

Healing or Harming? United Nations Peacekeeping and Health

PROVIDING FOR PEACEKEEPING NO. 9

SARA E. DAVIES AND SIMON RUSHTON



Cover Photo: A Jordanian doctor serving with the UN Mission in Liberia (UNMIL) inspects a young woman's face during the medical outreach event held by the Jordanian contingent in Monrovia, Liberia, on December 15, 2012. UN Photo/Staton Winter.

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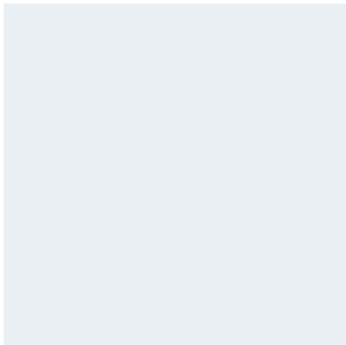
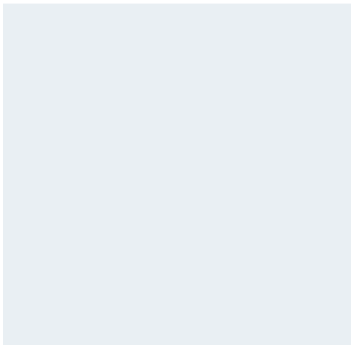
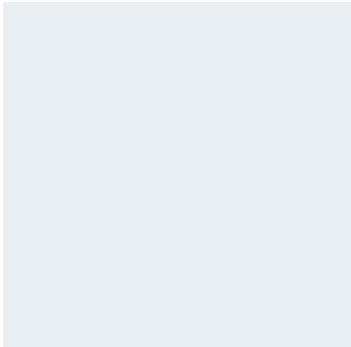
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CONTENTS

Abbreviations	iii
Executive Summary	1
Introduction	1
Peacekeeping as a Health Problem	4
THREATS TO THE HEALTH OF PEACEKEEPERS	
PEACEKEEPERS AND POPULATION HEALTH	
RECOMMENDATIONS	
Peacekeeping as an Opportunity to Improve Population Health	15
CIVILIAN HEALTH ASSISTANCE IN THEORY	
CIVILIAN HEALTH ASSISTANCE IN PRACTICE	
RECOMMENDATIONS	
Conclusion	28

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CIMIC	Civil Military Cooperation
CMO	Chief Medical Officer
DPKO	Department of Peacekeeping Operations
HIA	Health Impact Assessment
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
MINURSO	United Nations Mission for the Referendum in Western Sahara
MINUSCA	United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic
MINUSMA	United Nations Multidimensional Integrated Stabilization Mission in Mali
MINUSTAH	United Nations Stabilization Mission in Haiti
MONUSCO	United Nations Organization Stabilization Mission in the Democratic Republic of the Congo
MOU	Memorandum of Understanding
MSF	Médecins Sans Frontières
NGO	Nongovernmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
OIOS	Office of Internal Oversight Services
QIP	Quick Impact Project
SOTG	Special Operations Task Group
TAM	Technical Assessment Mission
TCC	Troop Contributing Country
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNAMA	United Nations Assistance Mission in Afghanistan
UNAMID	African Union-United Nations Hybrid Operation in Darfur

UNAMSIL	United Nations Mission in Sierra Leone
UNDOF	United Nations Disengagement Observer Force
UNFICYP	United Nations Peacekeeping Force in Cyprus
UNHCR	United Nations High Commissioner for Refugees
UNIFIL	United Nations Interim Force in Lebanon
UNISFA	United Nations Interim Security Force for Abyei
UNMEER	United Nations Mission for Ebola Emergency Response
UNMIH	United Nations Mission in Haiti
UNMIK	United Nations Interim Administration Mission in Kosovo
UNMIL	United Nations Mission in Liberia
UNMISS	United Nations Mission in the Republic of South Sudan
UNMOGIP	United Nations Military Observer Group in India and Pakistan
UNOCI	United Nations Operation in Côte d'Ivoire
UNTSO	United Nations Truce Supervision Organization
WHO	World Health Organization

Executive Summary

This study examines the impact that United Nations (UN) peacekeeping operations have on health—both negative, in terms of the health threats that peacekeepers can present to the host population, and positive, in the contribution that peacekeepers can make to health by facilitating access for humanitarian aid agencies and also delivering health assistance directly. The report assesses the existing guidelines, principles, and practices.

In the first part of the report, “Peacekeeping as a Health Problem,” we find a need for greater attention to medical checks and health care provision for peacekeepers both before and during deployment. This is necessary to protect the health of peacekeepers themselves and of the civilian populations with whom they come into contact.

In the second section, “Peacekeeping as an Opportunity to Improve Population Health,” we find that peacekeepers can play a vital role in delivering health care in emergency settings, as well as facilitating and assisting humanitarian access. However, it is also evident that such initiatives can create new problems associated with the politicization of health aid—a danger that is particularly acute in cases where peacekeepers seek to use health assistance to “win hearts and minds.” We also find that the practice of health assistance in missions is not always in line with UN guidance and mandates, creating problems for planning, oversight, and coordination with humanitarian agencies. Although we accept that there are situations in which peacekeepers should play a direct role in delivering health assistance, the ultimate aim, we argue, should be to support—not supersede—the work of humanitarian actors.

From our analysis of current guidelines, principles, and practices we make the following recommendations:

- Pre-deployment medical checks (which are carried out by troop contributing countries, or TCCs, and verified by the mission’s chief medical officer) should be strengthened, with the UN and TCCs cooperating to ensure the pre-deployment medical requirements have been properly

fulfilled. With the adoption of a new reimbursement rate for TCCs (some of whom had cited the cost of pre-deployment medical care, among other things, to argue for an increased reimbursement rate), it seems legitimate for conditions regarding health assessments to be toughened in memoranda of understanding between the UN and TCCs. This report suggests that an identifiable payment specifically for pre-deployment health care would help ensure that the necessary medical checks take place.

- Health impact assessments should be conducted prior to deployment and on an annual basis thereafter, so that all missions can systematically monitor the impact peacekeepers have on the health of the host population and to guide risk minimization strategies.
- The UN Department of Peacekeeping Operations’ principles and guidelines for peacekeepers should be revised to clarify the need for coordination with the Office for the Coordination of Humanitarian Affairs (OCHA), the host state, and other relevant agencies in the provision of humanitarian assistance (including health assistance) and to more clearly identify the roles and responsibilities of UN peacekeepers in different situations.
- These guidelines should be tailored for each mission and reviewed as part of the mandate renewal (six-month and/or twelve-month intervals) to ensure that prevailing coordination agreements reflect the changing circumstances on the ground and the findings of the latest health impact assessments.

Introduction

At the time of writing, the United Nations Department of Peacekeeping Operations (DPKO) has seventeen missions deployed across four continents. In all, 128 countries contribute personnel to those missions—a workforce of 112,696 made up of troops, police, international and local civilian staff, and UN volunteers.¹ Keeping those personnel fit and healthy, particularly within the difficult and dangerous environments in which they are frequently deployed, is a

¹ Data as of October 31, 2014, available at www.un.org/en/peacekeeping/about/, accessed December 8, 2014.

significant medical undertaking. Accordingly, the missions currently deployed include thirty hospitals and 284 clinics.²

Death, injury, and mental trauma arising directly from peacekeeping duties are the threats that most immediately spring to mind. Yet malicious acts of violence account for only a small proportion of the cases that a mission's medical services deal with.³ Furthermore, the physical and mental health of peacekeepers themselves is only one aspect of what is a two-way interface between peacekeeping personnel and the civilian populations of the societies in which they serve. The health of peacekeepers can be affected by diseases present in the local environment (for example, malaria or dengue fever). But the reverse is also true: in Haiti, cholera was allegedly spread from peacekeeping troops to the local population. In these ways, peacekeepers and local populations can face

“shared” health risks—often in environments where health resources and expertise are already severely strained.

At the same time, there are opportunities for peacekeepers to make a positive contribution to the health of the local population, either through the direct provision of medical and other health services or by creating the conditions within which humanitarian aid organizations, UN agencies, and other service providers can work. The idea that peacekeeping forces can play a role in providing health services beyond the mission itself is one that the UN has been keen to project in recent years, including in its latest public relations campaign, which uses images showing a female medic standing in a UN hospital corridor and a blue bereted medic holding a child (see figure 1).⁴

Figure 1. UN campaign depicts peacekeepers in health care roles.



² In a UN peacekeeping mission, the difference between a clinic and a hospital relates to the medical care and expertise available. These facilities are classified according to three levels: Level I: Medical clinics – Formed units; Level II: Field hospitals – Surgical units; Level III: Field hospitals – Major capabilities.

³ James I. Rogers and Caroline Kennedy, “Dying for Peace? Fatality Trends for United Nations Peacekeeping Personnel,” *International Peacekeeping* 21, No. 5 (2014): 658–672.

⁴ This campaign was launched to tie in with the International Day of United Nations Peacekeepers, May 29, 2014, available at www.un.org/en/peacekeeping/forceforfuture/.

Such images of peacekeepers fulfilling a broader social mission, including medical assistance, have become increasingly prominent. Yet the attribution of a broader humanitarian role to peacekeeping missions is not uncontroversial. First, it raises serious questions about the division of roles and responsibilities between military and humanitarian actors in the delivery of medical assistance to civilians. Second, peacekeeping operations have political objectives and are in this respect not impartial—something that can raise tensions between peacekeepers and humanitarian agencies keen to defend the apolitical nature of humanitarian aid. Third, clear budgetary and resource constraints on what UN peacekeeping missions can realistically do in this area leads to the possibility of the UN over-promising and under-delivering.

In this report, we explore the relationship between UN peacekeeping missions and health, and examine the contribution that peacekeepers make to improving health outcomes as well as the negative effects that they can have. In addition to analyzing current policies, procedures, and practices, we make a number of recommendations designed to augment the positive and reduce the negative health impacts associated with UN peacekeeping.

In the first section, we explore peacekeeping as a health problem. Peacekeepers themselves face a wide range of risks to their physical and mental health, and they are more likely to die from accidents or from infectious diseases than from combat. Civilians, meanwhile, can be put at risk by the presence of peacekeepers deployed without pre-deployment medical checks or appropriate safeguards for infection control. We recommend measures to ensure that pre-deployment medical checks take place, the introduction of pre-deployment and subsequent annual Health Impact Assessments (HIA), and the extension of UN audits of peacekeeping missions. These steps could ensure that the health of peacekeepers themselves is protected to the maximum possible extent (while recognizing, of course, that peacekeeping is an inherently dangerous occupation) and also that UN missions adopt a “do no harm” approach to the

civilian population’s health.

We have seen all too clearly in recent months that serious public health events that are perceived to threaten the safety of peacekeeping personnel can create tensions between troop-contributing countries (TCCs) and DPKO. The Ebola epidemic in West Africa and its potential impact on peacekeeping troops—especially those serving with the UN Mission in Liberia (UNMIL)—has attracted significant attention. A number of TCCs expressed concern for the safety of their troops, including the Philippines, which withdrew its 115 troops from the mission, despite assurances from Secretary-General Ban Ki-moon about the limited threat posed to them:

All United Nations personnel in Liberia have been educated about the appropriate preventive measures that would minimize the risk of contracting Ebola, which is not airborne and requires direct contact with the bodily fluids of a symptomatic infected person or the deceased. I am therefore confident that United Nations personnel may continue their important work in Liberia.⁵

In addition to what it demonstrates about the health risks to peacekeepers themselves, the Ebola outbreak in Liberia has also highlighted issues of relevance to the second section of this report, which addresses the provision of medical assistance by peacekeepers to the local population. The decision to keep peacekeepers within the UNMIL compound during the initial stages of the Ebola outbreak had a significant impact on the local health programs that mission medical units had previously been delivering within Liberia.⁶ The precariousness of such arrangements is just one of the potential issues that we raise in relation to peacekeepers taking on a wider humanitarian aid delivery role.

In section two, we also explore how DPKO has come to understand the relationship between civilian and military operations in the area of medical assistance. It has long been understood that there is a necessary division of roles and responsibilities between humanitarian and military actors. In reality, this division often becomes more complicated as different actors’ roles and responsi-

5 Quoted in Colum Lynch, “Ban Says U.N. Troops Are Safe, Needed to Quash Ebola Unrest,” *Foreign Policy*, September 2, 2014, available at http://thecable.foreignpolicy.com/posts/2014/09/02/ban_says_un_troops_are_safe_needed_to_quash_ebola_unrest.

6 Here it is important to distinguish between the UNMIL mission and UNMEER—the UN Mission for Ebola Emergency Response, the UN’s first ever emergency health mission. For a description of UNMEER, see www.un.org/ebolareponse/mission.shtml.

bilities shift or break down—often for well-intentioned reasons. In these situations, the mission mandate and the existence of clear guidelines to structure the relationships between military and civilian actors become essential. We examine current UN missions' approaches to the provision of medical assistance, to identify what conditions enable a positive health contribution by a peacekeeping operation—and where dangers may lie. Our recommendations include the need for routine cooperation between the Office for the Coordination of Humanitarian Affairs (OCHA) and DPKO in establishing the guidelines for each mission prior to its deployment, and the routine appraisal of these guidelines at time of mandate renewal to ensure that they correspond with both conditions on the ground and capabilities within the mission.⁷

Peacekeeping as a Health Problem

THREATS TO THE HEALTH OF PEACEKEEPERS

As with all military deployments, the health of peacekeepers has a significant bearing on their effectiveness. Nearly 3,326 peacekeeping personnel have died in service since 1948 (see figure 2);⁸ the overwhelming majority of them have been peacekeeping troops (2,408), but there also have been significant numbers of local staff (332), police (237), international civilian staff (232), military observers (87), and others (30).⁹ Malicious acts account for only one quarter (857) of these deaths, significantly outnumbered by both accidents (1,245) and illness (1,027).¹⁰

As figure 2 shows, the number of peacekeeper deaths increased significantly since the end of the Cold War. Although some of these deaths have been the result of unusual and catastrophic events

(in 2010, for example, ninety-six peacekeepers lost their lives in the earthquake that struck Haiti on January 12th¹¹), questions have been raised about whether peacekeeping has become more dangerous. In 2000, Benjamin Seet and Gilbert M. Burnham noted the significant increase in the number of peacekeeper deaths through the 1990s as compared to previous decades and attributed this to both “the increase in number and scale of peacekeeping operations conducted since the end of the Cold War” and “the changes in nature and characteristics of peacekeeping missions that have made them more dangerous with higher fatality risks.”¹² It is certainly the case that the dramatic increase in the number of deaths reflected the simultaneous expansion of UN peacekeeping activities through the 1990s and the larger number of peacekeepers deployed, although it is less clear whether peacekeeping missions became more dangerous per se. Indeed, Seet and Burnham found no significant increase in crude death rates.

