectual property rights into their legislations, thereby allowing them to import HIV/AIDS drugs from the most affordable international sources.⁷²

There are several barriers to the use of TRIPS flexibilities in West Africa. First, many West African countries have not incorporated efficient and compulsory licensing provisions into their laws. Such provisions are necessary to ensure that all TRIPS flexibilities are utilized including authorization for public, non commercial use.⁷³ Most West African countries do not have the required multidisciplinary expertise needed to effectively implement patents and test data provision under domestic law. In fact, many of these countries lack the manufacturing capacity to produce antiretroviral drugs. It is therefore highly imperative that effective legal frameworks are put in place to provide for the production and export of generic medicines.

Second, the effective use of compulsory licensing requires adequate technical knowledge and an effective administrative infrastructure which is currently lacking in most West African countries. The greatest barrier is the lack of well defined, clear, and simple administrative procedures necessary for the implementation of the TRIPS flexibilities.⁷⁴ It has been opined that effective coordination of the related functions of the

⁷² UNDP, "Access to ART and other Essential Medicines in Sub-Saharan Africa: Intellectual Property and Relevant Legislations," online, http://www.soros.org/initiatives/health/focus/access/articles_publications/publications/artafrica_20090313 (accessed July 4, 2010).

⁷³ V. B. Kerry & K. Lee, "TRIPS, the Doha Declaration and paragraph 6 decision: what are the remaining steps for protecting access to medicines?" (2007) 3:3 *Globalization and Health*.

⁷⁴ Patrick L. Osewe, Yvonne K. Nkrumah, Emmanuel K. Sackey, *Improving Access to HIV/AIDS Medicines in Africa: Trade Related Aspects of Intellectual and Property Rights* (Washington: The International Bank for Reconstruction and Development/The World Bank, 2008) at 33.

different state agencies involved is crucial when the issuance of a compulsory license is anticipated.⁷⁵

Third, a number of countries have negotiated, or are in the process of negotiating, bilateral free trade agreements that have some levels of intellectual property protection which exceed the minimum standard required by the TRIPS Agreement. These further provisions may hinder access to generic medicines. Specifically, the provisions include: limitations on the circumstances under which compulsory licenses may be issued; extending the minimum period of patent protection beyond the 20 years required by TRIPS; requiring Drug Regulatory Authorities (DRAs), most of whom have limited expertise in patents, to consider the patent status of drugs before granting marketing authorization to generic manufacturers and provisions restricting the use of data submitted to DRAs. DRAs typically rely on this data to establish the efficacy and safety of generic products which has the effect of hastening the registration process. Some bilateral trade agreements contain a requirement to join the Patent Co-operation Treaty; and potentially restrict parallel imports to certain geographical configurations, which may prevent developing countries from sourcing medicines from the cheapest global supplier.⁷⁶

Parallel importation, like compulsory licensing, requires administrative and institutional capacity that is lacking in most African countries. If parallel importation is to be helpful to countries in the region, administrative, institutional, and managerial capacity

⁷⁵ *Ibid.*

⁷⁶ *Supra* note 44.

must be developed for effective implementation to ensure that substandard and counterfeit medicines do not reach markets.⁷⁷

4.5.1 Local Production of ARVs

Prof. Obijiofor Aginam suggests that developing countries that have production technology should pursue the Brazilian model of generic drugs to address the humanitarian catastrophe of HIV/AIDS and this should be done within the framework for the TRIPS agreement.⁷⁸ There have been several attempts at domestic production of ARVs in Zimbabwe, Kenya, Ghana, South Africa, Uganda and recently, Mozambique. The essence of the domestic production of essential medication is to fill the gap in the supply of ARVs for people living with HIV/AIDS. But the political environment of the country must be stable to support this venture and institutional capacity must be adequate.

Domestic producers have been able to offer prices that are competitive with the market. Hence, the cost of treatment with ARVs has been reduced. For instance, before the expansion of Varichem to include ARVs in Zimbabwe, cost of treatment per person ranged from \$30-\$50 per month. However, Varichem's generic versions of lamivudine-

⁷⁷ *Ibid.*

⁷⁸ Obijiofor Aginam, "International Law, HIV/AIDS and Human Rights in Africa: A Post-Colonial Discourse" (American Society of International Law, ASIL, Proceedings of the 100th Annual Meeting, March 29-April 1, 2006) 350 at 353. See also, Obijiofor Aginam, "Global Health Governance, Intellectual Property and Access to Essential Medicines: Opportunities and Impediments for South-South Cooperation", (2010) 4:1 Global Health Governance: The Scholarly Journal for the New Health Security Paradigm (Special Issue on "Global Health Governance and the AIDS Response).

zidovudine cost about \$15 per person.⁷⁹ This same scenario replicated itself in Kenya. Kenyan's domestic producer Cosmo, was granted a voluntary license by pharmaceutical giants *GlaxoSmithKline* Inc (GSK) and Boehringer Ingelheim (BI) for the production of lamivudine, nevirapine, and zidovudine. Although Cosmo offered lower prices for their generic versions, GSK and BI cut their prices for these drugs in order to compete with the domestic producer.⁸⁰

Domestic producers have sometimes functioned as key suppliers during times of drug shortage. For instance, during a 2004 shortage of ARVs in Ghana caused by a change in patent laws and the issuance of a compulsory license to Danadams, Ghana was forced to find new sources of ARVs. During this time, Danadams received a one-time contract worth over \$250,000, or a little over 5 percent of the ARV market in Ghana. The other 95% came largely from Indian generic manufacturers.⁸¹

However, the benefits of domestic production of ARVs are not tapped into because few African countries have tried to exercise the flexibilities in the TRIPS. Besides, there is political pressure from foreign countries to dissuade African countries from utilizing the TRIPS flexibilities.⁸² Furthermore, many domestic manufacturers cite the high cost of

⁷⁹ Patrick L. Osewe, Yvonne K. Nkrumah, Emmanuel K. Sackey, *Improving Access to HIV/AIDS Medicines in Africa: Trade Related Aspects of Intellectual and Property Rights* (Washington: The International Bank for Reconstruction and Development/The World Bank, 2008) at 31.

⁸⁰ *Ibid* at 33-34.

⁸¹ *Ibid* at 40.

⁸² Reuters, "Update 2-SAfrica's Apen wins tender, shares soar", online, <http://www.reuters.com/article/idUSL2661471720080626> (Accessed July 6, 2010).

bio-equivalency tests and active pharmaceutical ingredients (API) import costs as barriers to entry into the market. For example, it has been said that:

The prices of locally produced ARVs in Ghana, Kenya, and Zimbabwe do not include the extremely high cost of in vivo bio-equivalence tests. Given that in vivo bio-equivalence is a prerequisite for the attainment of WHO pre-qualification, the current prices will most likely increase sharply should these countries attempt to meet this requirement.⁸³

The chief executive of Danadams (Ghana) identified three major challenges to domestic production as (a) the high cost of bio-equivalence tests for each product that are required for the acquisition of WHO pre-qualification, (b) the high cost of APIs when purchased in relatively small quantities, and (c) the inadequate market share and lack of economies of scale that result from an inability to supply under the Global Fund arrangements, which in turn results in the absence of WHO pre-qualification.⁸⁴

However, the cost of bio-equivalence tests represents a minor hindrance; the major hindrance to a successful domestic production lies in breaking into the supply chain that is already well established. This point has been argued by Sarah Perkins and De Wit:

Quality assurances are important for antiretrovirals, [and] obtaining WHO approval is expensive and daunting for burgeoning manufacturers. By linking Fund money to WHO approval, a monopoly has been created, ensuring that only well established manufacturers, such as those in the USA, Canada, Europe, and India, will be able to supply most of the world's antiretrovirals. Unless something changes, manufacturers in developing countries will be left out from the potential boon in antiretrovirals created by the Fund and WHO.⁸⁵

⁸³ *Supra* note 47 at 43.

