

The Enemy Within: Southern African Militaries' Quarter-Century Battle with HIV and AIDS

EDITED BY
MARTIN RUPIYA

The Institute for Security Studies' MilAIDS Project is funded by the
Rockefeller Brothers Fund

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ISBN: 1-920114-03-3

First published by the Institute for Security Studies
P O Box 1787, Brooklyn Square 0075
Tshwane (Pretoria), South Africa

Cover photography, manipulation and design: Dave Labour Artwork and Design
Editing, layout and production: Tyrus Text and Design (082 416 2918)
Capture Press (012 349 1802)

Acknowledgements

The MilAIDS Project would like to thank the governments of the Republic of Botswana, the Kingdom of Swaziland and the Republic of Zambia for allowing their militaries to contribute towards the groundbreaking research on the phenomenon of HIV/AIDS and the armed forces.

We also extend our appreciation to the selected country teams, drawn from serving soldiers with an equal gender representation and colleagues from civil society who have interacted with the military on the HIV/AIDS issue. Without their enthusiastic participation, it would not have been possible to compile this work. The teams comprised Col (Dr) Anne Namakando Phiri, Col (Dr) Lawson Simapuka, Lt Col Shayilanga Cornelius Kunene, Maj Tsembeni Magongo, Prof. Hamilton S. Simulane, Maj Raymond J. Molatole, Capt Steven Laki Thaga, Dr Jonathan Mutayoba Kakulu Lwehabura, Mrs Jeanne Karamaga Ndyetabura and Dr Reginald Matchaba-Hove.

Even after this seminal delivery of empirically grounded results, whose purpose, among other expectations, was to build confidence between researchers and practitioners, HIV/AIDS issues remain extremely sensitive. Against such a background, the willingness of the stakeholders to pursue the objectives of the project must be commended. This may yet serve as a bridge, providing links and opportunities for further collaboration in the future.

The Institute for Security Studies would like to acknowledge with gratitude the financial support provided by the Rockefeller Brothers Fund, without which it would have been impossible to address the complex issues around HIV/AIDS and the militaries—a subject matter that has challenged Southern Africa for the last 25 years.

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Foreword

HIV and AIDS have emerged as a major challenge to communities in Southern Africa since its widespread manifestation in the 1980s. This epidemic has escalated alarmingly over the past 25 years to affect over 20% of populations in its global epicentre, sub-Saharan Africa, and especially Southern Africa. Faced with this health crisis, nations have reacted to raise awareness, increase prevention, provide adequate care and treatment, and have even attempted to find a cure, but so far without success.

National research and policy and strategy formulation to respond to the epidemic and related challenges have been mandated to national commissions that in turn have turned towards sectors such as agriculture, tourism, mining, labour and uniformed services, requesting these entities to develop sector-specific policies that will then form the basis of a comprehensive national HIV and AIDS policy and strategy.

Uniformed services are in many ways at the coalface of the HIV/AIDS epidemic, in the sense that they are vulnerable both to contracting HIV/AIDS and serving as agents for its transmission. Reliable estimates of HIV/AIDS prevalence within Southern African militaries are, however, hard to come by and the implications for the military is at present almost entirely speculative. It is thus extremely important that effective, comprehensive, forward-looking responses be put in place to mitigate the possible effects of the epidemic on the militaries of the sub-region.

It is against this background that a country-based research initiative by the Institute for Security Studies was initiated to seek to develop policy options for the mitigation of the impact of the epidemic on the armed forces of Southern Africa. This book, *The Enemy Within: Southern African Militaries' Quarter-Century Battle with HIV and AIDS*, is the product of that research, and forms an important part of ongoing initiatives aimed at enhancing our understanding of the challenges and offering a platform from which to launch further focused initiatives that should ultimately lead to our winning the battle against the ravaging epidemic. It draws from the experience of the armed forces of Botswana, Swaziland, Tanzania, Zambia and Zimbabwe, and makes a significant contribution to our understanding of the epidemic, its implications for armed forces and for sharing possible solutions.

Defence departments and armed forces within the Southern African Development Community have been challenged by political leadership to begin to harmonise and coordinate their efforts towards combating the scourge of HIV and AIDS, and this book forms an important contribution thereto as a source of information on common practice for militaries to learn lessons for the future. The objective of this endeavour is to protect the health of soldiers and their communities, and ultimately to support the primary role of the armed forces of the sub-region, to adequately contribute to regional and national security as well as to human security in Southern Africa.