However, a more nuanced picture becomes apparent if we look at the causes of peacekeeper deaths. Table 1 shows the numbers and causes of deaths across two years in the seventeen peacekeeping missions currently deployed.

These figures highlight the extent to which illness impacts upon peacekeeper death rates: it was the largest single cause of deaths in the period 2013–2014. And illnesses that lead to death are only the tip of the iceberg. In many more cases, peacekeepers require medical treatment and/or recuperation time, are prevented from fulfilling their normal duties, and, in some cases, have to be repatriated.

The physical health issues that a mission's medical services are most commonly required to address are often mundane. A five-month study of the United Nations Mission in Haiti (UNMIH) medical service undertaken in 1995 found that the

7 UN General Assembly, *Letter dated 25 February 2011 from the Chair of the 2011 Working Group on Contingent-Owned Equipment to the Chair of the Fifth Committee*, UN Doc. A/C.5/66/8, October 27, 2011, p. 37.

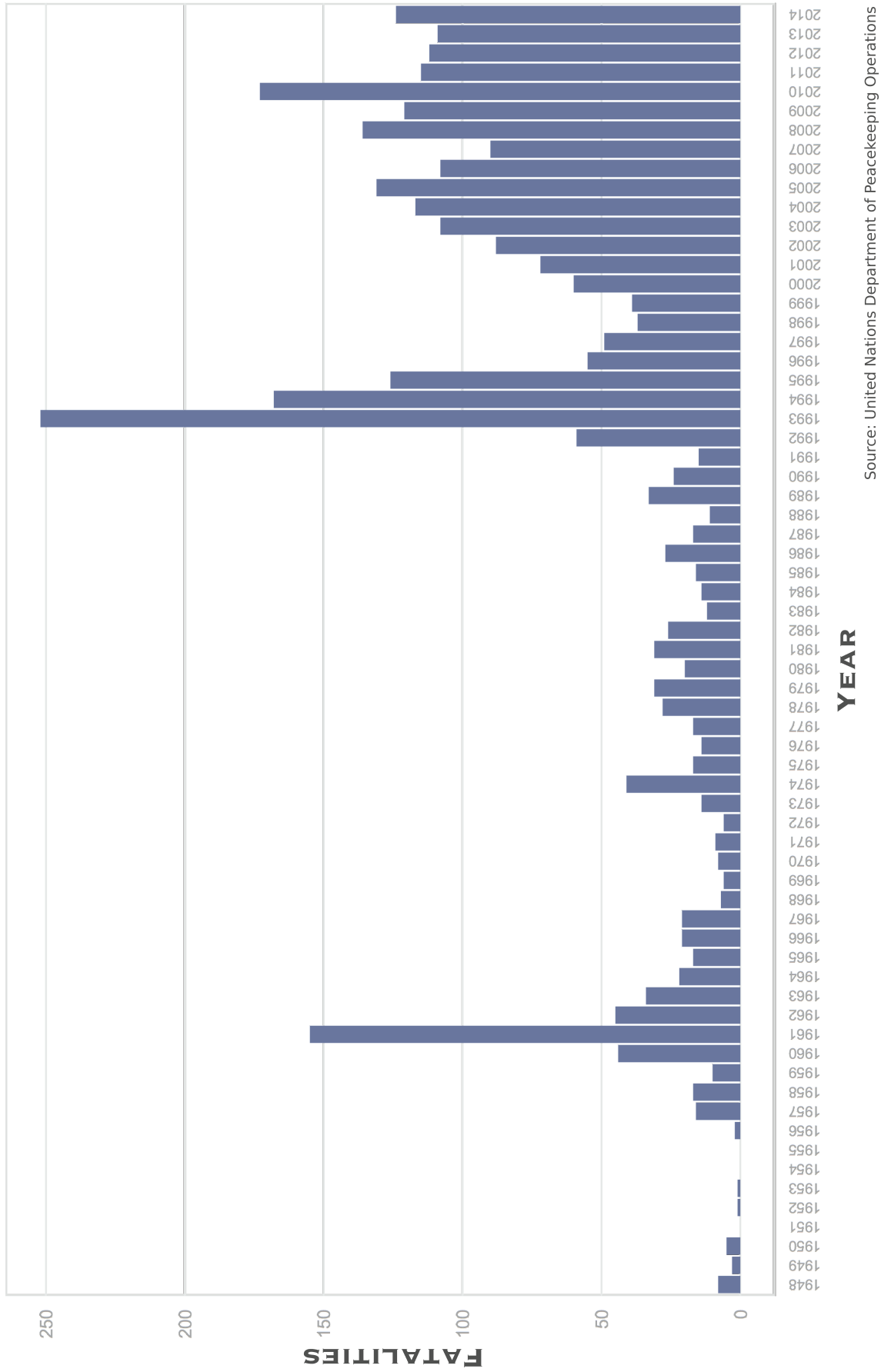
8 UN Department of Peacekeeping Operations, “Fatalities by Year,” as of January 31, 2015, available at www.un.org/en/peacekeeping/fatalities/documents/stats_1.pdf.

9 UN Department of Peacekeeping Operations, “Fatalities by Mission and Appointment Type,” as of January 31, 2015, available at www.un.org/en/peacekeeping/fatalities/documents/stats_3.pdf.

10 UN Department of Peacekeeping Operations, “Fatalities by Year and Incident Type,” as of January 31, 2015, available at www.un.org/en/peacekeeping/fatalities/documents/stats_5.pdf.

11 UN Department of Peacekeeping Operations, “MINUSTAH: United Nations Stabilization Mission in Haiti,” available at www.un.org/en/peacekeeping/missions/minustah/.

12 Benjamin Seet and Gilbert M. Burnham, “Fatality Trends in United Nations Peacekeeping Operations, 1948–1998,” *Journal of the American Medical Association* 284, No. 5 (2000): 598–603.



Source: United Nations Department of Peacekeeping Operations

Figure 2. UN peacekeeper fatalities per year, 1948-2014

Table 1. Mission deaths by incident type, 2013–2014

Mission	Year	Accident	Illness	Malicious act	Other	Total
MINURSO ¹³	2013	0	0	0	0	0
	2014	0	0	0	0	0
MINUSCA	2013	0	0	0	0	0
	2014	0	0	2	0	2
MINUSMA	2013	0	1	4	1	6
	2014	4	5	27	1	37
MINUSTAH	2013	0	2	0	1	3
	2014	0	0	0	0	0
MONUSCO	2013	2	8	4	2	16
	2014	4	9	1	0	14
UNAMA	2013	2	0	0	0	2
	2014	0	1	1	0	2
UNAMID	2013	9	16	16	3	44
	2014	3	13	6	2	24
UNDOF	2013	0	0	1	0	1
	2014	1	0	0	0	1
UNFICYP	2013	0	0	0	0	0
	2014	0	0	0	1	1
UNIFIL	2013	1	1	0	1	3
	2014	3	2	0	3	8
UNISFA	2013	0	1	2	1	4
	2014	3	0	1	0	4
UNMIK ¹⁴	2013	0	0	0	0	0
	2014	0	0	0	0	0
UNMIL	2013	0	7	0	0	7
	2014	1	7	0	0	8
UNMISS	2013	0	3	9	0	12
	2014	5	3	1	1	10
UNMOGIP ¹⁵	2013	0	0	0	0	0
	2014	0	0	0	0	0
UNOCI	2013	1	6	0	1	8
	2014	3	2	0	0	5
UNTSO ¹⁶	2013	0	0	0	0	0
	2014	0	0	0	0	0
Total	2013–2014	42	87	75	18	222

Source: www.un.org/en/peacekeeping/fatalities/documents/stats_5a.pdf. Data correct as of November 30, 2014.

13 Last recorded death was 2007, one death by illness.

14 Last recorded death was 2012, one death by accident.

15 Last recorded death was in 2005, one death by accident.

16 Last recorded death was in 2009, one death by other.

majority of outpatient visits were for orthopedic injuries (most of which were exercise- or sports-related injuries), dermatology, and respiratory issues. Of those who were hospitalized, meanwhile, the most common diagnoses were febrile illness (many of these being suspected dengue cases, which were a particular problem in the UNMIH context but do not apply to all missions), gastroenteritis or diarrhea, abdominal pain or surgery, and dental or oral problems.¹⁷ The Haiti study, however, found far higher levels of contact with mission medical services compared to an earlier (1989) study of the UN mission in Namibia.¹⁸ The authors of the Haiti study suggested a number of possible explanations for this, including the inadequacy of pre-deployment screening of some national contingents.

Within the medical literature, the peacekeeping-related health issue that has attracted the most sustained attention is the mental health of peacekeeping personnel, in particular issues of stress, trauma, alcohol and substance misuse, and suicide.¹⁹ Given the difficult and traumatic circumstances that peacekeepers often face, it is unsurprising that many of these studies find that the mental health effects on troops (for example, post-traumatic stress disorder) can continue long after their deployment has finished. Most of these studies have been conducted by European, North American, and Australasian institutions surveying their returned troops. Far less data are available on the mental or physical health of troops from other regions, although the vast majority of deployed UN

peacekeepers hail from Asia and Africa.²⁰

Aside from individual physical health problems and mental health impacts, the issues that pose the greatest threat to peacekeepers during deployment are communicable diseases, which have the potential to spread through a mission and/or from the surrounding population (or animals) to peacekeepers. Examples are legion, including dengue infections among troops serving with UNMIH,²¹ and Lassa fever, contracted by a member of the Indian contingent of the UN Mission in Sierra Leone (UNAMSIL) in 2000, possibly through food contaminated with rodent excreta or urine.²² Malaria is prevalent in many of the countries in which peacekeepers are deployed: DPKO estimated in 2006 that one peacekeeper dies every month from malarial infection, and many TCCs report high rates of malaria among returning troops who have served in African peacekeeping missions.²³

A particular concern relates to HIV and “the potential damaging impact of HIV/AIDS on the health of international peacekeeping personnel, including support personnel,” in the words of Security Council Resolution 1308.²⁴ A number of HIV programs have been established by DPKO, with the support of the Joint United Nations Program on HIV/AIDS (UNAIDS), in an attempt to increase knowledge and awareness of HIV prevention among peacekeepers and to improve the availability of services, including voluntary confidential counseling and testing and the availability of condoms and post-exposure prophylaxis.

17 Jeffrey M. Gambel, Joseph J. Drabick, and Lester Martinez-Lopez, “Medical Surveillance of Multinational Peacekeepers Deployed in Support of the United Nations Mission in Haiti, June–October 1995,” *International Journal of Epidemiology* 28 (1999): 321–328.

18 R. Steffen, M. Desaulles, J. Nagel, F. Vuillet, P. Schubarth, C.-H. Jeanmaire, and A. Huber, “Epidemiological Experience in the Mission of the United Nations Transition Assistance Group (UNTAG) in Namibia,” *Bulletin of the World Health Organization* 70, No. 1 (1992): 129–133.

19 See, for example, Lars Mehlum and Lars Weisæth, “Predictors of Posttraumatic Stress Reactions in Norwegian U.N. Peacekeepers 7 Years after Service,” *Journal of Traumatic Stress* 15, No. 1 (2002): 17–26; Susan M. Orsillo, Elizabeth Roemer, Brett T. Litz, Pete Ehlich, and Matthew J. Friedman, “Psychiatric Symptomatology Associated with Contemporary Peacekeeping: An Examination of Post-Mission Functioning among Peacekeepers in Somalia,” *Journal of Traumatic Stress* 11, No. 4 (1998): 611–625; Jun Shigemura and Soichiro Nomura, “Mental Health Issues of Peacekeeping Workers,” *Psychiatry and Clinical Neurosciences* 56 (2002): 483–491; Siri Thoresen and Lars Mehlum, “Suicide in Peacekeepers: Risk Factors for Suicide Versus Accidental Death,” *Suicide and Life-Threatening Behavior* 36, No. 4 (2006): 432–442; Albert Wong, Michael Escobar, Alain Lesage, Michael Loyer, Claude Vanier, and Isaac Sakinofsky, “Are UN Peacekeepers at Risk for Suicide?” *Suicide and Life-Threatening Behavior* 31, No. 1 (2001): 103–112.

20 See Chris Perry and Adam C. Smith, “Trends in Uniformed Contributions to UN Peacekeeping: A New Dataset, 1991–2012,” *Providing for Peacekeeping* No. 3, New York: International Peace Institute, June 2013.

21 Gambel, Drabick, and Martinez-Lopez, “Medical Surveillance of Multinational Peacekeepers.”

22 Jan Ter Meulen, Oliver Lenz, Lamine Koivogui, N’Faly Magassouba, Sushil Kumar Kaushik, Rosamund Lewis, and William Aldis, “Lassa Fever in Sierra Leone: UN Peacekeepers Are at Risk,” *Tropical Medicine and International Health* 6, No. 1 (2001): 83–84.

23 UN Department of Peacekeeping Operations, “Standard Generic Training Module (SGTM) 16B: Malaria,” UN Military Observers Course, 2006, available at www.powershow.com/view/1/1c144c-ZDc1Z/SGTM_16B_Malaria_powerpoint_ppt_presentation; “Rwanda: 13 African Countries Meet to Discuss Malaria Threat on Peacekeepers,” *The New Times*, August 26, 2014, available at <http://allafrica.com/stories/201408270796.html>; K. Kanani, Z.S. Amr, B. Shadfan, M. Al-Rashadan, and R.A. Bani Hani, “A Retrospective Study on Imported Malaria in Jordan: Malaria among Jordanian UN Peacekeeping Forces,” *Le Bulletin de la Société de pathologie exotique* 107, No. 2 (2014): 110–114; Denise Hruby, “RCAF in Africa: Fears of Drug Resistant Malaria,” *The Cambodia Daily*, March 1, 2014, available at www.cambodiadaily.com/archives/rcaf-in-africa-fears-of-drug-resistant-malaria-53384/.