⁸⁴ *Ibid* at 41.

⁸⁵ Perkins S. & de Wit M, "The Private Sector Steps In To Fill The Drug Gap" (2007) 370.9589 *Lancet* 722-3.

African nations can however utilize the provision of Article 6(i) of the Doha Declaration on the TRIPS Agreement and Public Health Decision of the General of 30 August 2003. The clause has never been invoked but it allows domestic producers to bypass the complicated paperwork involved in applying for a voluntary license.

West African countries through ECOWAS which consist of 9 out of 13 Least Developed Countries can have Danadams in Ghana produce and export to other West African countries these essential medications. The advantages of this arrangement are numerous. First, exportation to a regional grouping allows local producers to focus specifically on the gap between what donor countries are offering, and those that need treatment in the West African Region. They could also benefit from lower transportation costs by importing the drug from a regional producer rather than importing from a foreign one. Second, countries grouping together around a shared health concern would serve a positive regional integration purpose. As well, African countries would be seen as taking responsibility for solving the ballooning HIV/AIDS crisis.

4.6 Conclusion

Attempts have been made in this chapter to critically examine the TRIPS as a barrier to essential medications in Africa. I have argued that although TRIPS initially constituted a hindrance to access to essential medications, its flexibilities can be explored by West African countries to improve the supply of ARVs.

It is clear that solving the problem of access to essential medication in West Africa is a collective responsibility of all countries including the African Nations as well as the developed countries. International Organisations such as the UNDP and the WHO

can provide technical assistance to African countries that seek to implement the TRIPS flexibilities.

Therefore, it is highly imperative that countries with manufacturing capacity should amend their patent laws to facilitate the exporting of generic drugs to West African countries as well as other African countries in line with the WTO 30 August 2003 mechanism. The developed countries should also encourage and facilitate technology transfer to developing countries for the production of antiretroviral therapies.⁸⁶

ECOWAS, as a regional organisation, should foster regional cooperation by developing intellectual property and trade policies consistent with the TRIPS and which allow for the full utilization of the TRIPS flexibilities to ensure access to affordable generic HIV medications for the West African population. Also, there should be investment in regional and national production capacity in the pharmaceutical sector to improve and develop local expertise. Mechanisms should be developed to reduce the price of essential medications by pooling regional procurement of antiretroviral therapies; as well as relevant pricing information during procurement negotiations with pharmaceutical companies. Finally, there should be a strategic elimination of taxes and tariffs on HIV/AIDS medicines to make these medications affordable.

⁸⁶ See TRIPS Article 66.2.

Chapter Five

Postscript: Towards Enhancing Human Security in West Africa

In chapter 3, I highlighted West African initiatives aimed at tackling the HIV/AIDS pandemic amongst military forces, women and children. I also identified the weaknesses and shortcomings of these initiatives. Having seen the stark realities of the HIV/AIDS pandemic in West Africa, there is need for a concerted effort to slow down the spread of HIV and to reduce the vulnerabilities of peacekeepers, women and children to the pandemic. In the present chapter, my aim is to offer strategies for improving the prevention, treatment and care for HIV/AIDS patients in West Africa.

First, the realities in West Africa reveal that the available testing centers are grossly inadequate to meet the needs of the West African people. Most services are based in hospital facilities and are mostly located in tertiary and secondary facility levels. There is little access to service at the community level. Therefore, there is need for access to qualitative HIV counseling and testing can be improved through the integration of health services at all levels to increase reach and coverage. This is important in gaining accurate data on the prevalence rate amongst the military, local militias, and other security operatives in the region.

Second, it is imperative that strategies are put in place to tackle mother-to-child-transmission (PMTCP) of HIV/AIDS. This can be done by accelerating prevention of PMTCP services in West Africa at the grassroots with development of training and services manual for primary health care workers. Furthermore, male participation and

community involvement in preventing PMTCP should be strengthened and the scope of PMTCT services broadened to be more comprehensive and engaging.

Third, condom promotion must be a priority. Interventions should be put in place to increase awareness, acceptance and the use of condom in the West African region. This can be done by West African governments increasing the availability and access to condoms across the region, including making condoms available at non-traditional outlets. Female condoms must be made readily available to women. These condoms can help women to protect themselves from HIV infections if used correctly. However, a shortcoming of the female condom is that it requires, to some degree, the cooperation of the male partner.

Fourth, prevention of HIV transmission in the militaries can be done by raising awareness through the provision of peer education and condom and through the provision of care and support services for those infected with HIV/AIDS. Members of West African military forces must also be involved as advocates in the fight against HIV/AIDS. West African states must provide military personnel with tools to contribute to the national response on HIV/AIDS. Peacekeepers involved in missions in Africa must be educated on the risks of contracting and spreading the disease. Furthermore, demobilised soldiers should be used as community HIV educators.

Fifth, there are major inequalities between women and men in Africa. This can be seen in access to employment opportunities, education, and political power. There are also inequalities in intimate relationships. These inequalities are entrenched in gender roles that restrict women to positions where they lack the power to protect themselves

from HIV infection. Also, culture and traditional practices contribute to the subordination of African women and the spread of HIV. This includes genital mutilation, wife inheritance, and forced and early marriages, especially when the husband is a much older man. It is essential that women's rights in West Africa are protected because most of the challenges and inequalities facing women in West Africa stem from the denial of their basic rights. Promoting women's rights will enhance their status in the society, protect them against the risk of HIV infection and protect their human security.

Sixth, there has to be a transformation of gender roles. Gender-based roles can increase the vulnerability of both men and women to HIV infections. For instance, in many African societies, women are expected to be innocent and submissive when it comes to sex, preventing them from accessing sexual health information and services. For many men, masculinity is linked with taking risks and being tough, which can increase vulnerability to HIV infection and discourage men from seeking testing and treatment. It is very important that West African Governments recognise and challenge these negative gender roles to prevent the spread of HIV. Specifically, programs that focus on transforming men's attitude and behaviours towards their spouses and families must be implemented.

Seventh, education is no doubt an effective way of preventing HIV infections. It has been estimated by the Global Campaign for Education that if every child receive a complete primary education, around 700,000 new HIV infections in young adults could

be prevented every year.⁸⁷ The importance of education cannot be underestimated in protecting girls and women from HIV infection. Schools can teach vital HIV prevention methods, such as condom use, having fewer sexual partners, and the importance of greater communication about HIV prevention between couples. Also, girls who frequently attend school are more likely to be able to make decisions about their sexual lives, are more independent, and are more likely to earn a higher income in the future.⁸⁸ Furthermore, increasing HIV/AIDS education can create awareness which will drastically reduce the stigma that people living with HIV/AIDS face. Eradicating such stigma is important in the fight against HIV/AIDS because stigma can increase the vulnerability of a group that may already be at a high risk of HIV infection.

