Governance, Violence and AIDS in West Africa

Alastair Roderick,

Justice Africa.

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The African Civil Society Governance and AIDS Initiative's stated purpose is to raise public understanding of HIV/AIDS as a threat to democratic governance in Africa. The reasons for this threat are the nature of the societal challenge posed by HIV/AIDS, and the considerable difficulties that are faced in ensuring that the response to the HIV/AIDS epidemic in Africa is consistent with both the technical requirements of effective public health policy, and also supportive of democratic governance.

The focus of GAIN has been on Eastern and Southern Africa, mainly due to the large amount of the work on HIV/AIDS that is publicly available. One obvious area of interest for GAIN is to understand why HIV/AIDS has taken a more muted course in West Africa, where adult prevalence ranges from 3.5-4.5%, and is seen to be stabilising in many places, compared to the rest of Sub-Saharan Africa, where rates reach 7.4% [1]. Several explanations are required here. First, statistics are rarely collected regionally. They are either combined sets of national data, or are extrapolations from various data-sets collected in different parts of each region. Second, these statistics- as well as having the capacity for error- are based on UNAIDS/WHO data for the whole of the West African region as they deem it: and this includes the Sahelian countries of Chad, Mali, Niger and Mauritania as well as the whole of the Democratic Republic of Congo, where the difficulty of collecting data on HIV/AIDS in a war-torn nation that stretches all the way to Tanzania and Zambia is well documented. This changes the dynamic of the 'West' African epidemic. Third, while quantitatively West Africa seems of less concern than neighbouring regions, qualitatively the pressures of large populations, high birth rates, greater social and physical mobility within the region, and the presence of cross-border conflict would indicate that West Africa is of growing, rather than reducing concern for AIDS activists.

Two main concerns inform thinking on HIV/AIDS and conflict in West Africa. Firstly, a 'policy gap' has developed between West Africa and Southern and Eastern Africa in terms of HIV/AIDS policy and planning. Whilst global attention has focused upon the political and humanitarian catastrophe of HIV/AIDS in Southern Africa, West Africa has not escaped the effects of the epidemic; with infection rates above 5% in most nations, and reaching Southern African levels in Côte d'Ivoire and the Mano River Union nations of Liberia, Sierra Leone and Guinea (MRU+1). A lack of attention on West Africa, coupled with the difficulties of coordinating policy in such an ethnically and linguistically mixed region, has led to an underdevelopment of HIV/AIDS control mechanisms and strategies, and prevented the fostering of a culture of AIDS awareness and prevention that has been effective in Southern and Eastern Africa.

Secondly, violent conflict has been repeatedly shown to drive HIV/AIDS as it leads to sexual exploitation, increased social mobility, destruction of healthcare infrastructure and rapid decline in the ability for health monitoring in a population to be maintained. In turn, HIV/AIDS increases the burden on fragile health structures, depletes public revenues and increases competition for resources, all of which can increase the capacity in fragile states for social enmity to develop, political antagonism to increase, and democratic and other pluralistic governance structures to lose public legitimacy, increasing the opportunity for conflict and violence.

Armed conflict nurtures HIV/AIDS in vulnerable societies by creating an increase in both forced and voluntary population movements, public resources being redirected to military expenditure, declining public revenues leading to a de-prioritisation of HIV/AIDS prevention programmes in favour of military expenditure, sexual exploitation and an increase in associated risky behaviour, erosion of public health infrastructure, and the suspension of the monitoring programmes necessary to plan HIV/AIDS control strategies

West Africa shows the highest concentration of conflicts in Africa: thirteen violent or potentially violent conflicts existed in the region in 2004 and continue in 2005, according to the Heidelberg Institute on International Conflict Research 2, and is home to three of the six United Nations' Peacekeeping missions in Africa, as well as the ECOWAS mission in Liberia (ECOMIL). This has led to a complex politico-humanitarian catastrophe where conflict breeds social destruction that breeds more conflict. Evidence from Uganda, Rwanda and Ethiopia supports the close relationship between AIDS and violence; the danger in the Mano River nations is that a rapid increase in the spread of HIV/AIDS is just one more factor adding to the intractability of the sub-regional political and social emergency.

ECOWAS has recently made a firm commitment to regional security and intervened notably in Sierra Leone (ECOMOG, 1998) and Liberia (ECOMIL, 2003). The evolution of ECOWAS into a security body, however, and its fraught history, are probably better illustrations of a culture of disunity, rather than of unity, in West Africa. Although the Non-Aggression Protocol was signed by member-states in 1978, the more wide-ranging Protocol on Mutual Assistance on Defence (1981) that would have governed interventions in member states, has never been implemented, something Adeniji (1997) 3 attributes to fear among Francophone states in the region of the hegemonic ambitions of Nigeria. The Nigerian-led forces in both countries were deployed against regional protests, and have been criticised on both occasions for their partiality and slack observance of international humanitarian law.

The West African security crisis, therefore, that began with Liberian interference in Sierra Leone in the late 1980s, is a sub-regional pattern of violence and political instability that has engulfed Côte d'Ivoire, Liberia, Sierra Leone and Guinea, and extends out from these states through corridors of violence throughout the region; both physical and figurative. HIV/AIDS is not only being driven by violence in the sub-region, but the structural damage that HIV/AIDS is able to inflict, the demographic changes that it forces upon an society, and the, so-to-speak, social-dissolution that HIV/AIDS applies to communities and states, lays the antecedents of problems that inspire the desperate answer of violence.