24 UN Security Council Resolution 1308 (July 17, 2000), UN Doc. S/RES/1308.

laxis kits within missions. All peacekeeping missions now have an HIV/AIDS policy adviser (or, for smaller missions, an HIV/AIDS focal point).²⁵ The expectations on TCCs in relation to HIV testing prior to deployment are set out in the generic guidelines,²⁶ with the roles and functions of mission HIV/AIDS units being the subject of a separate policy directive (see box 1).²⁷

The possibility of peacekeepers contracting HIV (and infecting others) during deployment is naturally a significant concern, but HIV also highlights broader issues around the health of troops within national militaries prior to their deployment as UN peacekeepers. It is well known that national militaries vary widely in their approach to testing for HIV and in the ways in which those found to be HIV positive are treated. The UN's granting of discretion to TCCs to decide whether to require HIV testing of soldiers²⁸ dates back to a 2001 report for DPKO and UNAIDS by an expert panel that determined there was no reason to exclude HIV-positive peacekeepers from deployment.²⁹

Although it has been suggested that the levels of HIV within African militaries in particular may not be as high as some of the more alarmist estimates circulating at the beginning of the twenty-first century led people to believe,³⁰ there have nevertheless continued to be concerns over the potentially detrimental effects that high levels of HIV infection could have on military effectiveness.³¹ At least in theory, this could undermine the capabilities of UN

peacekeeping operations. For example, HIV-infected persons are more vulnerable to opportunistic infections including viral hepatitis and tuberculosis, both of which are prevalent in many conflict-affected environments.³² There is a possibility that a HIV-positive peacekeeper co-infected with one of these diseases could create a risk of contagion for the rest of the mission, not to mention (as examined below) a risk of contagion passing to the civilian population, particularly as civilians increasingly shelter near missions for protection.³³

The risk of HIV infection itself is also a concern. Peacekeepers could spread HIV through sexual relations among troops or with civilians, despite the UN's zero tolerance policy on all sexual relations for UN mission staff.³⁴ HIV transmission via infected blood also remains a risk, particularly in cases of accident or violence. However, in a 2011 Security Council meeting on the issue, UN Secretary-General Ban Ki-moon suggested that there was a need to also understand the positive contribution that peacekeeping can make to HIV reduction, in particular the benefit of the normalization of HIV testing in pre-deployment checks and during the mission. The inclusion of HIV training for all personnel deployed in UN missions, he argued, also created an opportunity for peacekeepers to become "agents of prevention, care, and treatment" within their units and the local community in which they are based.³⁵

25 UN Department of Peacekeeping Operations, "Peacekeeping Resource Hub: HIV/AIDS Advisory Area," 2014, available at <http://peacekeepingresourcehub.unlb.org/PBPS/Pages/Public/HivAidsAdv.aspx>.

26 UN Department of Peacekeeping Operations, "Generic Guidelines for Troop Contributing Countries Deploying Military Units to the United Nations Peacekeeping Missions," 2008, available at [https://cc.unlb.org/COE%20Documents/Generic%20Guidelines%20-%20Military%20\(TCC\)/Generic%20Guidelines%20for%20TCCs%20Deploying%20Military%20Units%20to%20the%20UN%20Peacekeeping%20Missions\(Mar%2008\).pdf](https://cc.unlb.org/COE%20Documents/Generic%20Guidelines%20-%20Military%20(TCC)/Generic%20Guidelines%20for%20TCCs%20Deploying%20Military%20Units%20to%20the%20UN%20Peacekeeping%20Missions(Mar%2008).pdf).

27 UN Department of Peacekeeping Operations, "The Role and Functions of HIV/AIDS Units in United Nations Peacekeeping Operations," December 1, 2007, available at <http://monusco.unmissions.org/LinkClick.aspx?fileticket=-v-FXQo8gAo0%3D&tabid=10760&mid=13761&language=en-US>.

28 Although it is a policy that remains controversial with some TCCs, the UN does not require HIV testing prior to deployment, stating, "In accordance with current medical and human rights guidelines, the HIV status of an individual is not in itself considered an indication of fitness for deployment in a peacekeeping mission." UN Department of Peacekeeping Operations, "Generic Guidelines," p. 35.

29 UNAIDS, "Report of the UNAIDS Expert Panel on HIV Testing in United Nations Peacekeeping Operations," Bangkok, November 2001, available at http://data.unaids.org/Pub/report/2001/20011130_peacekeeping_en.pdf. See also "South Africa: HIV-testing Row in the Military," *PlusNews*, October 29, 2003, available at www.hst.org.za/news/south-africa-hiv-testing-row-military.

30 Alan Whiteside, Alex de Waal, and Tsadkan Gebre-Tensae, "AIDS, Security and the Military in Africa: A Sober Appraisal," *African Affairs* 105, No. 410 (2006): 201–218.

31 Obijiofor Aginam and Martin R. Rupiya, eds., *HIV/AIDS and the Security Sector in Africa* (New York: United Nations University Press, 2012).

32 World Health Organization, "Tuberculosis and HIV," 2014, available at www.who.int/hiv/topics/tb/en/; Stefan Wiktor, Nathan Ford, Andrew Ball, and Gottfried Hirnschall, "HIV and HCV: Distinct Infections with Important Overlapping Challenges," *Journal of the International AIDS Society* 17 (2014): 19, 323.

33 Victoria Holt and Glyn Taylor, with Max Kelly, "Protecting Civilians in the Context of UN Peacekeeping Operations: Successes, Setbacks, and Remaining Challenges," Independent Report Jointly Commissioned by UN Department of Peacekeeping Operations and the Office for the Coordination of Humanitarian Affairs, 2009, available at www.peacekeepingbestpractices.unlb.org/PBPS/Pages/Public/viewdocument.aspx?id=2&docid=1014; "Health, Protection Risks at Overcrowded UN Bases in South Sudan," *IRIN News*, April 28, 2014, available at www.irinnews.org/report/100003/health-protection-risks-at-overcrowded-un-bases-in-south-sudan.

34 Olivera Simic, *Regulation of Sexual Conduct in UN Peacekeeping Operations* (Heidelberg: Springer, 2012).

35 "UN Security Council Notes Peacekeepers Role in Combating HIV/AIDS," *Voice of America*, June 6, 2011, available at www.voanews.com/content/un-security-council-notes-peacekeepers-role-in-combating-hiv-aids-123390593/158259.html.

Box 1. HIV/AIDS units in UN peacekeeping operations

The role and functions of HIV/AIDS units in UN peacekeeping operations is outlined in an institutional policy directive, which states that the units have the following two objectives:

The HIV/AIDS Unit is responsible for the implementation of awareness and prevention programmes to reduce the risk of mission personnel contracting and/or transmitting HIV. Programmes must target all United Nations mission personnel, both civilian and uniformed. This objective is hence internal to the mission.

The Chief HIV/AIDS Officer will advise the Head of Mission on HIV/AIDS related issues and support the integration of HIV/AIDS concerns in the specific mission mandate, in collaboration with the relevant mission Units and the United Nations Country Team/HIV/AIDS Theme Group. The second objective hence relates to the implementation of the mission mandate.³⁶

The policy directive goes on to set out the specific roles of HIV/AIDS units in relation to HIV awareness training; voluntary confidential counseling and testing; provision of condoms; and post-exposure prophylaxis kits and HIV/AIDS in a clinical setting.

To date, and based on the evidence available, the UN secretary-general appears justified in his call for a recalibration of attitudes toward HIV. Certainly, there is no evidence to indicate that HIV has had a significant impact on peacekeeping effectiveness to date. This may be attributable, at least in part, to the programs and policies the UN has put in place.³⁷ Yet, from the information

available, it seems clear that health issues other than HIV have had a far greater effect on peacekeepers. Infections acquired during deployment, such as dengue and malaria, are reported as a major disease risk for peacekeepers,³⁸ leading in some cases to the disease returning “home” with the peacekeepers at the end of their deployment.³⁹ There have not been similar reports of elevated incidence of HIV among returning soldiers.⁴⁰

Aside from HIV, the UN has made increased efforts to address other infectious diseases in recent years. The current guidelines for TCCs (see box 2) require them to provide DPKO with details of medical preparations, including “any clinical examinations, x-rays and laboratory tests, as well as all vaccinations administered.”⁴¹ The guidelines also include provisions for the availability of supplies required in areas of high epidemiological risk, including “malaria pills, insect repellent, fogging solutions and chemicals, insecticides, rat poison, animal traps and other vector control measures,”⁴² and they outline the respective responsibilities of TCCs and the UN for ration supply, water treatment, waste disposal, and other activities vital to maintaining the health of the mission. Part 3 of the guidelines sets out the UN’s standards for physical condition and the minimum immunization requirements.

While these generic guidelines apply to all TCCs, they are not specifically referred to in the mandate for each mission. Mission mandates do, however, frequently include a statement that the mission will be provided with the necessary logistical support, which includes the required medical and health facilities.

Despite the existence of guidelines covering medical services before and during deployment, there is evidence that in some cases these are not fully met. In our observations of the Security

36 UN DPKO, “The Role and Functions of HIV/AIDS Units in United Nations Peacekeeping Operations,” December 1, 2007, paras. 7.1 and 7.2, available at <http://monusco.unmissions.org/LinkClick.aspx?fileticket=vFXQo8gAo0%3D&tabid=10760&mid=13761&language=en-US>.

37 For example, one of the most regular courses that appears in the medical courses at the United Nations Logistics Base – Global Service Centre (UNLB/GSC) Conference and Learning Centre is a dedicated course on “Living in the World with HIV/AIDS.” See www.trainingcentre.unlb.org/show_training.asp?id_cat1=32.

38 J.M. Gambel, J.J. Drabick, M.A. Swalko, E.A. Henchal, C.A. Rossi, and L. Martinez-Lopez, “Dengue among United Nations Mission in Haiti Personnel, 1995: Implications for Preventive Medicine,” *Military Medicine* 164, No. 4 (1999): 300–302; Patricia C. Juliao, Silvia Sosa, Luis D. Gonzalez, Norma Padilla, Lucia Ortiz, Ira Goldman, Venkatachalam Udhayakumar, and Kim A. Lindblade, “Importation of Chloroquine-resistant Plasmodium Falciparum by Guatemalan Peacekeepers Returning from the Democratic Republic of the Congo,” *Malaria Journal* 12, No. 1 (2013): 344–351.

39 Scott Kitchener, Peter A. Leggat, Leonard Brennan, and Bradley McCall, “Importation of Dengue by Soldiers Returning from East Timor to North Queensland, Australia,” *Journal of Travel Medicine* 9, No. 4 (2002): 180–183.

40 We are not suggesting this is not a concern; we are stating that we were unable to locate reports that discuss HIV in returning soldiers.

41 UN Department of Peacekeeping Operations, “Generic Guidelines,” p. 42.

42 *Ibid.*, p. 19.

Box 2. Health-related guidelines for TCCs deploying military units

In its generic guidelines for TCCs deploying military units to UN peacekeeping missions, DPKO includes a number of guidelines specific to physical health and medical issues, as shown in the following excerpts.

Pre-deployment Preparation

Pre-deployment Medical Preparations

A standard list of pre-deployment medical preparations conducted for their peacekeeping personnel prior to their deployment should be made available to DPKO by the TCCs. This shall include any clinical examinations, x-rays and laboratory tests, as well as all vaccinations administered. Medical screening results of individuals are not required, unless specifically requested by DPKO.

Contingent Logistics Responsibilities

High Risk Areas (Epidemiological)

High Risk Areas (Epidemiological) is a self-sustainment category and responsibility for its provision is agreed through the MOU. This covers medical supplies, chemoprophylaxis and preventive measures against common diseases found in the mission area, [for] which there are no available vaccines. The provisions include but are not limited to the following: malaria pills, insect repellent, fogging solutions and chemicals, insecticides, rat poison, animal traps and other vector control measures.

Repatriation of Individuals

Medical Repatriation

Contingent members/military personnel may be repatriated to their home country if they are assessed to be unfit for duty for the next 30 days, or if they require treatment that is not available in the mission.

When a UN member is repatriated for medical reasons, the UN will cover all travel costs, both for him and his replacement.

The evacuation and/or repatriation out of the mission area of any contingent member to their home or a third country as a result of a pre-existing medical, dental, and/or psychiatric condition shall be at National expense if this results from inadequate medical, dental, and/or psychological screening prior to deployment to the mission area. In circumstances where disease, injury, or death results directly from such pre-existing conditions, the UN may not be liable for any compensation to be paid for such disease, injury, or death.

Source: UN DPKO, "Generic Guidelines for Troop Contributing Countries Deploying Military Units to the United Nations Peacekeeping Missions," 2008, paras. 14, 71, and 118–120, available at <https://cc.unlb.org/>.

Council's discussions of the sixteen missions currently deployed,⁴³ there were at least two cases—MINUSCA in the Central African Republic and MINUSMA in Mali—where it was noted in follow-up Security Council resolutions that troops did not yet have the required logistics or facilities available to fulfill their mission.⁴⁴ In the cases of UNMIL (Liberia), UNOCI (Côte d'Ivoire), and UNMISS (South Sudan), audits by the UN's Office of

Internal Oversight Services (OIOS) in 2009, 2012, and 2013, respectively, identified failures in the safety and adequacy of pre-deployment medical checks and in the quality of medical care being provided in these missions to both troops and civilian populations.⁴⁵ To take the case of UNMIL, the 2009 audit found significant shortcomings in the medical services available and in the operation of the mission's medical facilities, including the

43 The seventeenth mission, the UN Assistance Mission in Afghanistan (UNAMA), was excluded due to no UN peacekeepers being deployed in this mission, only military observers.

44 UN Security Council Resolution 2149 (April 10, 2014), UN Doc. S/RES/2149; UN Security Council Resolution 2164 (June 25, 2014), UN Doc. S/RES/2164.