Eighth, children living with HIV have many practical and material needs, but they also have social, psychological and emotional needs. It is essential that emotional care is provided to all children affected by HIV, including those who have lost their parents or relatives to AIDS in West Africa. Children need multi-layered care when they are first diagnosed and when they start receiving treatment. They also need to be educated on how to deal with discrimination and trauma as a result of one or both parents dying from AIDS. It is true that families, friends, caregivers and health care workers provide children with the first line of social and emotional support, but West African governments and

⁸⁷ Global Campaign for Education, “Learning to Survive: How Education For All Would Save Millions of Young People from HIV/AIDS”, online, http://siteresources.worldbank.org/CSO/Resources/Learning_to_Survive_by_Oxfam.pdf (accessed May 17, 2010).

⁸⁸ The Global Coalition on Women & UNAIDS, “Educate Girls, Fight AIDS”, online, http://data.unaids.org/GCWA/gcwa_fs_girlseducation_sep05_en.pdf (accessed May 17, 2010).

other agencies in Africa have a responsibility to ensure that children and families are linked with available services and initiatives.

Finally, existing national policies on HIV/AIDS within the West African region must be harmonised and avenues for collaboration and synergies must be created to tackle the HIV/AIDS pandemic. Political commitments shown towards HIV/AIDS globally have declined and other health issues such as pandemic influenza and bioterrorism have dominated the security discourse. However, the threats posed by HIV/AIDS are real and world leaders must renew their interest and commitment to fight the HIV/AIDS pandemic.

BIBLIOGRAPHY

PRIMARY SOURCES

INTERNATIONAL INSTRUMENTS

Agreement on Trade-Related Aspects of Intellectual Property Rights, April 15, 1994, Marrakesh Agreement Establishing the World Trade Organisation, Annex 1C, LEGAL INSTRUMENTS- RESULTS OF THE URUGUAY ROUND vol. 31, 33 I.L.M. 81 (1994)

Convention on the Rights of the Child [1989]

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [1984]

Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field [1949]

Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea [1949]

Geneva Convention Relative to the Protection of Civilian Persons in Time of War [1949]

Geneva Convention Relative to the Treatment of Prisoners of War [1949]

International Convention of All Forms of Racial Discrimination [1965]

International Convention on the Elimination of All forms of Discrimination Against Women [1979]

International Covenant on Economic, Social and Cultural Rights [1966]

UN Declaration of Commitment on HIV/AIDS [2001]

UN Millennium Development Goals [2000]

UN Resolution on HIV/AIDS and International Peacekeeping Operations [2000]

Universal Declaration of Human Rights [1948]

SECONDARY SOURCES

BOOKS

- Abbott Frederick M. & Rudolf V. Van Puymbroeck, *Compulsory Licensing for Public Health: A Guide and Model Documents for Implementation of the Doha Declaration Paragraph 6 Decision* (Washington, DC: World Bank, 2005)
- Adeyi Olusoji, *AIDS in Nigeria: A Nation on the Threshold* (Cambridge: Harvard University Press, 2006)
- Aginam Obijiofor, *Global Health Governance: International Law and Public Health in a Divided World* (Toronto: University of Toronto Press, 2005)
- Ahanihu E, *Closing Ranks: An Account of Nigeria's Response to HIV/AIDS, 1986–2003* (Ibadan: Spectrum Books, 2005)
- Akwara Priscilla A., Gabriel B. Fosu, et.al, *An In- Depth Analysis of HIV Prevalence in Ghana: Further Analysis of Demographic and Health Surveys Data* (Calverton, Maryland, USA: ORC Macro, 2005)
- Brockington Fraser, *The Health of the Developing World* (Lewes: Book Guild, 1985)
- Buzan Barry, *People, States and Fear* (Hemel Hemstead: Harvester Wheatsheaf, 1991)
- Chen L., J. Leaning & V. Narasimhan ed., *Global Health Challenges for Human Security* (Cambridge, MA, Harvard University Press, 2003)
- Chen Lincoln, Jennifer Leaning & Vasant Narasimhan, ed., *Global Health Challenges for Human Security* (Cambridge, USA: Harvard University Press, 2003)
- Cohen Jillian, Patricia Illingworth & Udo Schuklenk, eds, *The Power of Pills: Social, Ethical and Legal Issues in Drug Development, Marketing and Pricing* (London: Pluto Press, 2006)
- Collins Alan, ed., *Contemporary Security Studies*, (Oxford: Oxford University Press, 2007)
- Elbe Stefan, *Strategic Implications of HIV/AIDS* (New York: Oxford University Press 2003)
- Fidler David P., *International Law and Public Health: Materials on and Analysis of Global Health Jurisprudence* (New York: Transnational Publishers, Inc., 2000)

- Finkelstein, Marina S. & Lawrence S., ed., *Collective Security* (San Francisco: Chandler, 1966)
- Foster Geoff, Carol Levine & John Williamson, ed., *A Generation at Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children* (New York: Cambridge University Press, 2006)
- Hough Peter, *Understanding Global Security* (London: Routledge, 2004)
- Jeong Ho-Won, *Peace and Conflict Studies*, (Aldershot, England: Ashgate Publishing Company, 2000)
- Kaldor Mary, *New and Old Wars: Organised Violence in a Global Era*, 2nd ed. (Cambridge, Polity 2006)
- Kolodziej Edward A., *Security and International Relations* (Cambridge: Cambridge University Press, 2005)
- MacPherson C.B, ed., *T.Hobbes: Leviathan (1651)* (New York: Penguin, 1968)
- McNamara Robert, *The Essence of Security: Reflections in Office* (New York: Harper and Row, 1968)
- Mgbeoji Ikechi, *Collective Insecurity: The Liberian Crisis, Unilaterism and Global Order* (Vancouver: UBC Press, 2003)
- Mohammed Ayoob, *The Third World Security Predicament* (Boulder: Lynne Rienner, 1995)
- Osewe Patrick L., Yvonne K. Nkrumah, Emmanuel K. Sackey, *Improving Access to HIV/AIDS Medicines in Africa: Trade Related Aspects of Intellectual and Property Rights* (Washington: The International Bank for Reconstruction and Development/The World Bank, 2008)
- Pascale Boulet, Christopher Garrison & Ellen 't Hoen, *Drug Patents under the Spotlight: Sharing Practical Knowledge about Pharmaceutical Patents* (Geneva: Medecins Sans Frontieres, 2004)
- Peter Drahos, ed., *Death of Patents* (London: Lawtext Publishing Limited, 2005)
- Pick Otto & Julian Critchley, *Collective Security* (London: Macmillan Press, 1974)
- Price-Smith A. T., *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development* (Cambridge, MA: MIT Press, 2002)

Price-Smith A. T., *Contagion and Chaos: Disease, Ecology, and National Security in the Era of Globalisation* (Cambridge, MA: MIT Press, 2009)

Schechter Roger E., & John R. Thomas, *Principles of Patent Law* (Minnesota: Thomson West, 2004)

Sen Amatrya, *Development as Freedom* (New York: Knopf Publishers, 1999)

Sterckx Sigrid ed., *Biotechnology, Patents and Morality*, 2nd Ed. (Aldershot: Ashgate, 2000)

Stimson Henry L. & McGeorge Bundy, *On Active Service in Peace and War* (New York, Harper & Brothers, 1947)

Stoett Peter, *Human and Global Security: An Exploration of Terms*, (Toronto; University of Toronto Press, 1999)

Thakur Ramesh, *The United Nations, Peace and Security: From Collective Security to the Responsibility to Protect* (Cambridge: Cambridge University Press, 2006)