Len Le Roux

Head: Defence Sector Programme

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List of abbreviations

ACHAP	African Comprehensive HIV/AIDS Partnerships
AFZ	Air Force of Zimbabwe
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal clinic
ARV	Antiretroviral
AU	African Union
AWA	AIDS Watch Africa
BDF	Botswana Defence Force
CBO	Community-based organisation
CBoH	Central Board of Health
CD4+	Cluster Differentiation 4 positive T-lymphocytes
CDC	Centre for Disease Control
CIO	Central Intelligence Organisation
CMA	Civil–Military Alliance
CMTC	Crisis Management and Technical Committee
CMV	Cytomegalovirus
DFMS	Defence Force Medical Services
DNA	Deoxyribo-nucleic acid
DRC	Democratic Republic of the Congo
ELISA	Enzyme-linked immunosorbent serum assay
FAO	(United Nations) Food and Agriculture Organisation
FMTF	First Medium Term Programme
GDP	Gross domestic product
GPA	Global Programme on AIDS
HAARD	Highly active antiretroviral drugs
HAART	Highly active antiretroviral therapy
HBC	Home-based care
HDI	Human Development Index
HIV	Human immunodeficiency virus
IEC	Information, education and communication
ILI	Influenza-like illness
ILO	International Labour Organisation
IMET	International Military Education and Training
IMF	International Monetary Fund
ISDSC	Inter-State Defence and Security Committee
M & E	Monitoring and evaluation

MAP	Multi-sectoral Project
MCZ	Medical Council of Zambia
MoH	Ministry of Health
MTP	Medium-term programme
MTP2	Multi-Sectoral Second Medium Term Plan
NAC	National AIDS Council
NACA	National AIDS Coordinating Agency
NACP	National AIDS Control Programme
NAPCP	National AIDS Prevention and Control Programme
NEDPP	National Economic Development Priority Programme
NERCHA	National Emergency Response Committee on HIV/AIDS
NGO	Non-governmental organisation
NMEF	National Monitoring and Evaluation Framework
NMSSF	National Multi-sectoral Strategic Framework
OVC	Orphans and other vulnerable children
PCR	Polymerase chain reaction
PEP	Post exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHA	People living with HIV/AIDS
PMO	Prime Minister's Office
PMTCT	Prevention of mother-to-child transmission
PSRP	Public Services Reform Programme
RICA	Royal Initiative to Combat AIDS
SADC	Southern African Development Community
SIDA	Swedish International Development Agency
SNAP	Swaziland National AIDS/STI Programme
SSIP	Specific Sector Implementation Plan
STI	Sexually transmitted infection
TACAIDS	Tanzania Commission for AIDS
TAS	Tanzania Assistance Strategy
TB	Tuberculosis
TPDF	Tanzania People's Defence Force
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
URT	United Republic of Tanzania
US	United States
USDF	Umbuto Swaziland Defence Force

VCT	Voluntary counselling and testing
WFP	World Food Programme
WHO	World Health Organisation
WTO	World Trade Organisation
ZANARA	Zambian National Response to HIV/AIDS
ZANLA	Zimbabwe African National Liberation Army
ZDF	Zambia Defence Force
ZDF	Zimbabwe Defence Force
ZIPRA	Zimbabwe Peoples' Revolutionary Army
ZLWVA	Zimbabwe Liberation War Veterans' Association
ZNA	Zimbabwe National Army
ZPS	Zimbabwe Prisons Service
ZRP	Zimbabwe Republic Police

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Context of the study

Martin Rupiya

This study, *The Enemy Within: Southern African Militaries' Quarter-Century Battle with HIV and AIDS*, traces the experiences of three defence forces—those of Botswana, Swaziland and Zambia—through the eyes of serving senior officers. A complementary perspective on Tanzania and Zimbabwe is provided by civil society researchers with an intimate knowledge of military–civil relationships in these countries.

The result has been the first in-depth social science study to provide insights into the militaries as they have come to grips with the pandemic. It shows their struggle to receive policy guidance from policy makers. When this was slow in coming, the organisations were forced to improvise in order to maintain the integrity of their national mandate, which is to be always ready and prepared to safeguard their countries' national security.

Given the major route of transmission—which has been heterosexual relations that have crossed the boundaries between uniformed forces and the rest of society—the role of civil society participants in the research has been particularly important.

Despite this productive collaboration, we have to acknowledge that we do not know the true extent of the presence and impact of HIV/AIDS in Southern Africa. The available statistics are incomplete, and our methodology has had to rely on partial or extrapolated evidence. This evidence has generally been limited to the results of tests of pregnant women at anti-natal clinics, evaluations of donated blood and the prevalence suggested by the testing of those volunteers who have agreed

to a determination of their HIV status. (In post-conflict conditions such as apply, for example, in Angola or the Democratic Republic of the Congo [DRC], even this evidence may not be available.)

Owing to the situation described, any type of research that contributes to our aggregate knowledge is welcome, even where the research has had to take place without an adequate infrastructure or skills base. The conceptual framework and intended focus of our work has recognised these shortcomings.

The study is particularly welcome in the light of the suspicion and stigma created in the mid-1990s by elements in the international community, reinforced by media hype. Various allegations targeted African militaries as one of the major vectors for the spread of the disease.