45 UN Office of Internal Oversight Services, "Audit of the Provision of Medical Services in UNMIL," April 8, 2009, Assignment No. AP2008/626/08, available at <http://usun.state.gov/documents/organization/140720.pdf>; UN Office of Internal Oversight Services, "Audit of Medical Services in UNOCI," November 6, 2012, Assignment No. AP2011/640/09, available at <http://usun.state.gov/documents/organization/206698.pdf>; UN Office of Internal Oversight Services, "Audit of Medical Services in the United Nations Mission in South Sudan," December 5, 2013, Assignment No. AP2013/633/02, on file with author.

following:

- no standard operating procedures;
- no professional support and training available to upgrade medical personnel skills;
- “chronically ill” peacekeepers deployed with “risk of spreading infection”;
- inadequate maintenance of TCC clinics—substandard hygiene and safety (Bangladesh, China, Nigeria);
- inappropriate drug donations to local hospitals and clinics by three TCC clinics (India, Bangladesh, China)—out-of-date drugs provided, no record of transfer in some cases, and quality of drugs could not be independently assessed;
- MOUs with seven medical service providers had expired—clinics operating without agreements in place;
- troops did not meet World Health Organization (WHO) guidelines on disposal of medical waste (Nepal, China, Bangladesh, India, Jordan, Pakistan); and
- apparent failure by the mission’s chief medical officer to check the pre-deployment medical and vaccination status of arriving troops and to monitor the quality of medical facilities.⁴⁶

In particular, the OIOS warned that the lack of proper pre-deployment medical screening raised the risk of disease transmission within the UNMIL mission:

Chief Medical Officer (CMO) confirmed that medical services had witnessed cases of contingent members diagnosed with chronic/serious illnesses such as HIV/AIDS, cancer, tuberculosis, etc., which were clearly developed prior to that deployment for mission duty...The affected troop members could spread communicable disease such as tuberculosis to other troops and mission personnel.⁴⁷

During the six months of the OIOS audit, twenty-two peacekeepers were repatriated on medical grounds. The ten cases reviewed (those for

which records were available) “strongly indicated shortcomings in conducting the mandated pre-deployment medical examination and clearance tests.”⁴⁸ All ten arrived at the mission with chronic illness requiring “extensive hospitalization and repatriation,” and no copies of medical clearance certificates or vaccination certificates were available for the cases examined.⁴⁹ During the audit, the OIOS also found that peacekeepers were providing medical treatment to local populations despite their clinics not meeting basic medical standards for hygiene and waste management.

Three years later, a similar story was reported in UNOCI in Côte d’Ivoire when the OIOS audited its medical services. It found that there had been no medical training provided from 2009 to 2011 for non-medics; no basic first aid training; and again, similar to UNMIL, pre-existing medical conditions had not been detected in police and troops. Over the period audited by OIOS, 38 percent of medical consultations were treated at UN-operated medical facilities, despite the fact that TCCs were being reimbursed for providing medical care under the self-sustainment process.⁵⁰ The audit also found poor practices in both drug inventory management and waste management.⁵¹

Despite these serious shortfalls in medical provision for its own peacekeeping personnel, UNOCI reported to OIOS that its “policy is to provide non-emergency medical support to the local population based on humanitarian grounds, where feasible...This approach has allowed the military to connect with the population in areas of their deployment and has proved very beneficial in winning the hearts and minds of the local population.”⁵² Moreover, UNOCI reported to OIOS that populations receiving treatment “often tend to be of great assistance in supporting the military in their operations. In these cases, the patients sign a waiver.”⁵³

If, for the moment, we put to one side the ethical concerns that may arise over medical treatment

46 UN Office of Internal Oversight Services, “Audit of the Provision of Medical Services in UNMIL,” pp. 5–7.

47 *Ibid.*, p. 5.

48 *Ibid.*, pp. 5–6.

49 *Ibid.*, p. 5.

50 One of the report’s key recommendations was that the mission should establish a process for recovering the costs of this treatment and for medical evacuations due to pre-existing conditions (see box 2).

51 UN Office of Internal Oversight Services, “Audit of Medical Services in UNOCI,” p. 4.

52 *Ibid.*, p. 3.

53 *Ibid.*, p. 3.

being provided instrumentally in order to elicit intelligence from local civilians (an issue to which we return in the second part of this report), there are two particularly significant findings from these internal audits. The first is the continued practice of deploying troops who had not undergone the necessary medical checks. As already noted, under the DPKO's guidelines, the TCC is responsible for undertaking medical examinations and for ensuring that vaccinations are up to date before deployment. However, the mission's chief medical officer is responsible for confirming upon arrival that each individual within the contingent has indeed received medical clearance and up-to-date vaccinations. The reliance on TCCs fulfilling their responsibilities in this area and the assumption that the chief medical officer has the capacity to keep track of thousands of deployed troops, without robust measures to ensure that either of these things happens in practice, appear to have compromised adherence to the medical guidelines. This has implications not only for the health of those within the mission but also—as we will see in the next section—the health of civilians in the local population.

The provision of medical services for peacekeeping personnel has recently become an issue in the context of discussions over increasing the reimbursement to TCCs—a claim that was justified in part by some TCCs on the basis of the cost of carrying out pre-deployment medical checks. In June 2014, an increased stipend was approved (the first increase in eighteen years).⁵⁴ As we suggest below, the increased reimbursement presents an opportunity for a greater emphasis on ensuring pre-deployment medical checks are taking place, and that troops are being deployed with the necessary medical examinations and vaccinations completed.

The second key point is the problem of peacekeepers providing health care to the local population in situations where the quality of medical care provided to the mission's own personnel is not always in accordance with WHO guidelines.

PEACEKEEPERS AND POPULATION HEALTH

As noted by the OIOS audit of UNMIL in 2009, one of the major health concerns surrounding UN peacekeeping is the potential for peacekeepers to be “vectors” of disease—to spread infection through the local community. As well as the obvious negative health impact on affected civilians, such events can have a number of other damaging effects including straining relations between a mission and the host community, worsening a crisis situation by imposing a new disease burden, and potentially making parties to conflicts less willing to consent to the presence of a UN mission.

Prior to 2010, HIV was the most prominent issue in this regard. Although the Security Council was primarily concerned about peacekeeper health, as we discussed previously, its first deliberations on HIV/AIDS in 2000 were also prompted in part by the fear that peacekeeping personnel could spread HIV among the local population. In Resolution 1308 the Security Council

request[ed] the Secretary-General to take further steps towards the provision of training for peacekeeping personnel on issues related to preventing the spread of HIV/AIDS and to continue the further development of pre-deployment orientation and ongoing training for all peacekeeping personnel on these issues.⁵⁵

The concern that peacekeepers could infect members of the host population with HIV was again highlighted in Resolution 1983 in 2011, which called for a strengthening of “efforts to implement the policy of zero tolerance of sexual exploitation and abuse in UN missions.”⁵⁶ This policy is clearly broader than HIV in its concerns (being partly in response to a number of sexual abuse scandals involving peacekeeping personnel) but also addresses it and other sexually transmitted infections.⁵⁷

Since 2010, however, the cholera outbreak in Haiti, which was traced back with some confidence to UN

54 UN General Assembly, “Administrative and Budgetary Aspects of the Financing of the United Nations Peacekeeping Operations, Report of the Fifth Committee (A/68/918),” June 30, 2014, UN Doc. A/68/PV.99, pp. 6–8, available at www.un.org/ga/search/view_doc.asp?symbol=A/68/PV.99; Katharina Coleman, “UN to Act in Battle Over Peacekeeping Reimbursements,” *The Global Observatory*, May 2, 2013, available at <http://theglobalobservatory.org/2014/05/un-to-act-in-battle-over-peacekeeping-reimbursements/>.

55 UN Security Council Resolution 1308 (July 17, 2000), UN Doc. S/RES/1308.

56 UN Security Council Resolution 1983 (June 7, 2011), UN Doc. S/RES/1983.

57 *Ibid.*; UN Department of Peacekeeping Operations, “Conduct and Discipline,” 2014, available at www.un.org/en/peacekeeping/issues/cdu.shtml. The policy forbids “sexual relations with prostitutes and with any persons under 18, and strongly discourage[s] relations with beneficiaries of assistance (those that are receiving assistance food, housing, aid, etc... as a result of a conflict, natural disaster or other humanitarian crisis, or in a development setting).”

peacekeepers, has been at the forefront of debates around the responsibility of missions to protect the health of the host population. It is also the clearest example in the history of peacekeeping of the detrimental health impact that missions can have.

The cholera crisis in Haiti first became apparent in October 2010, only a few months after the earthquake that devastated much of Port-au-Prince and the surrounding area. Cholera spreads rapidly and can cause severe illness very quickly. Infected patients can die within twelve hours. This rapid onset was certainly evident in Haiti—previously a cholera-free country, where those infected would have had no pre-existing immunity. In the case of one hospital, St. Nicolas Hospital in Saint-Marc in the Artibonite River Delta, there were 404 hospitalizations of suspected cholera cases on October 20th alone (one every 3.6 minutes) and 44 deaths.⁵⁸ It would be difficult for any health system to deal with such a rapidly developing public health emergency, let alone one as under-equipped and under-resourced as that found in Haiti.

As the first occurrence of cholera in Haiti for over a century, the outbreak caused immediate speculation over its source.⁵⁹ Amid accusations from some quarters that soldiers serving with MINUSTAH were responsible for introducing cholera to the country, UN Secretary-General Ban Ki-moon convened an independent panel to investigate the outbreak. The panel used a variety of approaches in its work including molecular analysis of samples, epidemiological and hydrological analysis, and visits to hospitals and medical facilities. Although the panel's final report did not provide conclusive evidence that the origins of the outbreak lay with Nepalese peacekeeping troops, it did find that it originated in Mirebalais (the site of a MINUSTAH camp) and that the bacteria was of the type found in South Asia. Examination of the MINUSTAH camp found deficiencies in the pipe

work in the toilet/showering area, which could have led to the contamination of an open drainage ditch, as well as a nearby open septic pit into which “black water waste” (including human feces) was emptied. This was another potential source of the contamination of the local river system.⁶⁰ The report's authors concluded “The sanitation conditions at the Mirebalais MINUSTAH camp were not sufficient to prevent contamination of the Mere Tributary System with human fecal waste.”⁶¹ The report also strongly emphasized the fact that the outbreak, which it stressed “was not the fault of, or deliberate action of, a group or individual,” was exacerbated by a range of circumstances, including poor water and sanitation provision in Haiti; the regular use of river water for washing, bathing, and drinking; the lack of immunity among the Haitian population; and poor facilities and conditions in hospitals treating patients.⁶²

In an article written after the publication of their report, the members of the independent panel reflected on the reaction to it—of particular interest was the UN's reaction. The immediate response of the organization, the panelists noted, was to argue that the report did not present “conclusive scientific evidence linking the outbreak to the MINUSTAH peacekeepers or the Mirebalais camp” and that “anyone carrying the relevant strain of the disease in the area could have introduced the bacteria into the river.”⁶³ In November 2011, a group of NGOs filed a legal case against the UN on behalf of 5,000 victims of the cholera outbreak. In response, the UN asserted its legal immunity, and Ban Ki-moon made it clear that the UN would not compensate victims.⁶⁴ Further suits were later filed, including a class-action one in a New York court by Marie Laventure, whose parents had died, and others in March 2014 that argued that the UN had waived its immunity in the Status of Forces Agreement⁶⁵

58 A. Cravioto, C. F. Lanata, D. S. Lantagne, and G. Balakrish Nair, “Final Report of the Independent Panel of Experts on the Cholera Outbreak in Haiti,” May 4, 2011, p. 16, available at www.un.org/News/dh/infocus/haiti/UN-cholera-report-final.pdf.

59 *Ibid.*, p. 8.

60 *Ibid.*, p. 21–23.

61 *Ibid.*, p. 23.

62 *Ibid.*

63 D. Lantagne, G. Balakrish Nair, C.F. Lanata, and A. Cravioto, “The Cholera Outbreak in Haiti: Where and How Did It Begin?,” *Current Topics in Microbiology and Immunology* 379 (2013): 145–164.

64 R. Roshan Lall and E. Pilkington, “UN Will Not Compensate Haiti Cholera Victims, Ban Ki-moon Tells President,” *The Guardian*, February 21, 2013, available at www.theguardian.com/world/2013/feb/21/un-haiti-cholera-victims-rejects-compensation.

65 United Nations, *Agreement between the United Nations and the Government of Haiti Concerning the Status of the United Nations Operation in Haiti*, Port-au-Prince, July 9, 2004, available at <http://opiniojuris.org/wp-content/uploads/4-Status-of-Forces-Agreement-1.pdf>. The paragraph in question is paragraph 54.

reached with the government of Haiti.⁶⁶ Yet, outside of the courts, the UN *has* been making efforts to address some of the health-related issues that have arisen in Haiti, including Secretary-General Ban Ki-moon's backing of an appeal to eliminate cholera in Haiti and the use of MINUSTAH's logistical capabilities to help battle the epidemic.⁶⁷

RECOMMENDATIONS

The specific findings on the Haiti cholera case combined with the OIOS audits of peacekeeping missions provide instructive lessons on the need to better protect the health of peacekeepers themselves and, as a consequence, to reduce the potential for peacekeepers to be vectors of disease. Crucially, the health interface between peacekeepers and the populations in which they serve has to be seen as two-way, with the health of one group inextricably connected to that of the other.

Many of the recommendations made by the independent panel examining the Haiti cholera outbreak have broader applicability, both to other missions and to other diseases. The panel's first three recommendations have particular relevance in highlighting that the current pre-deployment guidelines are inadequate in the way they assign specific roles and responsibilities to TCCs and DPKO.⁶⁸ As seen above, these problems were also found by the UN's internal audits, which questioned the quality of pre-deployment medical checks and the safety practices of medical services provided to UNMIL, UNOCI, and UNMISS, echoing the key findings of the independent panel on Haiti.

The first two of the independent panel's recommendations related to pre-deployment medical procedures, suggesting that UN personnel from cholera-endemic regions should "either receive a prophylactic dose of appropriate antibiotics before departure or be screened with a

sensitive method to confirm absence of asymptomatic carriage of *Vibrio cholera*, or both" and that personnel "traveling to emergencies should receive prophylactic antibiotics, be immunized against cholera with currently available vaccines, or both, in order to protect their own health and to protect the health of others."⁶⁹ This clearly relates to the broader issues about pre-deployment procedures—issues that have also come to the fore in OIOS audits. Our recommendation is that policies and procedures for ensuring that pre-deployment medical checks are completed need to be strengthened, with DPKO and TCCs working together to devise a more comprehensive checklist of pre-deployment medical requirements (recognizing that for human rights reasons HIV may be a special case). Funding should be specifically allocated to the proper completion of these checks rather than subsumed within the general reimbursement, strengthening lines of accountability and responsibility.

The third recommendation of the independent panel concerned the treatment of fecal waste at UN installations, but again this points to a broader concern with the health impact of UN facilities worldwide. It is clearly impossible (and undesirable) to prevent peacekeepers from mixing with the host population, and necessarily their bases are located in the places where their presence is most needed. Our proposal here is that health impact assessments are conducted as a standard part of the pre-deployment technical assessment missions, to minimize the risks associated with the presence of peacekeeping forces. Health impact assessments (HIAs) are commonly defined as

a combination of procedures, methods and tools that systematically judges the potential, and sometimes unintended, effects of a policy, plan, program or project on the health of a population and the distribution of those effects within the population. HIA identifies appropriate actions to manage those effects.⁷⁰

66 *LaVenture et al. v. United Nations et al.*, 1:14-cv-01611 (New York Eastern District Court, 2014), available at www.documentcloud.org/documents/1073738-140311-laventure-v-un-filed-complaint-2.html.