The Independent Commission on Disarmament and Security Issues (Palme Commission) *Common Security: A Blueprint for Survival* (New York: Simon and Schuster 1982)

The Rt. Hon. Sir Robin Jacob, Daniel Alexander & Lindsay Lane, *A Guidebook to Intellectual Property: Patents, Trade Marks, Copyright and Designs*, 5th ed. (London: Sweet & Maxwell, 2004)

Tigerstrom Von, *Human Security and International Law* (Oxford: Hart Publishing, 2007)
Trevor Cook, *A User's Guide to Patents* (London: Butterworth Lexis Nexis, 2002)
University Press, 1962)

Van Niekerk Anton A. & Loretta M. Kopelman, ed., *Ethics and AIDS in Africa* (South Africa: David Philip Publishers, 2005)

White Nigel D., ed., *Collective Security Law* (Aldershot: Ashgate Publishers, 2003)

Wolfers Arnold, *Discord and Collaboration* (Baltimore: John Hopkins Press, 1962)

ARTICLES

Aginam Obijiofor, "Global Health Governance, Intellectual Property and Access to Essential Medicines: Opportunities and Impediments for South-South Cooperation", (2010) 4.1 Global Health Governance: The Scholarly Journal for the New Health Security Paradigm (Special Issue on "Global Health Governance and the AIDS Response)

- Aginam Obijiofor, "International Law, HIV/AIDS and Human Rights in Africa: A Post-Colonial Discourse" (American Society of International Law, ASIL, Proceedings of the 100th Annual Meeting, March 29-April 1, 2006) 350
- Anderson J.A., Kramer K.J. & K.A. Shambley, "AIDS issues in the military," (1990) 32 Air Force Law Review 353 - 375
- Andreff J. L., "The Power Imbalance between Men and Women and Its Effects on the Rampant Spread of HIV/AIDS among Women", (2001) 9:1 Human Right Brief 24
- Aniekwu N. I., & Ayo Atsenuwa, "Sexual Violence and HIV/AIDS on Sub-Saharan Africa: An intimate Link", (June 2007) 12.3 Local Environment 313
- Astill James, "War Injects AIDS into the tragedy of Sierra Leone': Armies Spread AIDS in Africa" (2001) Atlanta Journal of Constitution
- Attaran Amir & Lee Gillespie-White, Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa? (2001) 286 JAMA 1886
- _____, *How do Patents and Economic Policies Affect Access to Essential Medicines in Developing Countries?* (2004) 23 Health Affairs 155 - 166
- Axworthy Lloyd, "A New Scientific Field and Policy Lens" (2004) 35.3 Security Dialogue 348
- Barnett T. & G. Prins, "HIV/AIDS and Security: Fact, Fiction and Evidence – A report to UNAIDS" (2006) 82 International Affairs 359
- Barry Buzan, "Peace, Power and Security: Contending Concepts in the study of International Relations" (Jun 1984) 21. 2 Journal of Peace Research, "Special Issue on Alternative Defense", 109 – 125
- Bazergan Roxanne, "UN Peacekeepers and HIV/AIDS" (2001) 57.5 World Today 6
- Bellamy Ian, "Towards a theory of International Security" (1981) 29.1 Political Studies 29
- Berwick Donald, "We all have AIDS: Case for reducing the cost of HIV Drugs to zero" (2002) 324:7331 BMJ 214 - 218
- Bluestone Ken, "Safeguarding Developing Countries' Rights to Affordable Medicines for HIV/AIDS: How Effective are International Trade Rules?" (2001) 6:3 Trop Med Int Health 161-162

- Booth Ken, "Security and Emancipation" (October 1991) 17.4 *Review of International Studies*, 313 – 326
- Booth Ken, "Security and Emancipation" (October 1991) 17.4 *Review of International Studies* 313
- Boyle Kevin & Sigmund Simonsen, 'Human Security, Human Rights and Disarmament' (2004) *Disarmament Forum* 1
- Brunnee Jutta & Stephen J. Toope, "Canada and the Use of Force: Reclaiming Human Security", spring 2004, Vol. LIX No. 2, *International Journal* (Canadian Institute of International Affairs) 247 - 260
- Bruntland G. H., "Global Health and International Security' (2003) 9 *Global Governance* 417
- David A. Baldwin, "The Concept of Security" (Jan. 1997) 23.1 *Review of International Studies* 5 – 26
- Decker M., "Intimate partner violence functions as both a risk marker and risk factor for women's HIV infection: findings from Indian husband-wife dyads" (2009) 51.5 *Journal of Acquired Immune Deficiency Syndromes*
- der Straten A. Van, R. King & O. Grinstead, "Sexual Coercion, Physical violence and HIV infection among women in steady relationships in Kigali, Rwanda" (1998) 2.1 *AIDS and Behaviour* 61-73
- Dunkle D.L., "Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa" (2004) 363.9419 *The Lancet* 1415
- Ellen 't Hoen, "TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha" (2002) 3 *Chicago J. Int'l L.* 29
- Ellen 't Hoen, *The Global Politics of Pharmaceutical Monopoly Power: Drug Patents, Access, Innovation and the Application of the WTO Doha Declaration on TRIPS and Public Health* (AMB Publishers, 2009)
- Eric Noehrenberg, *Report of the Commission on Intellectual Property Rights, Innovation and Public and Public Health: An industry Perspective* (2006) 84 *Bull. World Health Org.* 419
- Evelyn Su, "The Winners and the Losers: The Agreement on Trade-Related Aspects of Intellectual Property Rights and Its Effects on Developing Countries" (2000) 23 *Hous. J. Int'l L.* 169

- Feldbaum, Harley & Preeti Patel, "Global Health and National Security: The Need for Critical Engagement" (2006) 22.3 *Medicine, Conflict and Survival* 192
- Fleshman Michael, "AIDS Prevention between the Rank: UN targets peacekeepers, combatants in war against the disease" (2001) 15.1 *African Recovery* 16 – 19
- Fobil J. N. & I. N. Soyiri, "An assessment of government policy response to HIV/AIDS in Ghana", (2006) 3.2 *Journal of Social Aspect of AIDS* 457
- Ford N., *et al*, "Sustaining access to antiretroviral therapy in the less developed world: lessons from Brazil and Thailand" (2007) *AIDS* 21 (suppl 4)
- Forman J., & Carballo M., "A Policy Critique of HIV/AIDS and Demobilisation" (2001) 1.2 *Conflict, Security and Development* 73
- Garrett L., "The Return of Infectious Disease" (1006) 75 *Foreign Affairs* 66
- Garrett Laurie, "The Lessons of HIV/AIDS", 84.4 *Foreign Affairs* 54
- Heinbecker Paul, "Human Security: The Hard Edge" (Spring 2000) 1.1 *Canadian Military Journal* 1
- Heinecken L., "Living in Terror: The looming security threat to Southern Africa" (2001) 10.4 *African Security Review* 1
- Henderson D.A., "Bioterrorism as a Public Health Threat" (1998) 4.3 *Emerging Infectious Diseases* 488
- Hogg Robert & Amy Weber, *et al.*, "One World, One Hope: The Cost of Providing Antiretrovirals to all Nations" (1998) 12:16 *AIDS* 2203 – 2209
- Jenny C., T. Hooton & A. Bowers "Sexually transmitted diseases in victims of rape", (1990) 322(11) *New England Journal of Medicine* 713
- Jewkes R., J. Levin & L. Penn-Kekana, "Gender Inequalities, Intimate Partner Violence and HIV Preventive practices: Findings of a South African Cross-sectional study", (2003) 56 *Social Science & Medicine* 125
- Kerry V. B., & Lee K., "TRIPS, the Doha Declaration and paragraph 6 decision: what are the remaining steps for protecting access to medicines?" (2007) 3.3 *Globalization and Health* 33
- Kevin Outterson, "Pharmaceutical Arbitrage: Balancing Access and Innovation in International Prescription Drug Markets" (2005) 5 *Yale J. Health Pol'y, L & Ethics* 193-194