This activity coincided with international confusion about which organisations could best lead and coordinate the response to the growing HIV/AIDS epidemic. This situation saw, in 1996, the World Health Organisation and the World Bank handing over their previous responsibilities to a newly created cluster¹ agency of the United Nations, UNAIDS. Within UNAIDS, the Civil–Military Alliance (CMA) to Combat HIV and AIDS emerged in 1997. The CMA was required to work with the world’s armed forces to acquire empirical evidence that would inform policy recommendations.² In its wisdom, the CMA began its work by sending out to 120 countries a 40-point questionnaire asking for information on, for example:

- the prevalence rates in each of the militaries;
- the number of HIV-positive recruits;
- the number of HIV-positive persons on active duty;
- the total number of AIDS cases that had been diagnosed to date; and
- aggregated data for regions.³

These questions were not universally welcomed by the traditionally suspicious militaries, including those on the African continent. In their view, the information sought by the questionnaire focused on the state of their armies, their composition and their capabilities in relation to their human resources. In their view, therefore, such information should not be released or deposited with a civilian organisation somewhere in the West.

It is therefore not surprising that the CMA initiative soon admitted to a lack of positive response from the majority of militaries targeted.

According to submissions to the 32nd International Congress of Military Medical Practitioners held in Beijing, China in October 1996, there was a disappointing 30% response from Africa.

Another development that exacerbated research relations with the militaries was the question of the genesis and transmission of the virus. We now know that the reports of the empirically documented incidence in the United States San Francisco gay community coincided with the evidence emerging from Kinshasa, and later in Cameroon, that the HI virus may have crossed over from chimpanzees to affect humans. Following this research, there was a deliberate attempt not only to stigmatise the African continent but also to point to the sexual practices of militaries as the major vector spreading the disease.

Following these developments there was a clamming up of information by militaries and a reluctance to work with researchers, most of whom wished to sensationalise rather than to guide their work into constructive channels.

Against this background, it was a significant breakthrough that governments and their militaries signed up to the present research initiative.

This confidence has placed an obligation on those of us who have been responsible for managing the project to safeguard the confidential integrity of the activity through a continuous consultative process. This obligation, however, has had to be balanced against the demands placed on us as social science professionals.

In the event, we are confident that the end-result will prove beneficial for both sides. It is also our conviction that this study will serve to motivate other states in Africa, if not beyond Africa, to document their experience with HIV/AIDS since its 'discovery'.

If this project succeeds in its three initial objectives, namely to:

- trace and document empirically the policy responses by military institutions since the advent of HIV/AIDS;
- develop research and analysis tools on the related issues within both the armed forces and civil society; and
- provide a 'best-practice' template,

we may be provided with an opportunity for a second and much more intensive phase of research, which would take the form of impact studies.

In the same vein and with resources permitting, the present research initiative may be extended to countries in sub-Saharan Africa that we have not yet examined.

DOCUMENT ARRANGEMENT

This study is organised in three parts. Part I comprises four chapters—an introduction, including methodology and definitions, followed by three country chapters on the Botswana Defence Force, the Umtotfo Swaziland Defence Force and the Zambia Defence Force. Part II comprises two chapters—contributions from civil society organisations offering their perspectives on the Tanzania Defence Force and the Zimbabwe Defence Force, while Part III wraps up with chapter conclusions and recommendations.

NOTES

- 1 A cluster approach involves allocations from a number of existing UN agencies concerned with a particular issue, and lending part of their budgets and other related support to an entity that then bears lead responsibility.
- 2 See *Civil Military Alliance (CMA)* 3(1), newsletter, January 1997, p 1.
- 3 Ibid.

PART I

HIV/AIDS AND THE EXPERIENCE OF SOME SOUTHERN AFRICAN ARMED FORCES

Introduction: Southern African militaries' battle against HIV/AIDS

Martin Rupiya with assistance from Lawson Simapuka

INTRODUCTION

According to the available evidence, the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS) were not a problem in Southern Africa during the early 1980s. The incidence was numbered in the tens of hundreds, indicating that the problem had not yet become a public health issue. But a quarter-of-a-century later, the situation had changed dramatically. Today an estimated 25.4 million people in sub-Saharan Africa have contracted HIV or AIDS. This figure represents some 30% of all those in sub-Saharan Africa who have been infected by the pandemic. In the Southern African region alone, HIV/AIDS deaths are now estimated at 2.4 million.¹ The majority of those infected are in the highly productive and sexually active 18–49-year age group.

Almost in unison, governments have reacted with shock and have attempted to come to grips with the dynamics of HIV and AIDS. They have sought to understand the virus, how it is transmitted and which groups of their populations are at greatest risk. They have also tried to assess the impact of the virus on the fabric of their societies, and to seek counter-measures that might have the effect of reducing the incidence of HIV and AIDS to the low levels of the pre-1980s.