67 See United Nations Stabilization Mission in Haiti, "Cholera Outbreak in Haiti," available at www.un.org/en/peacekeeping/missions/minustah/emergency.shtml.

68 Cravioto et al., "Final Report of the Independent Panel," p. 30. Recommendations 4–7 are also important but specific to preventing cholera outbreak and the situation in Haiti.

69 *Ibid.*

70 R. Quigley, L. den Broeder, P. Furu, A. Bond, B. Cave, and R. Bos, "Health Impact Assessment: International Best Practice Principles," Special Publication Series No. 5, Fargo: International Association for Impact Assessment, September 2006, available at www.iaia.org/publicdocuments/special-publications/SP5.pdf?AspxAutoDetectCookieSupport=1.

A number of HIA toolkits already exist that could readily be applied (or adapted) for use. In addition, the creation of a HIA for each mission would enable an ongoing assessment and adjustment of medical services (and wet or dry lease for these services) at each mandate renewal.

Finally, a comment is warranted on the UN's responsibility to the host populations in which peacekeeping missions serve. It is certainly the case that significant progress has been made in recent years to advance the protection of civilians as an essential part of peacekeeping operations, and to tackle some of the abuses that have been revealed over the years (including cases of sexual abuse). At the same time, it seems to be generally accepted (including by key member states—see, for example, the statement of the United States⁷¹) that the United Nations has legal immunity in respect of its peacekeeping missions and cannot be held accountable in cases where its peacekeepers spread infections to the host population (notwithstanding ongoing court cases). That said, it is surely the case that the UN has at the very least a moral obligation to take all reasonable steps to prevent peacekeeping missions causing harm to the health of the civilian population. Although the UN may have been legally correct (and financially prudent, given the organization's stretched resources) in refuting liability for the Haiti cholera cases, the episode and the arguments advanced by the UN have damaged the organization's legitimacy and moral standing. This represents a clear risk to the overall reputation of UN peacekeeping, and one that can only be meaningfully addressed by improving overall planning for the health impact of missions (as we recommend), but also by systematically demonstrating that all reasonable steps have been taken to protect the health of civilians. We therefore recommend that OIOS audits of the health impact of each UN peacekeeping mission be carried out annually, with HIA assessments (and policies and procedures to mitigate negative impacts) updated accordingly.

Peacekeeping as an Opportunity to Improve Population Health

In this section, we examine the extent to which UN peacekeeping missions are engaged in delivering medical services to host populations (an activity that would, on the face of it, constitute a positive contribution to health). We begin by examining the status of such activities in the UN's generic guidelines and the mandates of individual missions before moving on to address the practice of currently deployed operations.

CIVILIAN HEALTH ASSISTANCE IN THEORY

The mandate for each peacekeeping mission is specified in the relevant resolution(s) of the UN Security Council. These resolutions set out the overall aims of each mission and determine the specific contributions and roles of peacekeeping personnel. However, in addition to each mission's specific mandate, DPKO has produced a range of other documents providing guidance and information, perhaps the most notable of which is the "Principles and Guidelines" document that provides generic guidance on the roles and responsibilities of peacekeepers serving in UN missions.⁷² A second key document that we draw on in this section is the "Medical Support Manual for United Nations Peacekeeping Operations," according to which the purpose of medical support for peacekeeping missions is to

secure the health and well-being of members of the United Nations peacekeeping operations through planning, coordination, execution, monitoring and professional supervision of excellent medical care in the field.⁷³

The medical aspects of a UN mission's work fall into two categories: (1) medical support to mission staff under the command of a chief medical officer, who oversees the provision of medical care in the mission hospital or clinic and oversees the care

71 US Department of Justice, *Georges v. United Nations et al.*, 1:13-cv-07146-JPO, document 21 (March 7, 2014), available at <http://personal.crocodoc.com/J4lRXpi>.

72 UN Department of Peacekeeping Operations, "United Nations Peacekeeping Operations: Principles and Guidelines," New York: United Nations, 2008, available at http://pbpu.unlb.org/pbpu/library/capstone_doctrine_eng.pdf.

73 UN Department of Peacekeeping Operations, "Medical Support Manual for United Nations Peacekeeping Operations," 2nd edition, 1999, para. 1.01, available at <http://reliefweb.int/sites/reliefweb.int/files/resources/D196C0B0FF3A637BC1256DD4004983B9-dpko-medical-1999.pdf>.

provided to troops and civilian staff; (2) ensuring the health of peacekeepers and civilian staff prior to their deployment in the mission. As we have already noted, TCCs are required to undertake medical checks of all troops prior to their deployment.⁷⁴ Under the self-sustainment process, TCCs are able to provide their own medics to ensure the health of their own units and the mission as a whole.

The size and composition of the medical services deployed with a mission depend on a variety of factors including the nature of the mandate, the size of the peacekeeping force, the availability of existing host country medical infrastructure, geography, and an assessment of medical threats.⁷⁵ In line with this, the UN has established a hierarchy of “levels” of medical service that can be deployed (see box 3), ranging from Level I, which comprises “primary medical care and immediate lifesaving and resuscitation services,” to Level III, which represents “definitive medical care and specialist treatment in all fields of surgery and medicine.”⁷⁶ All resourcing and logistics for missions’ medical clinics and hospitals are to be supported by the TCCs and the Department of Field Support’s Medical Support Section (a part of the Logistics Support Division). The equipment, particularly required to support Level III service, can be supplied to the UN mission under wet lease or dry lease agreement with TCCs.

Although the roles to be performed by the mission medical services are relatively clearly described, the extent to which peacekeeping missions have a responsibility to provide medical (or indeed other) services to the host population is far less clear in the guidance.

In 2008, the DPKO published the “Principles and Guidelines” for peacekeeping operations. To date, this is the “highest-level of the current doctrine framework for United Nations peacekeeping.”⁷⁷ It provides guidelines concerning the organization, management, and support to missions and states clearly that missions’ “core business” is to stabilize the situation and provide a secure environment for

Box 3. Levels of medical support for UN peacekeeping operations

There are three main levels of medical support in the UN medical support system for peacekeeping operations:

Level I: First line or “battalion” level

- This is the first level where trained medical personnel (including a doctor) are present.
- Organic medical teams of the field units usually provide this level of support.

Level II: Second line or “brigade/ sector” level surgical facility

- This is a medical facility with limited specialist expertise and limited surgical capabilities. Life, limb, and organ saving surgery can be performed here.

Level III: Third line “field hospital”

- This is a fully equipped and staffed multi-disciplinary field hospital.
- All major medical and surgical specialties are provided for.

In addition, there is a Basic Level (“soldier” level or “buddy-aid”), where immediate first aid is provided by the nearest person on-site.

Sources: UN DPKO/DFS, “DPKO/DFS UNMEM Manual: Selection, Deployment, Rotation, Extension, Transfer and Repatriation of United Nations Military Experts on Mission in United Nations Peacekeeping Operations,” April 2010, rev’d December 2012, p. 64, available at <https://cc.unlb.org/UNASAS%20Training%20Documents/UNMEM%20Documents/2010.30%20UNMEM%20Manual.pdf>; Nikolay Chulkov, “Review of the Medical Service in the United Nations System,” Geneva: United Nations Joint Inspection Unit, 2011, pp. 19–20, available at www.unjiu.org/en/reports-notes/JIUProducts/JIU_REP_2011_1_English.pdf.

civilians and humanitarian actors.⁷⁸ When it comes to the delivery of humanitarian assistance, the document notes that responsibility

rests primarily with the relevant civilian United Nations specialized agencies, funds and programmes, as well as the range of independent, international and local NGOs which are usually active alongside a United Nations peacekeeping operation. The primary

74 UN Department of Peacekeeping Operations, *Handbook on United Nations Multidimensional Peacekeeping Operations* (New York: United Nations, 2003), p. 125, available at <http://www.peacekeepingbestpractices.unlb.org/Pbbs/library/Handbook%20on%20UN%20PKOs.pdf>.

75 Nikolay Chulkov, “Review of the Medical Service in the United Nations System,” Geneva: United Nations Joint Inspection Unit, 2011, pp. 19–20, available at www.unjiu.org/en/reports-notes/JIU%20Products/JIU_REP_2011_1_English.pdf.

76 *Ibid.*, Annex III.

77 UN Department of Peacekeeping Operations, “Principles and Guidelines.”

78 *Ibid.*, figure 2, pp. 23–24.

role of United Nations peacekeeping operations with regard to the provision of humanitarian assistance is to provide a secure and stable environment within which humanitarian actors may carry out their activities.⁷⁹

Since Security Council Resolution 1265 in 1999, the protection of civilians has been incorporated into many peacekeeping mandates.⁸⁰ This protection includes both the physical protection of civilians and ensuring access to humanitarian assistance. The adoption of Resolution 1265 led to further discussion concerning the specific roles and responsibilities of peacekeepers, outlined the following year in Resolution 1296, which specifically referred to the need for peacekeepers to prioritize “civil-military coordination and sensitivity in the prevention of HIV/AIDS and other communicable diseases.”⁸¹

However, there seems to have been little strategic discussion about the expanded role that peacekeepers may (and in practice often do) play in providing medical assistance to civilians—situations in which peacekeepers are no longer facilitating civilian access to humanitarian assistance but providing it themselves. The focus in the guiding principles is on the role of peacekeepers in providing indirect assistance to civilians, such as by assisting humanitarian convoys in the delivery of supplies, goods, assets, and personnel.⁸² There is no specific mention of their role in the direct provision of medical or other forms of humanitarian assistance.⁸³

Civil affairs officers in UN missions also have guidelines to assist them in navigating their role in the delivery of humanitarian assistance, including medical assistance, to civilian populations. Again this defines their role as primarily facilitating the delivery of care by humanitarian actors through coordinated activity between UN specialized

agencies and peacekeeping forces. Civil affairs personnel within missions are expected to liaise with local communities and authorities, as well as to engage with the logistical and political environment in which the mission must perform its mandate. Specifically, civil affairs personnel should coordinate with humanitarian agencies and governments to ensure peacekeeping forces are present and available to assist with humanitarian action. They may be key informants in the early stages of a mission regarding the safety of and access available to humanitarian actors in different parts of the deployment area, and they can facilitate the sharing of information between UN agencies and the mission regarding humanitarian priorities.⁸⁴ Thus missions are explicitly mandated to facilitate access to allow other UN organizations, national and international NGOs, and others to deliver humanitarian assistance, including medical assistance.

However, as we discuss below, in practice peacekeepers also sometimes directly provide a range of health services to local communities, including emergency care, ongoing medical care, health system development and delivery, and health care training and education. This is largely unacknowledged in the UN’s formal guidelines for peacekeeping operations. Interestingly, however, in some of the documentation there are hints of the UN’s endorsement of a broader role for peacekeepers. In a DPKO training document titled “We are United Nations Peacekeepers,” for example, peacekeeping personnel are informed that “We will always...support and aid the infirm, sick and weak.”⁸⁵ Likewise, the DPKO images presented earlier valorize the work of medics in peacekeeping missions, suggesting that they play a role in delivering essential services to populations.

Where we do find official endorsements of a role

79 Ibid., p. 30.

80 UN Security Council Resolution 1265 (September 17, 1999), UN Doc. S/RES/1265; followed by UN Security Council Resolution 1296 (April 19, 2000), UN Doc. S/RES/1296, and UN Security Council Resolution 1674 (April 28, 2006), UN Doc. S/RES/1674.

81 S/RES/1296, para. 19.

82 See the following publications list: Office for Humanitarian Assistance and Affairs (OCHA), “Humanitarian Civil-Military Coordination: Publications,” 2014, available at www.unocha.org/what-we-do/coordination-tools/UN-CMCoord/publications; IASC on Civil-Military Coordination, “Updated Guidelines on the Use of Armed Escorts for Humanitarian Convoys - IASC Non-Binding Guidelines,” February 27, 2013, available at <https://docs.unocha.org/sites/dms/Documents/Armed%20Escort%20Guidelines%20-%20Final.pdf>.

83 However, the mission may be responsible for making medical services available to prisoners (temporarily) detained by the mission before being handed over to state authorities, according to the UN Planning Toolkit.

84 UN Department of Peacekeeping Operations, *DPKO/DFS Civil Affairs Handbook* (New York: United Nations, 2012), p. 231, available at www.un.org/en/peacekeeping/documents/civilhandbook/Civil_Affairs_Handbook.pdf.

85 UN Department of Peacekeeping Operations, “We are United Nations Peacekeepers,” undated, p. 2, available at www.un.org/en/peacekeeping/documents/un_in.pdf.

for peacekeepers in the direct delivery of humanitarian medical aid (rather than as facilitators of humanitarian access) is in two particular areas: civil-military cooperation (CIMIC), which includes health care delivery and services (sometimes referred to as quick impact projects, or QIPs),⁸⁶ and cases of extreme emergency.

The Department of Field Support in DPKO states that all civil assistance, including health care delivery, should be coordinated with other humanitarian entities. Specifically, “civil assistance tasks proposed by national military contingents should first be submitted to the UN-CIMIC structure to review and forward for processing in accordance with established missions guidelines.” Further, “requests for Civil Assistance in support of a humanitarian or development nature should be submitted through the mission approval process.”⁸⁷ Often, it appears, the impetus for undertaking such actions comes from national contingents themselves rather than from DPKO.