- Kilgour David, "The UN and the Challenge of Human Security" (Winter 2000) 1.1 McGill International Review 1
- King N. B., "Security, Disease, Commerce: Ideologies of Postcolonial Global Health" (2002) 32 Social Studies of Science 763
- Lowicki-Zucca Massimo, Sarah Karmin & Karl-Lorenz Dehne, "HIV among Peacekeepers and its Likely Impact on Prevalence on Host Countries' HIV Epidemics" (2009)16.3 International Peacekeeping 352 – 363
- Luciani Giacomo, "The Economic Content of Security" (1989) 8.2 Journal of Public Policy 151
- Lyerly W. H. Jr., Barry S. & N Miller, "HIV Transmission and the military", (1993) 1.1 AIDS and Society: International Research and Policy Bulletin 8-10
- Lyndy Heinecken, "Strategic Implications of HIV/AIDS" (2001) 1.1 Conflict Security and Development 111
- Machel J. Z., "Unsafe sexual behaviour among schoolgirls in Mozambique: A Matter of gender and Class", (2001) 9.17 Reproductive Health Matters 82 – 90
- Maclean Sandra J., "Microbe, Mad Cows and Militaries: Exploring the Links Between Health and Security" (2008) 39 Security Dialogue 475
- Maman S., J.K. Mbwambo & N. M. Hogan, "HIV positive women report more lifetime partner violence: findings from a voluntary counselling and testing clinic in Dar es Salaam, Tanzania" (2002) 92.8 American Journal of Public Health 1967 – 1972
- _____, Campbell, J., Sweat M.D. & Gielen, A., "The Intersections of HIV and Violence in West Africa: directions for future research and interventions" (2002) 50 Social Science and Medicine 456 – 478
- Marleen Boelaert, Lut Lynen, Wim Van Damme & Robert Colebunders, "Do Patents Prevent Access to Drugs for HIV in Developing Countries? (2002) 287 JAMA 840-841
- Martin G, Sorenson C & Faunce T "Balancing Intellectual monopoly privileges and the need for essential medicines" (2007) 3.4 Globalization and Health
- McInnes C., 'HIV/AIDS and Security' (2006) 82 International Affairs 315
- _____ & Simon Rushton, "HIV/AIDS and Security: Where are we now?" (2010) 86.1 International Affairs 225

- Michael Selgelid & Udo Schuklenk, "Do Patents Prevent Access to Drugs for HIV in Developing Countries?"(2002) 287 JAMA 842
- Mill J. E., & J.K. Anarfi, "HIV Risk Environment for Ghanaian Women: Challenges to prevention", (2002) 54 Social Science & Medicine 325 – 337
- Moreno Gracias & C. Watts, "Violence against Women: Its Importance for HIV/AIDS", (2000) 14 AIDS, 14 (Suppl.3) 253 -265
- Murray C.J.K., et al. "Armed Conflict as a Public Health Problem" (2002) 324 British Medical Journal 346
- Newell M. L., "Mortality of infected and uninfected infants born to HIV-infected mothers in Africa: a pooled analysis", (Oct 2004) 364.9441The Lancet
- Obaid, Thoraya Ahmed, '*Introduction*' to edition on "Sexual Violence: Weapon of War, Impediment to Peace' 27 Forced Migration Review 5
- Oliveira M.A., *et al.*, "Has the Implementation of the TRIPS Agreement in Latin America and the Caribbean produced Intellectual Property Legislation that Favours Public Health?" (2004) 82:11Bull. World Health Org. 815
- Oliveira Maria & Jorge Bermudez, *et al.*, "Has the Implementation of the TRIPs Agreement in Latin America and the Caribbean Produced Intellectual Property Legislation that favours Public Health?" (2004) 81:11 Bull. World Health Org. 815 - 821
- Ostergard R. L., "Politics in the Hot Zone: AIDS and National Security in Africa" (2002) 23 Third World Quarterly 333
- Owens Heather & Barbara Arneil, "The Human Security Paradigm Shift: A New Lens on Canadian Foreign Policy" (Fall 1999) 7.1 Canadian Foreign Policy 6
- Paris Roland, "Human Security: Paradigm Shift or Hot Air?" (2001) 26.2 International Security 87
- Perkins S. & de Wit M, "The Private Sector steps in to fill the drug gap" (2007) 370.9589 Lancet 722 – 3
- Rebecca Eisenberg, "Patents and the Progress of Science: Exclusive Rights and Experimental Use" (1989) 56 U. Chi. L. Rev. 1017
- Rothchild Emma, "What is Security" (Summer 1995) 124.3 Daedalus, The Quest for World Order 53 – 98

- Sabina Alkire, "A Vital Core that Must Be Treated with the Same Gravitas as Traditional Security Threats" (2004) 35.3 Security Dialogue 359
- Samuel A Oddi, "TRIPs- Natural Rights and a 'Polite Form of Economic Imperialism'" (1996) 29 Vand. J. Transnat'l L. 415
- Sarkar K., "Sex-trafficking, violence, negotiating skill, and HIV infection in brothel-based sex workers of eastern India, adjoining Nepal, Bhutan, and Bangladesh" (2008) 26.2 Journal of Health, Population and nutrition 223 – 231
- Singer Peter W., "AIDS and International Security", (2002) 44.1 Survival 145 -146
- Smallman- Raynor M. R., et al, "Civil war and the spread of AIDS in Central Africa", (1990) 107 Epidemiol Infect 69 - 80
- Suhrke Astri, "Human Security and the Interest of States" (1999) 30.3 Security Dialogue 265
- Thomas Nicholas & William T. Tow, "The Utility of Human Security: Sovereignty and Humanitarian Intervention" (2002) 33. 2 Security Dialogue 177
- Tripodi Paolo & Preeti Patel, "HIV/AIDS, Peacekeeping and Conflict Crises in Africa" (2004) 20.3 Journal of Medicine, Conflict and Survival 195
- Turmen T., "Gender and HIV", (2003) 82 International Journal of Gynaecology and Obstetrics 411
- Ulman Richard H., "Redefining Security" (1983) 8.1 International Security 129
- UNDP, "Redefining Security: The Human Dimension" (May 1995) 94 Current History 230
- Weissberg M., "Conceptualising Human Security" (2003) 37.3 Swords & Ploughshares: A Journal of International Affairs 1
- Wendy Lim, "Towards Developing a Natural Law Jurisprudence in the US Patent System" (2003) 19 Santa Clara Computer & High Tech. L. J. 559
- Whiteside Alan, Alex De Waal & Tsadkan Gerre-Tenae, "AIDS, Security and the Military in Africa, A Sober Appraisal" (2006) 105 African Affairs 201- 218
- Yamey Gavin & William Rankin, "AIDS and Global Justice" (2002) 324:7331 BMJ 181-82