In the preceding 25-year period, policy responses by governments appear to have traversed a similar course, generally divided into three phases. The first response was to create a special unit within the health ministry of each country. In some cases this had strong and direct links

with the Office of the Presidency and had responsibility for formulating HIV/AIDS counter-measures. However, as the impact of the virus continued to escalate, dedicated national commissions took over responsibility for each country's HIV/AIDS policy. Finally, the available evidence suggests that the various national commissions have realised their lack of capacity to address sector-specific problems. They have therefore called on their countries' agriculture, mining, transport, education, security and other sectors to come up with policies appropriate to their particular circumstances, but still in line with national HIV/AIDS policies.

Seen from this perspective, the policy-formulation process appears to have turned full circle over the quarter-of-a-century period referred to. Indeed, many of the economic sectors are no further forward than they would have been 25 years ago. This is because questions around HIV/AIDS have continued to be posed without adequate explanation. We are now therefore faced with the need to embark upon an urgent multifaceted research response in the realms of both medical science and each country's social and economic framework.

The research initiative reported in the present document forms part of this overall response. It has focused on the complex phenomena of HIV and AIDS and how these relate to African armed forces in Africa. Findings have been extrapolated from a limited assessment of the situation in the armed forces of five Southern African countries, namely Botswana, Swaziland, Tanzania, Zambia and Zimbabwe.

HIV/AIDS AND AFRICAN ARMED FORCES

The armed forces constitute one of African countries' most important sectors. They provide both national security and employment, and they are also a symbol of a country's sovereignty and nationhood. Any threat to a country's military institutions therefore has far-reaching implications, going beyond the men and women in uniform. The threat posed by HIV/AIDS has the potential to undermine all that is represented by the armed forces. In common with other sectors which operate in part in a country's more remote regions—such as agriculture (and its farm workers), transport (and its truck drivers) and education (and its teachers)—the armed forces of Africa face their own particular problems in interfacing with the many dimensions of HIV/AIDS.

Knowledge of how HIV/AIDS has affected the armed forces, and the extent of the impact of the pandemic on the armed forces, is still not

clear. This is not surprising. From a medical science perspective, there is still insufficient knowledge about the period HIV/AIDS takes to produce its disabling effects, even though the gestation period after victims have been infected is estimated as some ten years. There is also a related, but more immediate, window period of approximately 90 days during which time those infected show no signs of the infection when they are medically examined. Both these factors make it difficult to be certain about who is and who is not infected by the virus. Even when individuals test positive, medical science does not yet fully understand the nature and extent of factors, such as the side-effects of taking antiretroviral drugs (ARVs).

Another problem has been that research into HIV/AIDS within African armed forces has been ring-fenced and off-limits for several reasons, including a desire to protect national security concerns by not speculating about the level of infection in the armed forces, even when there has been extensive probing into the effect of the pandemic on the human resource capacity of the various armies.

Another issue has had to do with the use of research that was generated in the 1980s. Even if this research were to be made known, there would still be the broader question of what impact HIV/AIDS has had on the integrity of the armed forces' primary role of maintaining national security.

There remain significant impediments to research on HIV/AIDS in the armed forces. Any research initiative has to deal with the constraints, suspicions and reluctance to provide data by those in positions to do so. This situation allowed conclusions to be drawn, suggesting that the prevalence of HIV/AIDS in the armed forces was twice or even five times as high as in the population as a whole—even when such conclusions were not based on empirical studies or comparative data.

After early studies had helped fuel an armed forces HIV/AIDS stigma, misunderstandings and a resulting lack of collaboration between researchers and the armed forces establishment continued. Against this background, initiatives are urgently needed to help provide solutions to the multifaceted challenges.

Such initiatives need to involve the skills of the research community, working closely with the military. Only then will it be possible to analyse the effects of the pandemic and to reduce its impact in the shortest possible time.

For any assessment of recent and complex HIV/AIDS scenarios and their relationship with the armed forces, it is clear that there is an urgent

need for research that takes account of professional concerns and that is structured to increase our understanding of the related dynamics of the pandemic.

METHODOLOGY

The project described in the present document has relied on action research methodology. This is a tool that combines empirical research with probable intervention strategies for the purpose of improving conduct and practice.² This innovative approach is applicable to many subject areas. Those most relevant to our own focus include education awareness, health delivery and medicines, security, and legislation and policies that continually react to changing environments in qualitative and quantitative ways, guided by a high-value system. Hence, the end-game of an action research methodology is not only the results of certain conduct but also the improved qualitative nature of that particular outcome.

PROJECT OBJECTIVES

The research project described was structured to achieve at least three related objectives while laying the ground-work for more in-depth work in the future, either with the same institutions or with sister organisations in the Southern African region. Once confidence, research skills and capacity have been developed, it is hoped that they will be employed for a more extensive study involving medical and social science collaboration on the impact of HIV/AIDS on the armed forces, on the preparedness of—and structural and internal effects on—the armed forces, and on the economic implications of combating the pandemic in the defence and security sector.