DPKO does recommend in some circumstances that missions should engage in QIPs, projects designed to benefit the population through small-scale infrastructure and/or public communication projects, which may include a health or medical component. However, it stresses that these are “not a substitute for humanitarian and/or development assistance.”⁸⁸

Another set of circumstances in which peacekeepers may be given an explicit direct humanitarian role is in cases of extreme emergency. OCHA provides guidance on the relationship between civilian and military actors during complex emergencies, as well as mission-specific guidance.⁸⁹ The priority in both cases is to ensure that conflict is avoided between military and humanitarian actors and that the principles of neutrality and impartiality of humanitarian aid provision are respected (and are seen to be respected). In terms of coordination, these

guidelines seek to forward the broader UN integration policy to “deliver as one,” while at the same time ensuring that peacekeepers maintain primary responsibility for a mission’s political objectives as humanitarian agencies lead the response in that sector. The objective is to see these roles blend only in situations where an emergency is so great as to require it—for example, where “only the use of military assets can meet a critical humanitarian need” and then only as a “last resort.”⁹⁰

DPKO has similarly made reference to “emergency response periods” in which there may be a need for humanitarian assistance to be provided directly by a peacekeeping mission rather than by specialized humanitarian agencies. However, the only objective in this situation is to save lives, ensure protection, and meet basic, urgent needs. DPKO goes on to note that in these situations, “it is important to keep longer-term objectives in mind and begin planning for the more comprehensive humanitarian programs that will be possible in a more stable environment.”⁹¹

Yet, as we have found an increasing number of references to civilian health assistance as part of peacekeeping operations, there seems to be little guidance on the challenges that can come about in reconciling these “direct” and “indirect” roles.

One of the principal challenges is that the engagement of military forces (even those serving under the UN flag) in delivering aid can undermine the perceived neutrality of humanitarian assistance. In discussing QIPs, the 2008 principles and guidelines recommend that missions should consult with humanitarian actors and

be aware that humanitarian actors may have concerns about the characterization of QIPs, or Civil Military Coordination (CIMIC) projects, “hearts and minds” activities, or other security or recovery projects as being of a humanitarian nature, when they see these as primarily serving political, security or reconstruction priorities.⁹²

86 UN Department of Peacekeeping Operations, “Civil-military Coordination in UN Integrated Peacekeeping Missions,” 2010, p. 15, available at <https://docs.unocha.org/sites/dms/Documents/DPKO%20UN-CIMIC%20%282010%29.pdf>.

87 UN Department of Peacekeeping Operations, “Civil-military Coordination in UN Integrated Peacekeeping Missions,” 2010.

88 UN Department of Peacekeeping Operations, “Principles and Guidelines,” p. 30.

89 UN Office for the Coordination of Humanitarian Affairs, “Humanitarian Civil-Military Coordination: Publications,” 2014, available at www.unocha.org/what-we-do/coordination-tools/UN-CMCoord/publications.

90 UN Office for the Coordination of Humanitarian Affairs, “Civil-Military Guidelines and Reference for Complex Humanitarian Emergencies,” Geneva: United Nations, 2005, p. xi, available at <https://docs.unocha.org/sites/dms/Documents/ENGLISH%20VERSION%20Guidelines%20for%20Complex%20Emergencies.pdf>.

91 UN Department of Peacekeeping Operations, *Handbook on United Nations Multidimensional Peacekeeping Operations*, p. 175.

92 UN Department of Peacekeeping Operations, “Principles and Guidelines,” p. 30.

A clear expression of this fear was seen in 1997 when Cornelio Sommaruga, then president of the International Committee of the Red Cross, argued that the separation of peacekeeping duties from the provision of humanitarian assistance (which includes the delivery of medical assistance to civilians) was essential:

UN military missions are an essential component of successful conflict management; in certain anarchic situations they may prove indispensable in securing respect for international humanitarian law and thus restoring the necessary security environment for the conduct of humanitarian activities. That being said, peace-keeping, and especially peace-enforcement operations, should be clearly distinct in character from humanitarian activities. Military forces should not be directly involved in humanitarian action, as this would associate humanitarian organizations, in the minds of the authorities and the population, with political or military objectives which go beyond humanitarian concerns.⁹³

In short, the humanitarian assistance roles and responsibilities ascribed to peacekeepers in the general guidance (as opposed to the mandates of specific missions) are deliberately limited to preserve humanitarian space based on the principles of neutrality, universality, and humanity. Indeed, for the most part, the generic UN guidance for peacekeeping missions does not explicitly suggest a role in the direct delivery of medical or other forms of humanitarian aid, save in a limited set of exceptional circumstances.

But what of the mandates of individual missions? Here we find significant variation, with some missions being mandated to provide humanitarian assistance, others to facilitate access, and others again without any explicit humanitarian role.

CIVILIAN HEALTH ASSISTANCE IN PRACTICE

An independent study commissioned by DPKO and OCHA, “Protecting Civilians in the Context of UN Peacekeeping Operations,” found that there had been great progress in understanding how

separate roles and responsibilities need to evolve in multidimensional peacekeeping operations within UN missions.⁹⁴ However, the authors also noted that there remained instances where peacekeeping forces “blurred” the distinction between their military and political activities with humanitarian activities. Specifically, they noted that when military actors undertook roles or projects “to win hearts and minds” their work was often similar to that of humanitarian actors in the same area.⁹⁵ The problem, the study’s authors noted, was the absence of a “concrete policy framework to place the work of UN peacekeeping operations and their role in protection in relation to that of humanitarian actors.”⁹⁶ Since this report, there has been ongoing dialogue among and within various UN agencies, including DPKO, on civil-military relations and cooperation in the four civil-military scenarios presented in the Inter-Agency Standing Committee (IASC) civil-military coordination documents: (1) missions in a peacetime setting; (2) peacekeeping; (3) peace enforcement; and (4) combat.⁹⁷

Following on from the findings in the “Protecting Civilians” study that the multidimensional character of peacekeeping missions was leading to humanitarian assistance being used to achieve political ends (including the winning of hearts and minds), the 2011 WHO Global Health Clusters position paper on civil-military roles and responsibilities reported a similar concern. That report noted that neither the IASC nor the Security Council has adequately addressed the division of responsibilities that reflect the multidisciplinary UN mission environment. The concern, as voiced by the WHO, was that

[t]his blending of strategies and tactics serves to undermine the international humanitarian community’s core humanitarian principles. The integrated mission concept developed by the UN follows a similar trend. Although there are significant attempts to protect the humanitarian space within integrated missions, the concept foresees the integra-

93 Cornelio Sommaruga, “Humanitarian Action and Peace-keeping Operations,” *International Review of the Red Cross*, No. 317 (1997), available at www.icrc.org/eng/resources/documents/misc/57jn7.htm.

94 Holt and Taylor, “Protecting Civilians,” p. 69.

95 *Ibid.*, p. 71.

96 *Ibid.*, p. 72.

97 OCHA. “Humanitarian Civil-Military Coordination: A Guide for the Military,” Civil-Military Coordination Section, V 1.0, Geneva: United Nations, July 2014, available at <https://docs.unocha.org/sites/dms/Documents/UN%20OCHA%20Guide%20for%20the%20Military%20v%201.0.pdf>.

tion of different agencies and components into an overall political/strategic crisis management framework. This can blur the lines between the UN's different political and humanitarian branches, with predictably negative results.⁹⁸

In our observation of the missions that provide medical assistance to civilians, we see the integrated or “multidisciplinary” mission practiced in slightly different ways that appear to depend on the practices of individual TCCs. Sometimes, indeed, the practices of a mission go beyond the formal mandate, with peacekeepers evidently engaging in service delivery when they are not mandated to do so.⁹⁹ In this section we examine cases of peacekeeping missions that fall into each of the three categories identified in table 2 (those which are formally mandated to provide assistance; those mandated to facilitate access; and those with no explicitly mandated humanitarian role) and evidence as to whether they do or do not appear to provide medical assistance in practice, based on the available information.

Missions Mandated to Provide Humanitarian Assistance

Some missions are specifically mandated to deliver humanitarian assistance. The mandates for MONUSCO in the Democratic Republic of the Congo (DRC), UNAMID in Darfur, and MINUSTAH in Haiti all specifically refer to the troops providing—not just facilitating—the delivery of humanitarian assistance. In a situation such as the one confronted by UNAMID in Darfur, this reliance on peacekeepers to provide emergency medical assistance is understandable. This is an extremely dangerous mission, with 204 peacekeeper deaths between 2009 and 2014.¹⁰⁰ Facilitating a safe corridor for peacekeepers and civilians, as well as humanitarian aid agencies, is extremely difficult. In these situations, as the WHO Global Health Cluster recommends, direct

assistance from medics within the peacekeeping contingent may be the only way to provide vital humanitarian assistance to the internally displaced and those unable to access alternative humanitarian assistance. The Security Council's resolutions, which set out the UNAMID mandate, have expressly referred to the dual role of peacekeepers to facilitate humanitarian access and to provide such assistance (see table 2). In practice, it appears that the mission has maintained a close relationship with OCHA in the delivery of humanitarian assistance. There is an agreement in place between OCHA and UNAMID concerning civil-military relations, which sets a framework for the coordination of joint initiatives by the mission and OCHA to deliver humanitarian assistance where the peacekeepers facilitate humanitarian access by providing safe corridors.¹⁰¹

MONUSCO has one of the most specific mandates concerning the role of peacekeepers in providing humanitarian assistance. Again, given the situation that MONUSCO faces in the DRC, particularly in the north and east, it is not surprising that there is specific provision in its mandate that peacekeepers may both facilitate and deliver humanitarian assistance (see table 2). Here, there is not the type of MOU between OCHA and MONUSCO that is in place in the case of UNAMID. However, there appears to be recognition by DPKO and the mission leadership of the need to prioritize the provision of humanitarian assistance in coordination with humanitarian actors. Even in areas where access is constrained, it appears MONUSCO attempts to ensure humanitarian access for other agencies rather than turning to the peacekeepers themselves to deliver medical services.¹⁰² For example, joint protection teams coordinated by MONUSCO's civil affairs unit have facilitated “access and provision of health services by humanitarian actors” to particular areas that

98 WHO, “Civil-Military Coordination during Humanitarian Health Action,” Global Health Cluster position paper, February 2011, p.11–2, available at www.who.int/hac/global_health_cluster/about/policy_strategy/ghc_position_paper_civil_military_coord_2_feb2011.pdf?ua=1.

99 This same phenomenon has often been observed in deployments of national military forces where military medics have often been found to provide treatment to civilians when not ordered to do so—in some cases even in direct contravention of their orders.

100 See www.un.org/en/peacekeeping/fatalities/documents/stats_5a.pdf.

101 UN Office for the Coordination of Humanitarian Affairs, “United Nations Civil Military-Coordination Guidelines for Sudan,” Khartoum, April 23, 2008, available at [https://docs.unocha.org/sites/dms/Documents/Sudan%20UN-CMCoord%20GLs%20\(23%20April%202008\).pdf](https://docs.unocha.org/sites/dms/Documents/Sudan%20UN-CMCoord%20GLs%20(23%20April%202008).pdf); “UN Mission to Remote Area of Darfur Finds Thousands in Need of Aid,” UN News, August 16, 2011, available at www.un.org/apps/news/story.asp?NewsID=39307&Cr=Darfur&Cr1=#.VDIFeGke4mU; “Darfur: UN Official Urges Support for Peace Process Amid Unfolding ‘New Dynamics,’” UN News, April 24, 2014, available at www.un.org/apps/news/story.asp?NewsID=47647#.VDIfcWke4mU.

102 “Humanitarian Needs Could Rise if Situation in Eastern DR Congo Remains Unresolved – UN,” UN News, November 29, 2012, available at www.un.org/apps/news/story.asp?NewsID=43637&Kw1=MONUSCO&Kw2=&Kw3=#.VDIn5Gke4mV.

Table 2. Current UN missions and humanitarian mandates¹⁰³

Mandate to provide humanitarian assistance to civilians	Mandate to facilitate access to humanitarian actors ¹⁰⁴	No explicit humanitarian mandate
MONUSCO S/RES/2147 (2014) ¹⁰⁵ S/RES/1925 (2010)	UNOCI S/RES/2162 (2014) ¹⁰⁶ S/RES/1528 (2004)	MINURSO S/RES/2152 (2014) S/RES/690 (1991)
UNAMID S/RES/2138 (2014) S/RES/2113 (2013) ¹⁰⁷ S/RES/1769 (2007)	MINUSCA S/RES/2149 (2014) S/RES/2127 (2013)	UNDOF S/RES/2163 (2014) S/RES/350 (1974)
MINUSTAH S/RES/2119 (2013) ¹⁰⁸ S/RES/1542 (2004)	UNIFIL S/RES/1701 (2006)	UNFICYP
	UNMIK S/RES/1244 (1999)	UNMOGIP
	UNMIL S/RES/2116 (2013) S/RES/1509 (2003)	UNTSO
	UNMISS S/RES/1996 (2011)	
	MINUSMA S/RES/2164 (2014) S/RES/2085 (2013)	
	UNISFA S/RES/2104 (2013) ¹⁰⁹ S/RES/1990 (2011)	

103 Each mission's original authorization by the UN Security Council and most up-to-date resolution is provided (as of November 2014).

104 Evidence of joint missions in news and mission updates, and existence of shared guidelines and procedures with OCHA.

105 Mandate Item 6: "MONUSCO's military and civilian components to focus on a coherent division of labour in accordance with their respective comparative advantages and available capacities," p. 9.

106 "To facilitate, as necessary, unhindered humanitarian access and to help strengthen the delivery of humanitarian assistance to conflict-affected and vulnerable populations."

107 "Maximize the use of its capabilities, in cooperation with the United Nations country team and other international and non-governmental actors, in the implementation of its mission-wide comprehensive strategy for the achievement of [humanitarian access and assistance] objectives."

108 "Support of activity aimed at effectively improving the living conditions of concerned populations, in particular women and children."

109 "Facilitate delivery of humanitarian aid."

Table 3. Current UN missions and provision of medical assistance¹¹⁰

Mandate to provide humanitarian (including medical) assistance to civilians	Mandate to facilitate access, but provides medical assistance to civilians ¹¹¹	No mandate but provides medical assistance to civilians	No explicit humanitarian mandate & no apparent treatment of civilians
MONUSCO S/RES/2147 (2014) S/RES/1925 (2010)	UNOCI S/RES/2162 (2014) S/RES/1528 (2004)	MINURSO S/RES/2152 (2014) S/RES/690 (1991)	UNFICYP
UNAMID S/RES/2138 (2014) S/RES/2113 (2013) S/RES/1769 (2007)	MINUSCA S/RES/2149 (2014) S/RES/2127 (2013)	UNDOF S/RES/2163 (2014) S/RES/350 (1974)	UNMOGIP
MINUSTAH S/RES/2119 (2013) S/RES/1542 (2004)	UNIFIL S/RES/1701 (2006)		UNTSO
	UNMIK S/RES/1244 (1999)		
	UNMIL S/RES/2116 (2013) S/RES/1509 (2003)		
	UNMISS S/RES/1996 (2011)		
	MINUSMA S/RES/2164 (2014) S/RES/2085 (2013)		
	UNISFA S/RES/2104 (2013) S/RES/1990 (2011)		

would otherwise be too dangerous to travel to without military support.¹¹²

Both of these examples point to peacekeepers playing a role in the delivery of medical assistance in settings where the presence of humanitarian actors is dangerous and impractical or where humanitarian actors require physical protection by peacekeeping troops—thus fitting within the exceptions highlighted in the previous section. However, there are also instances in which the mandate permits the direct provision of medical assistance by peacekeepers, but it is less clear that the conditions are such that this is absolutely

necessary.