Zaba B., T. Boerma, & R. White, "Monitoring the AIDS epidemic using HIV prevalence data among young women attending antenatal clinics: Prospects and problems" (2000) 14 *AIDS* 1633- 1645

MONOGRAPHS AND REPORTS

A. Adefolalu, "HIV/AIDS as an Occupational Hazard to Soldiers – ECOMOG Experience" Unpublished paper presented at the Third All African Congress of Armed Forces and Police Medical Services, Pretoria, 24-28 October 1999

Abantu for Development, *Empowering Youth Through Comprehensive Reproductive Health Programs*. London/ (Accra: Abantu for Development, 2004)

Action Aid/Nigeria, *Mapping Civil Society's Involvement in HIV/AIDS Programmes in Nigeria* (Abuja: Action Aid, 2001)

African Union (AU), "Strategic Plan of the Commission of African Union", online, <http://www.africa-union.org/AU%20summit%202004/volume%202%20final%20-%20English%20-%20June%202004.pdf> (accessed 23 March 2010)

AIDS, Security and Conflict Initiative (ASCI), *HIV/AIDS, Security and Conflict: New Realities, New Responses*, online, http://asci.researchhub.ssrc.org/workingpapers/HIV_AIDS%2C%20Security%20and%20Conflict.pdf (accessed 23 March 2010)

Armed Forces Medical Intelligence Centre, *Impact of HIV/AIDS on Military Forces: Sub-Saharan Africa*, (Washington, DC: Defence Intelligence Agency, 2000)

Barnett Tony, 'HIV/AIDS and state fragility', ASCI synthesis paper, 2009, online, <http://asci.researchhub.ssrc.org/workingpapers/ASCI%20Synthesis%20Paper%20State%20Fragility.pdf> (accessed 23 March 2010)

Bennell P., Hyde K., & Swanson N., *The impact of the HIV/AIDS epidemic on the education sector in sub-Saharan Africa – A synthesis of the findings and recommendations of three country studies*. (Centre for International Education, University of Sussex Institute of Education, 2002)

Carr-Hill R., K.J. Katabaro & A.R. Katahoire, *The Impact of HIV/AIDS on Education and Institutionalizing preventive education* (Paris: International Institute for Education Planning and UNESCO, 2002)

Centre for Conflict Resolution, "HIV/AIDS and Militaries in Africa," online, http://www.ccr.org.za/images/stories/Vol_28_hiv_aids_militaries.pdf (accessed 23 March 2010)

- Cilliers Jakkie, *The African Standby Force: An Update on Progress* (Pretoria: Institute for Security Studies, 2008)
- Commission for Human Security, “Better Health for Human Security” in *Human Security Now*, online, <http://www.humansecurity-chs.org/finalreport/English/chapter6.pdf> (accessed 14 December 2009)
- _____, “Human Security Now”, online, <http://www.humansecurity-chs.org/finalreport/English/FinalReport.pdf> (accessed 14 December 2009)
- Falobi O., & Akanni O., ed., *Slow Progress: An Analysis of Implementation of Policies and Action on HIV/AIDS Care and Treatment in Nigeria* (Lagos: Journalists Against AIDS, 2004)
- Federal Ministry of Health Nigeria, “National HIV/AIDS and Reproductive Health Survey” (Abuja: NARHS, 2007)
- _____, *HIV/AIDS Emergency Action Plan* (Abuja: Federal Ministry of Health, 2001)
- Garrett Laurie, “*HIV and National Security: Where are the Links?*” (New York: Council on Foreign Relations, 2005)
- Ghana AIDS Commission, *Ghana HIV/AIDS strategic framework: 2001-2005* (Accra: Ghana AIDS Commission, 2001)
- Ghana AIDS Commission, *Ghana HIV/AIDS strategic framework: 2001-2005*. (Accra: Ghana AIDS Commission, 2001)
- Ghana AIDS Commission, *Ghana HIV/AIDS strategic framework: 2006 – 2010*. (Accra: Ghana AIDS Commission, 2006)
- Ghana Health Service, *HIV Sentinel Survey Report 2003* (Accra, Ghana: Ghana Health Service, 2004)
- Human Security Centre, *Human Security Report 2005: War and Peace in the 21st Century* (New York: Oxford University Press, 2005)
- Human Security: Safety for People in a Changing World’, Department of Foreign Affairs and International Trade, Ottawa, April 1999
- Integrating Intellectual Property and Development Policy*, UK Commission on Intellectual Property (CIPR), September 2002
- International Crisis Group, “HIV/AIDS as a Security Issue” (ICG Report June 2001), online,

http://www.crisisgroup.org/library/documents/report_archive/A400321_19062001.pdf (accessed 14 December 2009)

Kingma Stuart & Rodger Yeager, "A Civil-Military Alliance Response to the HIV/AIDS Epidemic in Nigeria", concept paper presented to the US Agency for International Development, February 2000, online, http://www.cert.org/cma/publications/Los_Alamos_Paper_6.pdf (accessed 23 March 2010)

Mba N. D., *Youth-for-Youth Health, Gender and Development NGOs: Report of a Mapping Exercise Prepared for the Ford Foundation* (Lagos: Ford Foundation, 2004)

National Action Committee on AIDS, *HIV/AIDS Strategic Framework 2005 – 2009* (Abuja: National Action Committee on AIDS, 2005)

_____, *National HIV/AIDS Behavior Change Communication Strategy (2004–2008)* (Abuja: National Action Committee on AIDS, 2004)

_____, "National HIV/AIDS strategic framework (NSF) 2010-15", online, http://www.naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=58&Itemid=268 (accessed July 6, 2010)

National AIDS / STI Control Programme, *2009 HIV Sentinel Survey Report* (Accra: National AIDS/STI Control Programme, Ghana Health Service, Ministry of Health, Accra Ghana, 2010)

_____, *2007 HIV Sentinel Survey Report* (Accra: Ghana Health Service, Ghana AIDS Commission, World Health Organisation, Department of International Development; 2008)

_____, *2008 HIV Sentinel Survey Report* (Accra: Ghana Health Service, Ministry of Health, 2009)

National Intelligence Council, *The Global Infectious Disease Threat and Its Implications for the United States* (Washington: NIC, January 2000)

Organisation for Economic Co-operation and Development (OECD) 2006 Meeting, Human Security in West Africa: Challenges, Synergies and Action for a Regional Agenda, Vol. 2, online, <http://www.oecd.org/dataoecd/57/31/38522363.pdf> (accessed 14 December 2009)

Physicians for Human Rights (2006) "Nigeria: Access to Health Care for People Living with HIV and AIDS," online, <http://physiciansforhumanrights.org/library/documents/reports/nigeria-access.pdf> (accessed July 6, 2010)