This has three interlinked objectives, namely to:

- trace and document empirically the policy responses by military institutions since the advent of HIV/AIDS;
- develop research and analysis tools on the issue within the armed forces and civil society; and
- provide a best-practice model to guide other military establishments on the continent.

Consequently, the more specific and limited objectives were to:

- produce a country-based experience account of how states and their armed forces have dealt with HIV/AIDS over the past 25 years;
- seek to establish a body of researchers on the issue, drawn from the armed forces and civil society to offer probable solutions; and
- provide a regional model to serve as the foundation for future best-practice guidelines for the relationship between HIV/AIDS and the armed forces of Africa.

DEFINITIONS

HIV is the virus that enters human bodies and affects the immune system. This type of virus is a member of a special class of the retroviruses. The HI virus can only replicate inside a living organ, affecting the cells and the surface of the special protein called CD4 lymphocyte. This process makes HIV dangerous as it attacks the immune system, which is the group of cells and organs designed to protect the body by fighting viruses and infections. According to Avert.org:

HIV has a number of tricks that help it to evade the body's defences, including very rapid mutation. This means that once HIV has taken hold, the immune system can never fully get rid of it.³

Once the above happens, "a damaged immune system is not only more vulnerable to HIV, but also to the attacks of other infections". Available evidence suggests that this condition, in association with what are commonly referred to as opportunistic diseases, deteriorates and develops into Acquired Immunodeficiency Syndrome (AIDS) after some ten years.⁴

HIV/AIDS IN SOUTHERN AFRICA

Sub-Saharan Africa is the region in the world that has been hardest hit by the HIV/AIDS pandemic. The reasons have included the:

- complexity of the disease in relation to this region's inadequate financial and other resources;

- intransigence of pharmaceutical companies, which have been determined to exact profits on research and development before releasing new medicines;
- confusion regarding the strategic focus on the pandemic, which included the shift in leadership in 1996 from the widely criticised World Health Organisation (WHO) under the influence of the World Bank, to the UNAIDS cluster approach under Peter Piot, which changed the existing strategy;⁵ and
- lack of a coordinated approach by the African continent's political leaders.

In combination, these reasons have exacerbated the impact of HIV and AIDS on the continent. HIV and poverty have made a lethal combination. The fact that those most affected by the pandemic have been the economically productive and sexually active 15–49-year age group has had a further negative impact on already sick economies.

Sub-Saharan Africa remains by far the world's worst-affected region, with some 25.4 million people (the estimates vary between 23 million and 28.4 million) infected by HIV at the end of 2004, or an increase of one million compared with 2002 (estimate band: 22.5–27.3 million). While the population of sub-Saharan Africa is some 10% of world population, nearly two-thirds (64%) of all the world's population—and 76% of all the world's female population—known to be infected by HIV live in this region. In Zambia and Zimbabwe, some 20% of all adults are infected with HIV or have AIDS, while the prevalence in both Swaziland and Botswana is near 40%.⁶

Many sub-Saharan countries have declared HIV/AIDS a national emergency in a bid to start manufacturing generic AIDS drugs under the World Trade Organisation (WTO). While Western pharmaceutical companies' ARVs are priced between \$300 and \$1,000 for a month's dosage, the majority of the sub-Saharan African population live below the World Bank poverty threshold of \$1 per day. And while the face of the epidemic has changed in Western Europe and the United States (US) with the advent of highly active antiretroviral therapy (HAART), the situation in Africa has been different, as most of those affected have no access to ARVs. Even those who have access to ARVs have problems of maintaining or accessing nutritious/balanced diets, which are essential for the management of HIV/AIDS.

THE HUMAN IMMUNODEFICIENCY VIRUS

The HI virus is a retrovirus belonging to the genus *Lentivirus*. There are two types of HI viruses, HIV-1⁷ and HIV-2.⁸ HIV-1 is the most common globally and is more virulent than HIV-2. HIV-2 is more common in West Africa. HIV causes AIDS: the disease is characterised by the destruction of the immune system by invading T-helper lymphocytes (CD4+ T-lymphocytes) that would ordinarily fight off such viral infections. The clinical progression is the same but slower in HIV-2 infection. There are many strains of both types and the virus mutates rapidly, making it especially difficult for researchers to find an effective treatment or vaccine.

The two viruses cannot be distinguished from each other under the electron microscope. The difference is in the molecular weight of the proteins and the order of the regulatory genes.