In Haiti, MINUSTAH forms part of the OCHA “Guidelines for Civil-Military Coordination in Haiti” between the UN country team, UN agencies, and the government of Haiti, signed in 2012. Of interest in this document, the MINUSTAH mission has, since the 2010 earthquake, adopted a humanitarian assistance function that focuses on building infrastructure, particularly engineering projects. This is a marked departure from its earlier functions before the earthquake, which encompassed a broad humanitarian and development focus that contributed to a “blurring of lines”

¹¹⁰ In all types of missions, peacekeepers are expected to provide for their own medical needs.

¹¹¹ Evidence of joint missions in news and mission updates; existence of shared guidelines and procedures with OCHA.

¹¹² UN Department of Peacekeeping Operations, *Civil Affairs Handbook*, p. 175.

between military and humanitarian actors, as noted in the guidelines.¹¹³ Post-2010, a new operational agreement was devised to coordinate action and assistance during emergency and non-emergency situations in Haiti. This shift can be seen clearly in MINUSTAH's own reports on its activities that have changed from regularly reporting (pre-earthquake) on the health assistance programs being implemented by battalions from Jordan and India, to now highlighting the engineering infrastructure projects, particularly water and sanitation projects, being delivered by the mission.

These missions with mandates to provide humanitarian assistance illustrate that coordination is possible between the civil and military sectors. They also show that a vital capacity of military units is the ability to respond rapidly to emergency situations and to work in insecure environments. These units have access to logistical capabilities (e.g., helicopters for medical evacuation) and the ability to deliver aid in areas where civilian agencies are unable to operate safely. However, what the MINUSTAH case and the UNMIL and UNIFIL cases discussed below also reveal is that there is a tendency for this emergency relief function to continue after the context has transitioned from an emergency to a non-emergency situation.¹¹⁴ In such instances, where aid could be delivered by civilian humanitarian agencies, the medical units within missions do not always transition from providing direct medical assistance to facilitating medical assistance. This can compromise the roles of civilian actors and even undermine governments' long-term capacity to create their own health systems in these regions, as we show below in more detail. What is clear is that OCHA's assistance in producing guidelines that bring the head of mission on board is vital to ensuring a clear division of roles and responsibilities between humanitarian and military actors.

Missions Mandated to Facilitate Humanitarian Access

In some of the missions mandated only to facilitate humanitarian access we again see close working relationships between OCHA, the mission, and DPKO, which appears to emphasize coordination through a clear division of roles and capabilities concerning the delivery of humanitarian assistance to local populations (e.g., MINUSMA and UNMISS). OCHA has developed guidelines in a number of country-specific situations for UN missions (e.g., South Sudan over a number of years) that provide details on the roles and responsibilities of humanitarian and military actors.¹¹⁵ However, some of these guidelines are out of date (e.g., UNMIL was part of the Liberia Civil-Military Coordination Guidance in 2006), and for most missions there appear to be no guidelines. This situation is of concern as we identify a number of missions that are quite vulnerable to troops interpreting their mandate and engaging in humanitarian assistance in ways that may contradict the DPKO principles and guidelines and the protocol suggested in the OCHA recommendations.

Of the eight missions mandated to facilitate humanitarian assistance, we observe significant variation in how they interpret their role in "facilitating" access. Some missions, such as MINUSMA and UNISFA, appear to adhere to their mandated obligation to facilitate humanitarian assistance. In these missions, we find regular reports of peacekeepers establishing "safe corridors" to facilitate humanitarian access to civilian populations. We found numerous reports of these peacekeepers facilitating medical evacuations. However, there was very little reporting or other evidence to suggest these missions are seeking to assert a more proactive role in providing medical assistance to civilians. The exception was a case concerning the

113 UN Office for the Coordination of Humanitarian Affairs, "Guidelines for Civil-Military Coordination in Haiti," July 2013, p. 6, available at [https://docs.unocha.org/sites/dms/Documents/Revised%20Guidelines%20for%20Civil-Military%20Coordination%20in%20Haiti%202013%20\(ENG\)%20-%20Signed.pdf](https://docs.unocha.org/sites/dms/Documents/Revised%20Guidelines%20for%20Civil-Military%20Coordination%20in%20Haiti%202013%20(ENG)%20-%20Signed.pdf).

114 OCHA suggests emergency may be defined as humanitarian access that cannot be facilitated by civilian humanitarian workers in conflict situations where the protection of civilians is jeopardized if they seek humanitarian services and in natural disaster situations where resources and trained staff may be dramatically compromised due to the event. See UN Office for the Coordination of Humanitarian Affairs, "Humanitarian Civil-Military Coordination: A Guide for the Military," July 2014, available at <https://docs.unocha.org/sites/dms/Documents/UN%20OCHA%20Guide%20for%20the%20Military%20v%201.0.pdf>.

115 UN Office for the Coordination of Humanitarian Affairs, "Humanitarian Civil-Military Coordination: Publications," 2014, available at www.unocha.org/what-we-do/coordination-tools/UN-CMCoord/publications.

MINUSMA mission. Under UN Security Council Resolution 2164 (2014), MINUSMA is mandated to “address the needs of victims of sexual and gender-based violence in armed conflict.”¹¹⁶ This statement could imply that MINUSMA is to provide medical assistance to victims of sexual and gender-based violence. We found one example to indicate this was the intention; a report on the rape of a woman by four UN peacekeepers in September 2013 stated that “MINUSMA provided medical assistance to the alleged victim.” While the mission may be mandated to provide medical assistance in this particular instance, because of the identity of the alleged attackers, it must be asked of future missions that face similar situations whether the victim should be treated by those in the same uniform as the attacker, or be immediately referred to a humanitarian agency for medical care and forensics.¹¹⁷

In contrast, despite their facilitation mandate, UNOCI peacekeepers from Jordan provided free medical check-ups and medicine to schoolchildren in Abidjan.¹¹⁸ The mission website states that its medical corps’ “skills [are] also put at [the] disposal of the civilian population.”¹¹⁹ Both the Pakistani and Ghanaian contingents have reported on their provision of free medical treatment to local populations in their areas of deployment.¹²⁰ None of these reports refer to emergency conditions necessitating this assistance, and there is no indication that these services are being provided in situations where humanitarian access cannot be facilitated by civilian means (the “last resort” principle). This leads to a concern that the delivery of medical care has become an almost automatic function for some contingents without external assessment of the need for these services, or critical assessment of how they will contribute to building long-term and sustainable national health sector capacity.

Although UNOCI is notable for publicizing its activities in this area, it seems likely that similar activities are carried out (on a more or less ad hoc basis) in other missions.

In the UNOCI case, an additional concern is that medical assistance provided by UN troops may have (had) an ulterior motive, which raises concerns (as we discussed previously) about the preservation of humanitarian neutrality and impartiality. The OIOS audit report in late 2012 reported that UNOCI’s policy was

to provide non-emergency medical support to the local population based on humanitarian grounds, where feasible and applicable. This approach has allowed the military to connect with the population in areas of their deployment and has proved very beneficial in winning the hearts and minds of the local population.¹²¹

The report goes on to note that this practice has prevailed because the population receiving treatment “often tend[ed] to be of great assistance in supporting the military in their operations. In these cases, the patients sign a waiver.”¹²² The content of the waiver is not provided, but it is a concern that this practice appears to contradict both the DPKO guidelines on conduct of peacekeepers and the OCHA Humanitarian Civil-Military Coordination Guidelines on protection of civilians.¹²³

There are similar concerns about the intent and implications of medical assistance provided by TCCs in the case of UNIFIL in Lebanon. As with UNOCI, despite the UNIFIL mandate clearly stating that the mission’s role is to facilitate humanitarian access, the mission’s website suggests that one of the contributions of UNIFIL battalions to South Lebanon has been the provision of medical, dental, and veterinary care.¹²⁴ Contrary to the recommendations of the WHO Global Health

116 UN Security Council Resolution 2164 (June 25, 2014), UN Doc. S/RES/2164, p.6, para. 13 (iii).

117 Dulcie Leimbach, “A Rape Accusation in Northern Mali and the UN’s Awkward Response,” *PassBlue*, January 28, 2014, available at <http://passblue.com/2014/01/28/a-rape-accusation-in-northern-mali-and-the-uns-awkward-response/>.

118 UN Department of Peacekeeping Operations, “United Nations Operation in Cote d’Ivoire,” available at www.un.org/en/peacekeeping/missions/unoci/.

119 Ibid.

120 “UNOCI in Korhogo, Cote d’Ivoire,” *UN News*, May 28, 2014, available at www.unmultimedia.org/photo/detail.jsp?id=592/592728&key=7&query=organization:UNOCI%20AND%20category:%22Field%20coverage%22&sf; “UNOCI Ghanbatt 15 Provides Free Medical Care,” *Modern Ghana*, October 11, 2011, available at www.modernghana.com/news/355418/1/unoci-ghanbatt-15-provides-free-medical-care.html; ONUCI, “Military Force,” available at www.onuci.org/ren.php?id_rubrique=156http://www.onuci.org/ren.php?id_rubrique=156.

121 UN Office of Internal Oversight Services, “Audit of Medical Services in UNOCI,” p. 3.

122 Ibid.

123 UN Office for the Coordination of Humanitarian Affairs, “Humanitarian Civil-Military Coordination: A Guide for the Military.”

124 UNIFIL, “UNIFIL Civil Interaction,” available at <http://unifil.unmissions.org/Default.aspx?tabid=11581&language=en-US>.

Cluster, most of the medical assistance provided is primary health care. It is clearly understood, some contend, that the value of this assistance is that it builds the mission's legitimacy among the local population and, furthermore, may assist UNIFIL's intelligence operations, especially when it needs information on the location of illicit arms and areas that support the armed insurgency, Hizbullah.¹²⁵ This raises at least two sets of serious concerns. First, while there is undoubted benefit from the services provided by medics attached to Spanish, Italian, Indonesian, Indian, and French troops since the UNIFIL mandate resolution in 2006, these actions threaten to compromise the impartial and neutral nature of humanitarian assistance. Second, the provision of direct primary health care has the potential to undermine the building of local health capacity and affect the relationship between the population and the state's health care system.

UNMIL, meanwhile, has been deployed in Liberia since 2003. This mission has had troops from a number of TCCs, including Bangladesh, Jordan, and Pakistan, on rotation since then. The mission has experienced relative stability for a number of years, and with this stability a number of TCCs began directing their contingents to provide non-emergency medical services on a regular basis. Pakistani peacekeepers, for example, provide "basic health care to the local people" on a weekly basis.¹²⁶ In 2007, the Irish Defence Forces noted that in its contribution to UNMIL:

Although providing humanitarian assistance is not a direct tasking for the [Special Operations Task Group], it became a regular feature mainly in the form of medical assistance to local population by the unit's [medical officers] and patrol medics.¹²⁷

The UNMIL case not only raises concerns about "quality control" within the medical facilities run by TCCs (and, given the OIOS audit of UNMIL in

2009, there appears to be cause for concern in both treatment and infection control), but also the separate issue of strengthening and building the capacity of health systems. Liberia's health system since the end of the war in 2003 has been plagued by the resource, capacity, and disease burdens that commonly befall postwar countries. In 2012, it was reported that the Liberian government had made progress in building its health system capacity, but, outside of Monrovia, populations remained without access to medical services, and the continuing deficiencies in health system capacities were all-too-clearly revealed by the 2014 Ebola outbreak.¹²⁸ On the one hand, the presence of TCCs willing to provide services relieves the burden from a government that has a particularly under-resourced health system, helping to provide stability in regions that were tense and divided post-2003.¹²⁹ On the other hand, it risked creating a situation in which the government became accustomed to medical needs being "met" by external actors. This moral hazard does not only apply to peacekeepers, it is one that all humanitarian actors feed into, particularly when most of the care in the country is provided by nongovernmental actors.¹³⁰

The relevance of the above concern is illustrated by the Ebola outbreak in Liberia that began in March 2014.¹³¹ Despite the record of direct health assistance being provided by peacekeepers in relative "peacetime" situations, the mission's immediate response to the Ebola outbreak was to remove peacekeepers from the frontline in delivering medical assistance. In a press conference on the situation in September 2014, Under-Secretary-General for UN Peacekeeping Operations Hervé Ladsous emphasized that "a peacekeeping mission is not a public health operation [as] this is not what we are trained for."¹³²

Yet this statement is somewhat contradicted by

125 Kamal Dev Bhattarai, "NA Peacekeepers Winning Hearts in Lebanon," *Ekantipur*, March 30, 2014, available at www.ekantipur.com/2014/03/30/top-story-na-peacekeepers-winning-hearts-in-lebanon/387471.html; Alberto Asarta Cuevas, "UNIFIL: Instrument for Peace in the Middle East," *IEEE*, October 11, 2014, available at www.ieee.es/en/Galerias/fichero/docs_opinion/2013/DIEEEO96-2013_FINUL_Libano_AlbertoAsartaCuevas_ENGLISH.pdf.

126 Pakistan Army, "United Nations Mission in Liberia (UNMIL)," available at www.pakistanarmy.gov.pk/AWPReview/TextContent.aspx?pid=67.

127 Emphasis added. Defence Forces Ireland, "United Nations Military in Liberia," available at www.military.ie/en/overseas/past-missions/africa/unmil/.

128 Richard Downie, "The Road to Recovery: Rebuilding Liberia's Health System," Washington, DC: Center for Strategic and International Studies, August 2012, available at http://csis.org/files/publication/120822_Downie_RoadtoRecovery_web.pdf.

129 Margaret E. Kruk, Peter C. Rockers, Elizabeth H. Williams, S. Tornorlah Varpilah, Rose Macauley, Geeter Saydee, and Sandro Galea, "Availability of Essential Health Services in Post-conflict Liberia," *Bulletin of the World Health Organization*, No. 88 (2010): 527–534.

130 *Ibid.*; Downie, "The Road to Recovery."