- Report of the UN Secretary General, *In Larger Freedom: Towards Development, Security and Human Rights For All*, UN GAOR, 59th Sess., UN Doc. A/59/2005 (2005)
- Riddell Roger, “Approaches to Poverty: A Note from the ‘Development’ Perspective” (2004), International Council on Human Rights Policy, Researcher’s Meeting on Poverty, Development, Rights (Geneva, 24-25 November 2004)
- Schneider M., & M. Moodie, *The destabilizing impacts of HIV/AIDS* (Washington DC: Center for Strategic and International Studies, 2002)
- Toebes Brigit, “The impact of acts of corruption on the enjoyment of the right to health” (A Report of the International Council on Human Rights Policy, 2007), online, www.abdn.ac.uk/law/documents/ReportRighttoHealthBTfinal.doc (accessed on 14 December 2009)
- Touray K. S., *Mapping of Support Groups for People Living with HIV/AIDS (PLWHAs) in Nigeria: National Report* (Abuja: National Action Committee on AIDS, 2005)
- UN Secretariat, “The impact of AIDS”, report by the Population Division, Department of Economic and Social Affairs, (New York: United Nations, 2003)
- UNAIDS, “2004 Report on the global Aids epidemic”, online, http://www.unaids.org/bangkok2004/GAR2004_pdf/UNAIDSGlobalReport2004_en.pdf (accessed May 17, 2010)
- _____, “2009 Report on the global AIDS epidemic”, online, http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf (accessed May 17, 2010)
- _____, UNICEF & WHO “Children and AIDS: Third stocktaking report”, online, http://www.unicef.org/publications/files/CATSR_EN_11202008.pdf (accessed May 17, 2010)
- UNICEF, “Children on the Brink: A Report of the New Orphan Estimates and a Framework for Action”, online, http://www.unicef.org/publications/files/cob_layout6-013.pdf (accessed May 17, 2010)
- United Nation Development Program UNDP, *Human Development Report 1994 – New Dimension of Human Security* (New York, Oxford: Oxford University Press, 1994)

_____, “Access to ART and other Essential Medicines in Sub-Saharan Africa: Intellectual Property and Relevant Legislations,” online, http://www.soros.org/initiatives/health/focus/access/articles_publications/publications/artafrica_20090313 (accessed July 4, 2010)

United Nations General Assembly, ‘Special Session of the General Assembly on HIV/AIDS: Report of the Secretary-General’ (16 February 2001) UN Doc A/55/779 [Special Session Report]

United Nations, *A More Secure World: Our Shared Responsibility, Report of the Secretary-General’s High Panel Threats, Challenges and Changes* (New York: United Nations. 2004)

United States General Accounting Office, *UN Peacekeeping: United Nations Faces Challenges in Responding to the Impact of HIV/AIDS on Peacekeeping Operations* (Washington DC: US General Accounting Office, December 2001)

Walsh Janet, LaShawn R. Jefferson & Joseph Saunders, *Kenya Double Standards: Women Property Rights Violations in Kenya*, (New York: Human Right Watch, 2003)

WHO/UNAIDS/UNICEF “Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector”, online, http://www.who.int/hiv/pub/tuapr_2009_en.pdf (accessed May 17, 2010)

World Health Organisation, “World Health Report 2001”, online, http://www.who.int/violence_injury_prevention/violence/collective/collective/en/index2.html (accessed on December 14 2009)

NEWS ARTICLES

Agence France Presse, “Obasanjo warns Soldiers against Unprotected Sex,” online, <http://www.aegis.com/NEWS/AFP/2000/AF000584.html> (accessed 23 March 2010)

AU Monitor, “Summit to focus on maternal and child health”, online, <http://www.pambazuka.org/aumonitor/comments/2699/> (accessed July 6, 2010)

Pambazuka News, “African Finance Ministers Dismiss Development Declarations”, online, <http://www.pambazuka.org/en/category/comment/63894> (accessed July 6, 2010)

Reuters Limited, “Nigeria opens 41 new AIDS treatment centres”, online, <http://www.aegis.com/news/re/2006/RE060316.html> (accessed July 6, 2010)

_____, “Update 2-SAfrica’s Apen wins tender, shares soar”, online, <http://www.reuters.com/article/idUSL2661471720080626> (Accessed July 6, 2010)

ONLINE PUBLICATIONS

African Union, “Strategic Plan of the Commission of African Union”, online, <http://www.africa-union.org/AU%20summit%202004/volume%202%20final%20-%20English%20-%20June%202004.pdf> (accessed July 6, 2010)

_____, “Abuja Declaration and Framework Plan of Action on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases”, online, http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (accessed 23 March 2010)

_____, “African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases”, online, http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (accessed July 6, 2010)

_____, “Common Position on HIV/AIDS,” Sp/Assembly/ATM/3 (I) Rev.2, online, http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/UNGASS_Common_Position.pdf (accessed 23 March 2010)

Avert, “HIV/AIDS in Nigeria”, online, <http://www.avert.org/aids-nigeria.htm> (accessed July 6, 2010)

Bertrand Ramcharan, ‘Human Rights and Human Security,’ online, <http://www.humansecurity-chs.org/activities/outreach/ramcharan.pdf> 2 (accessed 14 December 2009)

Center for Global Health Policy, “WHO Regional Director for Africa Discusses Abuja Declarations”, online, <http://sciencespeaks.wordpress.com/2010/05/08/who-regional-director-for-africa-discusses-abuja-declarations/> (accessed July 6, 2010)

Chen Lincoln C., Health as a “Human Security Priority for the 21st Century”, online, <http://www.helsinki.fi/netcomm/ImgLib/24/89/LCHelsinkiPaper12%5B1%5D.6.04.pdf> (accessed 14 December 2009)

Commission on Human Security, “San Jose Declaration”, online, <http://www.humansecurity-chs.org/activities/outreach/sanjosedec.pdf> (accessed 14 December 2009)

De Waal, Alex, “2005 ‘Issue Paper 1: HIV/AIDS and the Military”, paper presented at Expert Seminar and Policy Conference on ‘AIDS, Security and Democracy’,

Clingendeal Institute, The Hague, 2-4 May,
http://asci.ssrc.org/doclibrary/issue_paper1.pdf (accessed 14 December 2009)

Deneulin Séverine, “Ideas related to Human Development,” online,
http://www.idrc.ca/en/ev-146686-201-1-DO_TOPIC.html (accessed 14 December 2009)

Economic Commission for Africa, “Commission on HIV/AIDS and Governance in Africa: Impact of HIV/AIDS on gender, orphan and vulnerable children”, online,
http://www.uneca.org/CHGA/Cameroon/cameroon_orphans.pdf (accessed May 17, 2010)

Ellen Seidensticker, a Seminar on Human Security, Human Rights, and Human Development, Kennedy School, Harvard University, 5 February 2002, online,
<http://www.humansecurity-chs.org/activities/outreach/0206harvard.pdf> (accessed 14 December 2009)

FHI Nigeria, “Nigerian NGOs Foster a Caring Community,” online,
<http://www.fhi.org/en/HIVAIDS/pub/Archive/articles/IOH/ioh11/ioh112.htm>
(accessed July 6, 2010)

Ghana Ministry of Health, “HIV/AIDS in Ghana: background, projections, impacts, interventions and policy”, online,
http://www.policyproject.com/pubs/countryreports/GHA_AIM3rdEd.pdf
(accessed July 6, 2010)

Global Strategies for HIV Prevention, “A call to action to prevent HIV infections of Newborns. San Rafael, CA: Global Strategies for HIV/Prevention”, online,
http://globalstrategies.org/resources/call_to_action_newborns.html (accessed May 17, 2010)

Human Security Centre, “What is Human Security”, online,
http://www.humansecurityreport.info/HSR2005_PDF/What_is_HS.pdf (accessed 14 December 2009)

IFPMA, *WHO Commission Report on Biomedical Innovation, Patents and Public Health Contains many Sound Proposals but Mistakenly Underestimates the Vital Role of Patents*, April 3, 2006. Online: IFPMA,
<http://www.ifpma.org/News/NewsReleaseDetail.aspx?nID=4628> (accessed July 6, 2010)