THE TRANSMISSION OF HIV/AIDS

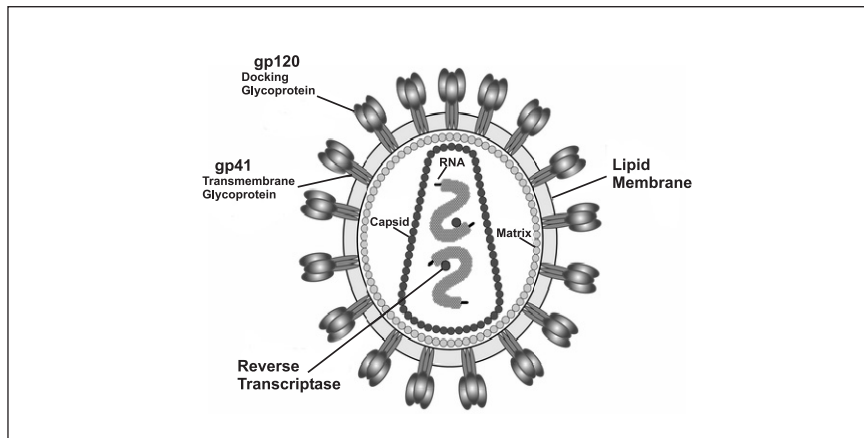
HIV infection is primarily transmitted through heterosexual intercourse and perinatal (mother-to-child) transmission during pregnancy, at birth and while breastfeeding. Another recognised mode of transmission is through contaminated blood and blood products. Other modes of transmission include the re-use of hypodermic needles, syringes, scissors and surgical knives. The virus is also transmitted through homosexual intercourse between men.

STRUCTURE OF HIV

The HI virus particle measures about 100 nanometres (nm) and has a lipoprotein envelope. There are 72 glycoprotein complexes in the envelope, measuring about 10 nm. These are made up of an external (gp120) and a transmembrane (gp41) protein, the two being loosely bound.

The viral envelope is also made up of different proteins—for example, HLA Class 1 and Class 2 molecules—which the virus acquires during the binding process with the host cell.

Also present are adhesion proteins such as ICAM-1. The p17-protein matrix is found in the inner envelope. The p24 capsular antigen is cylindrical and holds the two copies of the HIV-RNA. On the viral ribonucleic acid (RNA) are various enzymes—reverse transcriptase (RT), integrase and protease.

Figure 1: Organisation of the HI virus**HIV ENTRY IN HOST CELL**

The HI virus enters its target cells by attaching itself to CD4 receptors.⁹ The CD4 receptor is a glycoprotein found on the surface of approximately 60% of all T-lymphocytes, T-cell precursor cells in the bone marrow, thymus, monocytes, macrophages, eosinophiles, dendritic cells and microglial of the central nervous system. HIV also needs to bind to a core-receptor, CCR 5 to enter the human cell.¹⁰ Once the virus enters the human cell, it transcribes a deoxyrinucleic acid (DNA) copy of itself, which integrates into the host DNA when the T-cell is activated.

ACUTE HIV-1 INFECTION

The acute HIV-1 infection is seen in 40–90% of the cases, with a symptomatic infection associated with high viral replication and specific immune response against the HI virus. This is usually 11–15 days after contracting the infection. It is associated with a rise in viral load and a fall of more than 100 CD4 cells/mm³ in the first few weeks. The acute HIV infection rarely lasts more than one month.

With the worldwide rate of 14,000 new cases a day, acute HIV-1 infection becomes an important differential diagnosis in a patient with fever, malaise, maculopapular rash and lymphadenopathy. In many patients the acute infection is not diagnosed, and most patients are treated for malaria or influenza.

During this stage of infection there are no antibodies to help with the

diagnosis, but antibodies against HIV-1 are present after four to six weeks. A definitive diagnosis can only be made by identifying HIV-1 RNA or the p24-antigen. However, this is a highly skilled and expensive process requiring laboratory equipment that is rarely available in Africa. Furthermore, even where there is adequate technical support, HIV identification is complex; it can usually be made only by a doctor with considerable experience of the symptoms. A correct diagnosis at this stage can, however, result in the patient receiving therapy whereby the viral set-point—normally 10,000–50,000 copies/ml—can be reduced to a significantly low level. The viral set-point is significant in disease progression, with the higher the viral load, the faster the fall in the CD4 cells. The risk of transmitting the infection to the patient's sexual partner can also be reduced, as, without treatment at this stage, the patient is highly infectious because of the high viremia.

NATURAL COURSE OF HIV-1 INFECTION

The acute infection stage is followed by a chronic phase of a period of years without showing any symptoms of HIV infection. This phase is associated with a rise in the CD4 cell count within a few months after the acute infection. The rise rarely gets back to the normal CD4 cell count and is usually followed by a gradual fall over a period of eight to ten years. The normal CD4 count in an uninfected healthy person is 500–1,200 CD4+ T cells/mm³. When the CD4 cell count falls below 200 CD4 cells/mm³, the patient reaches a level of immunodeficiency and the onset of opportunistic infections by viruses, bacteria, fungi and parasites. Also common at this stage are kaposi sarcoma, malignant lymphomas, HIV encephalopathy and the wasting syndrome. With a fall below 50 CD4 cells/mm³, cases of CMV retinitis and atypical tuberculosis infection are observed.