131 Prior to the outbreak, UNMIL was planning to draw down its forces as a result of growing stability in the country. The Ebola outbreak led the UN Security Council, in September 2014, to opt to maintain UNMIL at its present strength.

132 "Ebola: UN Will 'Stay the Course' in Liberia, Peacekeeping Chief Says," *UN News*, September 11, 2014.

the practice of UNMIL peacekeepers themselves in providing health care in both emergency and non-emergency situations prior to the Ebola outbreak. From a humanitarian perspective, Ebola seems to provide a stronger rationale for the mission to provide assistance—if not directly in staffing Ebola clinics (depending on troops' access to protective equipment), at least in providing assistance with border infection control procedures, safe burials, ensuring safe supply of essential services, detection and response training across the country, supply of equipment, and the construction of Ebola treatment clinics.¹³³ UNMIL has reported some activities in these areas, but overall there appears to have been a limited response from the mission in helping meet the shortfall in essential services required to mount an effective Ebola response in Liberia. This appears to be primarily out of concern for protecting the troops and minimizing their exposure to the disease. A number of TCCs have been deeply concerned about their troops being exposed to the virus and have threatened withdrawal. At the time of writing, one TCC (the Philippines) had recalled its contingent from Liberia.¹³⁴ On the other hand, UNMIL's reluctance to recommend a more proactive role for peacekeepers during such a virulent outbreak may be justified given concerns—as indicated by the past audits—over whether the medical assistance provided adheres to international infection control standards.

In other cases, it has been suggested that the provision of health assistance to the local population could even undermine the ability of a mission's medical services to provide care to peacekeeping personnel themselves. The recent OIOS audit of UNMISS found that the mission was “unsatisfactory in providing reasonable assurance regarding the adequacy of the provision of medical

services to UNMISS civilian staff and military contingents.”¹³⁵ The report found that there were few Level I and Level II clinics available to provide care to military or civilian staff; the ones available were poorly resourced and inadequately staffed. Yet the few clinics available continued to attempt to provide care to the local civilian population. In all, UNMISS was failing to provide adequate care and risking the lives of those who sought medical care. The OIOS made ten recommendations that ranged from procuring necessary medical equipment and vaccines in clinics and hospitals to adequate training and appropriate disposal of medical waste. It was also noted that UNMISS was providing medical services to the civilian population when it was under “no obligation to provide or take responsibility for medical services to the local population” (with the exception of emergency medical care), and this was placing pressure on under-resourced medical clinics.¹³⁶

UNMISS has also been the subject of criticism from other agencies (particularly Médecins Sans Frontières) for the “squalid” conditions at its bases.¹³⁷ UN staff responded to this criticism by noting that with the rapid increase in the number of internally displaced persons (IDPs) seeking shelter at bases, peacekeepers had to quickly respond and provide makeshift IDP camps until further humanitarian assistance could be safely facilitated.¹³⁸ In this sense, the dilemma for UNMISS is different to that facing UNMIL (before the Ebola outbreak) and UNIFIL, for example. UNMISS is having to strike a balance between what the mission is mandated to do, what it is capable of doing in terms of both protecting humanitarian actors and its own troops, and what logistical support TCCs are providing to troops, while faced with a situation in which civilians are being targeted and are turning to UN peacekeepers for

133 UN Office for the Coordination of Humanitarian Affairs, “Ebola Virus Disease Outbreak: Overview of Needs and Requirements,” September 2014, available at http://reliefweb.int/sites/reliefweb.int/files/resources/Ebola_outbreak_Sep_2014.pdf.

134 Colum Lynch, “Ban Says UN Troops Are Safe, Needed to Quash Ebola Unrest,” *Foreign Policy*, September 2, 2014, available at http://thecable.foreignpolicy.com/posts/2014/09/02/ban_says_un_troops_are_safe_needed_to_quash_ebola_unrest; Fiji has announced they will stop sending peacekeepers to Liberia: “Fiji to Stop Sending Peacekeepers to Liberia,” *Authint Mail*, October 15, 2014, available at www.authintmail.com/2014/asia-pacific/fiji-stop-sending-peacekeepers-liberia.

135 UN Office for Internal Oversight Services, “Audit of Medical Services in the United Nations Mission in South Sudan,” p. 2. For example, “As the [medical] clinics were not properly equipped, Mission personnel had to be evacuated to a higher level clinic, resulting in increased evacuation costs and a higher risk of staff not being able to receive medical treatment on a timely basis,” p. 6.

136 *Ibid.*, p. 7.

137 Rick Gladstone, “UN Ignores South Sudan Camp Crisis, Charity Says,” *New York Times*, April 9, 2014, available at www.nytimes.com/2014/04/10/world/africa/medical-charity-sharply-criticizes-un-operation-in-south-sudan.html?_r=0.

138 “South Sudan: UN Mission Reaffirms Commitment to Protecting Civilians at Bases,” *UN News*, April 9, 2014, available at www.un.org/apps/news/story.asp?NewsID=47536#.VEESEGke4mU.

protection and assistance.

Almost immediately after the OIOS audit, UNMISS and OCHA established “Guidelines for the Coordination between Humanitarian Actors and the United Nations Mission in South Sudan.”¹³⁹

The purpose of these guidelines, developed by the Civil-Military Advisory Group from the Humanitarian Country Team and UNMISS, is to provide

succinct operational guidance on relations between UNMISS and humanitarian actors in South Sudan to avoid conflict between the actors, strengthen the coordination of activities and preserve humanitarian space, access and principles.¹⁴⁰

Similar to MONUSCO’s guidelines, the UNMISS guidelines detail the need for a careful division of roles and responsibilities between humanitarian actors and peacekeeping forces in South Sudan, specifically noting that activities, assets, bases, and escorts needed to be seen as separate by both civilians and combatants to ensure the protection of civilians. The need to specify the medical assistance that peacekeepers are obligated to provide in emergency and non-emergency situations is particularly important for those situations where capacity may not be available and quality control may be compromised due to different standards of care among TCCs.¹⁴¹ This practice, we suggest, is one that should be replicated across all missions irrespective of the humanitarian content of the mandate—a point we return to below.

Missions Providing Medical Assistance without an Apparent Mandate

Finally, some missions, such as MINURSO in Western Sahara and UNDOF in the Golan, have no mandated requirement to engage in medical assistance or support tasks. Such assistance is nevertheless commonly provided.¹⁴² In MINURSO, a Korean medical unit provided health advice to

patients and primary and preventive medical care to both military and civilian staff in the mission for twelve years (1994–2006). However, from 2004 to 2006, the Korean contingent expanded its service to include assistance to the Sahrawi people traveling to meet family members under an exchange program organized by the UN Refugee Agency (UNHCR). In addition, “when required and feasible,” the medical unit provided “humanitarian medical aid” to civilians in remote locations, including helping persons involved in mine incidents.¹⁴³ Likewise, UNDOF provides “medical treatment to the local population on request.”¹⁴⁴ Neither mission provides further information on what constitutes “feasible” or “required,” nor on the criteria against which a request for assistance leads to action.

RECOMMENDATIONS

Based on the preceding analysis, we make two further recommendations to add to those of section one. First, UN peacekeeping operations should routinely establish civil-military guidelines on coordinating and providing humanitarian assistance, devised by OCHA in coordination with the host state and/or UN agencies, to clearly identify the roles and responsibilities of UN peacekeepers. As we have seen, mandates do not usually stipulate a direct role for UN peacekeepers in the provision of medical assistance to the civilian population. DPKO’s guidelines specifically recommend that UN peacekeepers ought not to play this role, except in certain narrowly defined circumstances. The provision of medical assistance to the civilian population is not the “core business” of the peacekeeper.¹⁴⁵ The WHO Global Health Cluster also refers to the need for missions to ensure that their roles in the delivery of medical assistance to civilians are limited to emergency situations. However, in practice we find that there are

139 UN Office for the Coordination of Humanitarian Affairs, “Guidelines for the Coordination between Humanitarian Actors and the United Nations Mission in South Sudan,” December 6, 2013, available at <https://docs.unocha.org/sites/dms/Documents/A05%20Guidelines%20for%20the%20Coordination%20between%20Humanitarian%20Actors%20and%20the%20UNMISS.pdf>.

140 *Ibid.*, p. 2.

141 In particular, there are reports that MINUSCA is struggling to access and provide populations in displaced camps with much-needed emergency humanitarian assistance. This is a situation where many humanitarian actors have had to evacuate due to the comprised security situation in the country. Human Rights Watch, “New UN Mission in Central African Republic Should Urgently Improve Protection for Civilians,” September 15, 2014, available at <http://africajournalismtheworld.com/tag/un-minusca/>. Similar concerns have been raised with the MINUSMA mission: Norwegian Refugee Council, “Civilians in Northern Mali in Need of Protection,” NRC Briefing Paper, June 19, 2014, available at www.nrc.no/arch/_img/9179787.pdf.

142 Notwithstanding the recent exchange of fire in UNDOF.

143 “After 12 Years, Korean Medical Unit Departs UN Mission in Western Sahara,” *UN News*, May 15, 2006.

144 UNDOF, “Civil Affairs,” available at www.undof.unmissions.org/.

145 UN Peacekeeping Operations, “Principles and Guidelines,” p. 23.

numerous instances in which UN peacekeepers engage in the direct delivery of medical care and aid to civilians. The reality is that, more often than not, UN peacekeepers are providing medical assistance to civilians in emergency and non-emergency situations. These activities potentially blur the conventional separation of a mission's political objectives from "neutral" humanitarian aid. Joint guidelines would help clarify roles and responsibilities and mitigate some of the potential negative effects associated with this kind of work.

Second, these guidelines should be tailored to each mission and reviewed and updated when the mission's mandate is under review by the UN Security Council, not least because the humanitarian context in which missions are working can alter dramatically and rapidly. There is significant variation across UN missions, even those with similar mandates. On the one hand, there are instances where peacekeepers successfully provide humanitarian assistance; on the other, there are instances where UN missions do not have the necessary medical support, equipment, or training to support their own personnel let alone the surrounding civilian population. In our assessment of ongoing missions, it seems that best practice is more assured when there is specific reference in the mandate to medical or humanitarian assistance being a function of the peacekeeping operation. The longevity of a mission does not appear to determine best practice, but relative stability does seem to create the space for peacekeepers to expand their role and in some cases leads to them using spare capacity to provide medical assistance in non-emergency situations. What is determining the provision of assistance in these cases, it seems, is not a holistic appraisal of local needs but rather the desire of the peacekeepers to play a meaningful role. This introduces a range of risks—for example, when the medical service of one TCC is withdrawn and replaced with another that cannot provide that service or when the standard operating procedures for medical practice in one contingent differ from those in another. Such changes undermine the sustainability of, and equality of access to, the services provided. A more strategic approach based on an assessment of needs would better inform civil-military relations, give support to the chief medical officer in ensuring compliance with guidelines, clarify roles and responsibilities, and

improve the sustainability of medical outreach work.

Conclusion

One of the gravest challenges peacekeepers face is remaining healthy in conflict-affected environments. The environments in which peacekeepers are deployed are frequently beset by a high prevalence of infectious diseases as well as rudimentary, sometimes nonexistent, health facilities. The population seeking protection and medical assistance from these missions frequently suffers additional poor health outcomes, such as high levels of child and maternal mortality. UN peacekeepers are not in a position to solve these problems—their primary responsibility is to provide (or maintain) a stable situation in which other humanitarian actors and development agencies may work. Yet peacekeeping operations at the very least have a responsibility not to make health problems worse. They may also, if handled carefully and carried out appropriately, be able to make some contribution to providing health services to the community in which they serve, in addition to providing appropriate and necessary services to peacekeeping personnel themselves. This report has focused on ways in which some of the negative health impacts of peacekeeping can be mitigated, and some of the potential positive contributions augmented.

We make the following recommendations:

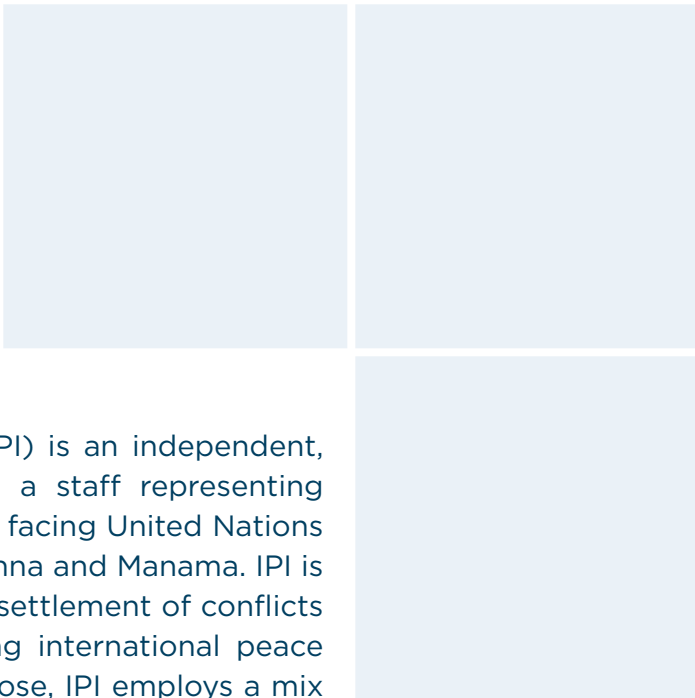
- Pre-deployment medical checks (which are carried out by TCCs and verified by the mission's chief medical officer) should be strengthened, with the UN and TCCs cooperating to ensure the pre-deployment medical requirements have been properly fulfilled. With the adoption of a new reimbursement rate for TCCs (some of whom had cited the cost of pre-deployment medical care, among other things, to argue for an increased reimbursement rate), it seems legitimate for conditions regarding health assessments to be toughened in memoranda of understanding between the UN and TCCs. This report suggests that an identifiable payment specifically for pre-deployment health care would help ensure that the necessary medical checks take place.
- Health impact assessments should be conducted prior to deployment and on an annual basis

thereafter, so that all missions can systematically monitor the impact peacekeepers have on the health of the host population and to guide risk minimization strategies.

- DPKO's principles and guidelines for peacekeepers should be revised to clarify the need for coordination with OCHA, the host state, and other relevant agencies in the provision of humanitarian assistance (including health assistance) and to more clearly identify the roles

and responsibilities of UN peacekeepers in different situations.

- These guidelines should be tailored for each mission and reviewed as part of the mandate renewal (six-month and/or twelve-month intervals) to ensure that prevailing coordination agreements reflect the changing circumstances on the ground and the findings of the latest health impact assessments.



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