International Commission on Intervention and State Sovereignty (ICISS), 2001, *The Responsibility to Protect*, online, at www.dfait-maeci.gc/iciss-ciise/menu-en.asp
(accessed 14 December 2009)

- Lang Michael, ed., HIV/AIDS: A Threat to the African Renaissance, online, <http://www.lib.uct.ac.za/asl/info/renaissance.pdf> (accessed 23 March 2010)
- Office of the High Commissioner on Human Rights, Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies (2002), online, <http://www.ohchr.org/english/issues/poverty/guidelines.htm112> (accessed 14 December 2009)
- Pharmaceutical Research and Manufacturers of America, *Intellectual Property*, Online, PhRMA, <http://www.phrma.org/issues/intprop> (accessed July 6, 2010)
- Pollard R., “UN forces more at risk from HIV than war”, online, <http://www.smh.com.au/articles/2002/07/10/1026185066992.html> (accessed 23 March 2010)
- Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Human Rights Guidelines to Pharmaceutical Companies in Relation to Access to Medicines, online, <http://www2.ohchr.org/english/issues/health/right/> (accessed 14 December 2009)
- Tandria Hilda, “The Gender Dimensions of HIV/AIDS in Africa”, online, http://www.uneca.org/chga/gender_hiv_aids.pdf (accessed May 17, 2010)
- The Population Council, Inc., “The experience of married adolescent girls in Northern Nigeria”, online, http://www.popcouncil.org/pdfs/Nigeria_MarriedAdol.pdf (accessed July 6, 2010)
- UNAIDS, “2008 Report on the global AIDS epidemic”, online, http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp (accessed May 17, 2010)
- _____, “2009 Report on the global AIDS epidemic”, online, http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf (accessed 17 May 2010)
- _____, “A strategic approach: HIV & AIDS and education”, http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090615_UNESCO.asp (accessed May 17, 2010)
- _____, “Gender and HIV/AIDS: UNAIDS technical update”, online, http://whqlibdoc.who.int/un aids/1998/gender_HIV_eng.pdf (access May 17, 2010)
- _____, “Nigeria`s progress report on the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS,” online,

http://data.unaids.org/pub/Report/2010/nigeria_2010_country_progress_report_en.pdf (accessed July 6, 2010)

_____, “United Nations General Assembly Special Session on HIV/AIDS: Declaration of Commitment on AIDS”, online, http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf (accessed May 17, 2010)

_____, “Women and girls”, <http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/WomenGirls/default.asp> (accessed May 17, 2010)

_____, 2008 Report on the global AIDS epidemic’, online, http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp (accessed 17 May 2010)

_____, Ghana’s progress report on the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS, online, http://data.unaids.org/pub/Report/2010/ghana_2010_country_progress_report_en.pdf (accessed July 6, 2010)

_____, *Uniting the World against AIDS*, online: UNAIDS http://www.unaids.org/en/Regions_Countries/Countries/south_africa.asp (accessed July 6, 2010)

UNAIDS/UNFPA/UNIFEM “Women and HIV/AIDS: Confronting the crisis”, online, <http://www.unfpa.org/hiv/women/report/index.htm> (accessed 17 May 2010)

UNAIDS: Joint United Nations Program on AIDS/World Health Organisation, “On the front line: A review of Policies and programmes to address HIV/AIDS among peacekeepers and uniformed services”, online, http://data.unaids.org/publications/IRC-pub05/jc950-frontline_en.pdf (accessed 23 March 2010)

UNICEF, “Child protection from violence, exploitation and abuse”, online, http://www.unicef.org/protection/index_orphans.html (accessed May 17, 2010)

UNIFEM & Action Aid, “Together we must end violence against women and girls and HIV & AIDS”, online, http://www.unifem.org/attachments/products/TogetherWeMust_en.pdf (accessed May 17, 2010)

United Nations Development Program (UNDP), “HIV and women's inheritance and property rights”, online, <http://content.undp.org/go/newsroom/updates/hiv-www->

news/womens-inheritance-and-property-rights-are-essential-to-effective-aids-response.en?src=print (accessed May 17, 2010)

_____, “Beyond scarcity: Power, poverty and the global water crisis”, online, <http://hdr.undp.org/en/media/HDR06-complete.pdf> (accessed 14 December 2009)

United Nations Population Fund, “Addressing gender perspectives in HIV Prevention, HIV Prevention now, programme briefs, no.4, online, <http://www.unfpa.org/hiv/prevention/documents/hivprev4.pdf> (accessed May 14, 2010)

_____, “Fact about Motherhood”, online, <http://www.unfpa.org/mothers/facts.htm>, (accessed 14 December 2009)

United Nations, “Fact Sheet – Violence against Women: Forms, Consequences and Costs”, online, <http://www.un.org/womenwatch/daw/vaw> (accessed May 17, 2010)

United States Department of State, “US International Strategy on HIV/AIDS”, online, <http://dosfan.lib.uic.edu/ERC/environment/releases/9507.html> (accessed 23 March 2010)

USAIDS, “West Africa Health Context”, online, <http://www.usaid.gov/westafrica/health/index.htm> (accessed 14 December 2009)

WHO, UNAIDS & UNICEF ‘Towards universal access: scaling up priority HIV/AIDS interventions in the health sector’, WHO online, http://www.who.int/hiv/pub/towards_universal_access_report_2008.pdf (accessed July 6, 2010)

World Bank, “World Development Report 1993: Investing in Health: World Development Indicators”, online, <http://files.dcp2.org/pdf/WorldDevelopmentReport1993.pdf> (accessed 14 December 2009)

World Health Assembly, 2005 Revision of the International Health Regulations, WHA 58.3, 23 May; online, http://www.who.int/csr/ihr/IHRWHA58_3-en.pdf (accessed 14 December 2009)

World Health Organisation, “Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes”, online, <http://www.who.int/gender/documents/en/genderdimensions.pdf> (accessed May 17, 2010)

- _____, “History of WHO and International Cooperation in Public Health”, online, http://www.who.or.jp/GENERAL/history_wkc.html (accessed 14 December 2009)
- _____, “Integrating gender into HIV/AIDS Programmes, review paper for Expert Consultation”, online, http://www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf (accessed May 17, 2010)
- _____, “WHO Multi-country Study on Women’s Health and Domestic Violence against Women: Initial Results on prevalence, health outcomes, and women responses”, online, http://www.who.int/gender/violence/who_multicountry_study/en/index.html (accessed May 17, 2010)
- _____, “Women & health: today's evidence tomorrow's agenda”, online, http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf (accessed 17 May 2010)
- _____, (WHO) “Celebrating water for life: The International Decade for Action 2005-2015: *Resource Sheet 1*”, online, <http://whqlibdoc.who.int/publications/2005/a85911.pdf> (accessed 14 December 2009)
- _____, “Facts and Figures: Water, Sanitation and Hygiene Links to Health”, Water and Sanitation Department, March 2004, online, http://www.who.int/water_sanitation_health/publications/factsfigures04/en/ (accessed 14 December 2009)
- _____, WHO, “World Health Report 2005: Make Every Mother and Child Count”, online, http://www.who.int/whr/2005/whr2005_en.pdf (accessed 14 December, 2009)
- _____, WHO, “World Health Report 2003: Shaping the Future”, online, http://www.who.int/whr/2003/en/whr03_en.pdf (accessed 14 December, 2009)