Figure 2 (*over page*) shows the course of HIV infection. Half of the patients without HAART die in the first ten years from an AIDS-defining illness, which usually occurs within two to four years of the start of a patient's first AIDS complication. Without therapy, more than 90% of all HIV cases die. In the present HAART era, this course of HIV infection is rarely seen in Western Europe. The infection time course, the Centre for Disease Control (CDC) classification and the WHO classification of HIV infection are given in Figure 2 and in tables 1 and 2 (*over page*). The WHO classification is used in countries with inadequate resources and is purely a clinical classification.

Figure 2: HIV infection time course

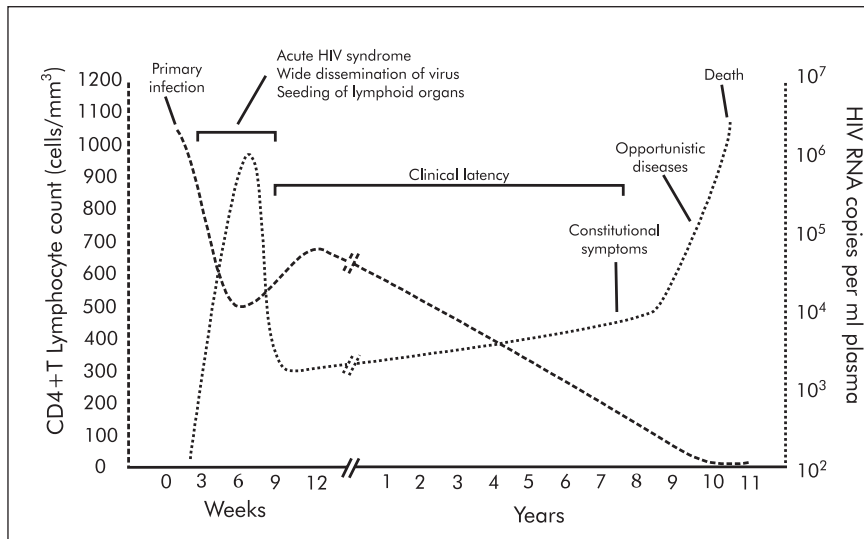


Table 1: The 1993 revised CDC system for HIV infection classification

CD4+ T cell categories (Cell/cu mm)	Clinical categories		
	A	B	C
1. >500 cells/mm ³	A1	B1	C1
2. 200–499 cells/mm ³	A2	B2	C2
3. > 200 cells/mm ³	A3	B3	C3

A = The acute HIV infection; asymptomatic HIV infection and persistent generalised lymphadenopathy (PGL).

B = Symptomatic infection but non-AIDS defining, e.g. oral candidiasis, persistent or recurrent fever of >38.5°C, intermittent diarrhoea longer than a month's duration, oral hairy leukoplakia, recurrent herpes zoster or simplex but which is not AIDS defining, idiopathic Thrombocytopenic purpura.

C = A3, B3, C1, C2, C3 AIDS defining diseases such as tuberculosis (pulmonary and extra-pulmonary), recurrent bacterial pneumonias within 12 months, non-healing ulcerative herpes simplex or disseminated herpes zoster, pneumocystis carinii pneumonia, CMV retinitis, kaposi sarcoma, toxoplasma infection and cryptococcal meningitis.

Table 2: WHO system for HIV infection classification

Stage 1	HIV disease is asymptomatic and not categorised as AIDS PGL. Acute HIV infection.
Stage 2	Includes minor mucocutaneous manifestations and recurrent upper respiratory tract infections. Herpes zoster within the previous five years. Unintentional loss of $\leq 10\%$ of body weight.
Stage 3	Includes unexplained chronic diarrhoea or fever for longer than one month, Severe bacterial infections and pulmonary tuberculosis. Oral hairy leukoplakia, oral candidiasis, vulvovaginal candidiasis. Unintentional loss of $\geq 10\%$ body weight.
Stage 4	AIDS defining includes toxoplasmosis of the brain, candidiasis of the oesophagus, trachea, bronchi or lungs, cytomegalovirus retinitis, lymphomas and kaposi sarcoma.