The initial research on the social, political and economic effects of HIV/AIDS on violent conflict in West Africa draws a number of conclusions that will inform future work by GAIN in the region. These can be summarised as follows.

• Very few resources have been devoted to HIV/AIDS and Conflict programmes globally, and little money has been allocated in the MRU+1. The Global Fund for AIDS, Tuberculosis and Malaria has allocated $60m for the four nations, 2003-2005 4, of which only half is for HIV/AIDS, with Sierra Leone receiving no specific funds for HIV/AIDS at all in the current funding round. Of this $30m, only one allocation, in Côte d'Ivoire for just over $1m, has been allocated specifically for a HIV/AIDS and conflict programme.

• Healthcare infrastructure has been repeatedly targeted and attacked in conflict zones, adding to the humanitarian crisis in the region. This is a problem in two respects. First, already stretched capacities are put under further strain. The Global Fund reports that in northern Côte d'Ivoire no public healthcare systems are in operation, 80% of healthcare groups and NGOs fail to operate at pre-2002 levels, and what public health coordination there is, is in the hands of foreign NGOs 5. Second, in conflict, declining health revenues have to be spent on larger numbers of emergency cases, and HIV/AIDS programmes- especially the monitoring programmes so crucial in controlling the spread of the epidemic- are left de-prioritised and un-funded.

• The suspension of monitoring activities during conflict should be judged to be among the most serious, if not the most serious, impact upon HIV/AIDS prevention programming. Of

the four nations, only Côte d'Ivoire is judged by UNAIDS to have reliably and accurately monitored it's epidemic (at least prior to the latest outbreak of violence); and Côte d'Ivoire has the highest adult prevalence rate in the region- 10.76% 6. Failure to record the pattern of the epidemic in a society, or obfuscation in releasing unfavourable data, makes planning impossible for a disease that is both fast moving and protracted. The political and social damage that HIV/AIDS can potentially inflict on a society

will continue to pose problems for policy-makers for decades; failure to record the strength and character of the epidemic hinders the political response to HIV/AIDS, which will have long-term effects upon good governance and the maintenance of democracy.

• The position of refugees and Internally Displaced Persons (IDP's) in driving both HIV/AIDS and fuelling the social problems that lead to conflict in the sub-region is central to understanding HIV/AIDS and violence in West Africa. One million refugees have been created in the sub-region since 1990, and two million IDP's. 967,220 [7] displaced persons remain, with two-thirds of these in Liberia, and are slowly dispersing. Refugees and IDP's are highly mobile, often concentrated in holding-camps, have limited healthcare access and are easy prey to sexual exploitation. In addition to flight from conflict, the region has experienced a second shock as more than 100,000 displaced persons have returned conflict is suspended, mainly to Sierra Leone. In addition to this are an unknown number of returned expatriates who fled political violence before major conflict erupted, and have not been monitored by the UNHCR or any other body.

• Conflict causes donors and external actors to de-prioritise programmes not related to ending violence or post-conflict rehabilitation. A major casualty of war will be HIV/AIDS treatment programmes, and still more HIV/AIDS monitoring. The breakdown in such activities leads to an unchecked epidemic, and treatment programmes, if any, fail to be adequately and appropriately deployed. Furthermore, HIV/AIDS monitoring is only possible given a minimum standard of healthcare infrastructure; destruction of this prevents monitoring from being initiated in post-conflict societies.

• The presence of peacekeeping forces has been shown to increase the incidence of HIV/AIDS in a population, and issues of HIV/AIDS, peace, security and conflict are of increasing concern. This is especially pertinent in West Africa as ECOWAS has taken a lead in African peacekeeping, and reports of prostitution and sexual exploitation have followed the ECOMOG and ECOMIL interventions. This not only creates a core of infection in conflict zones, but disengaging peacekeepers fuel the spread of HIV/AIDS more widely.

• West African nations have a complex system of inter-dependencies and antagonisms that derive both from the legacy of colonial division between British clients that were largely autonomous of each other, and French clients that are largely co-dependent, and also from post-colonial regional politics. The language barrier, between Anglophone and Francophone nations, added to complex political divisions, produces regional policy on healthcare and HIV/AIDS that is un-coordinated between states; yet these same states find themselves at the whim of events that occur in their neighbours.

West Africa remains at the front-line for AIDS-activism in Africa, as infection rates and patterns synchronise with those on the rest of the continent; but attention is still focused on nations in southern and eastern Africa. The complicating factor of conflict and humanitarian disaster centred on the Mano River nations- but importantly, not limited just to these- is both exacerbating, and exacerbated by the presence of HIV/AIDS in these nations. Not only is insufficient attention paid to this emergency, but the nature of armed conflict and humanitarian emergency emphasises the dangers of a long-wave problem such as HIV/AIDS being marginalised by the more visible emergency of armed conflict.

1 UNAIDS; AIDS Epidemic Update 2004

2 University of Heidelberg, Conflict Barometer 2004

3 Mechanisms for Conflict Management in West Africa: Politics of Harmonization': Adeniji O; ACCORD,(1997)

4 Global Fund for AIDS, Tuberculosis and Malaria;

5: Ibid. (2004 figures)

6: World Health Organisation

7: UNHCR; . The figure of 967,220 is based on UNHCR planning figures for January 2005. Statistics collected by other agencies, or national governments, may differ from this number.