NOTES

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- 2 J Elliott, *Action research for educational change*, Open University Press, Buckingham, 1993, pp 49-50 <<http://www.infed.org/research-b-actress.htm>> (27 February 2006); W Carr & S Kemmis, *Becoming critical: Knowing through action research*, Deakin University Press, Victoria, 1983, <<http://epaa.asu.edu/epaa/v1n1.html>> (27 February 2006); see also O Fals Borda & MA Rahman, *Action and knowledge: Breaking the monopoly*, Apex Press, New York, 1991.
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- 7 S Broder & RC Gallo, A pathogenic retrovirus linked to AIDS, *Science* 311, 1984, pp 1292-7; F Barre-Sinoussi, JC Chermann, F Rey, et al, Isolation of T-lymphotrophic retrovirus from a patient at risk for AIDS, *Science* 220, 1983, pp 868-71.
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Interventions against HIV/AIDS in the Botswana Defence Force

Raymond Molatole and Steven Laki Thaga

Armed forces are a crucial part of any state's security, but are often worst affected by this disease (HIV/AIDS) as it impacts directly on their operational effectiveness. Where armed forces face high infection rates, it renders them less capable of coping with the internal disruptions this disease causes as well as [with] the ability to provide humanitarian and peace support to those in need.¹

INTRODUCTION

Emerging as it did from the shadows some two decades ago, HIV/AIDS has come to take centre stage as the leading cause of death throughout the world today, with sub-Saharan Africa suffering the highest number of infections. This factor alone makes HIV/AIDS a critical issue for development in sub-Saharan Africa. Southern African Development Community (SADC) member states had an average adult HIV prevalence rate of 20.6% in 2001.² The most recent statistics for pregnant women attending antenatal clinics in Swaziland, Botswana and parts of South Africa reveal seropositivity rates of over 30%.³ In urban areas in Botswana the figure was 43.9%. Swaziland has the highest rate of per capita prevalence, with Botswana ranking second.

These figures indicate the devastating impact the disease has had on the economies of affected nations and communities. In essence, statistics make it clear that the disease is a catastrophe that threatens the core of

humanity and human security. The figures support the argument that HIV/AIDS has evolved from a disease that affected few individuals and mattered little a few decades ago, into an epidemic, now pandemic, that impacts human security and economic development in ways without precedent. More importantly, HIV/AIDS calls for measures that transcend medical-clinical responses and include physiological, social, economic and cultural variables.

Although national statistics on the pandemic are generally available, it is evident in much of the literature that little has been said about HIV/AIDS and its impact on the security forces generally, and the military in particular. A debate on HIV/AIDS in the military and its policy implications is, however, equally important and necessary. There are several reasons for this:

- The military represents a large population sector in all the countries in the region. In Botswana, for example, the military is the largest formal employment sector after the civil service.⁴ The Botswana Defence Force (BDF) had by 2004 grown to just over 12,000 personnel (with a planned ultimate level of about 15,000).⁵ Botswana's military is therefore a large and highly respected employer with considerable influence in the country.
- The military is also a powerful political instrument of the state and plays a crucial role in national security and state stability. HIV/AIDS thus poses a potential threat to the strength of the force and undermines its ability to defend the country.
- Militaries by their nature consume considerable amounts of their countries' national budgets. Owing to the historical circumstances surrounding its formation, the BDF has enjoyed remarkably high budgetary allocations over the years. Military expenditure in Botswana rose more than sixfold in less than two decades—from US\$34.3 million in 1985 to US\$228 million in 2003. In the 1990s it represented an average of 3.8% of Botswana's gross domestic product (GDP).⁶

Ignoring or paying little attention to the HIV situation in the military is a perilous undertaking under any circumstances. Several factors make the military a particularly high-risk sector:

- As elsewhere in the world, the military is among the region's sectors

that are most susceptible to HIV. By its nature, the military is highly mobile, exposing troops to high-risk sexual behaviour from the perspectives of vulnerability to, and transmission of, HIV infection.

- Generally, the military has an age and gender profile that is young, sexually active and predominantly male. In particular the BDF is a male-only military,⁷ with the core of the active force comprising mainly the highly reproductive age group of 18–49 years. The nature of the duty of the members of the military often keeps them away from their families and partners for prolonged periods, and in the process exposes them to high-risk sexual behaviour while also rendering their spouses vulnerable to sexual exploitation.

In essence, therefore, HIV/AIDS is like a corrosive acid that undermines the combat readiness of the military forces, eroding their capability to deliver on their mandate and impacting directly on the very fibre of human security. In this sense HIV/AIDS is a threat to national security. It has limited the national recruitment pool and has resulted in high recruitment costs for militaries and other organisations due to the need to replace human resources more frequently than ever before.

ARRANGEMENT

Against this backdrop, this chapter examines military HIV/AIDS prevention and care strategies and programmes in Botswana. First, the chapter gives an overview of the national geographic and population situation, noting developments in the structure of the population and other demographics as some of the readily discernible outcomes of the HIV/AIDS pandemic. In particular, the chapter notes national prevalence and infection rates, highlighting national responses and challenges. Second, the chapter investigates policy and other mitigation strategies (including prevention and care and treatment) adopted by the military against the pandemic. It seeks to establish the sustainability, cost-effectiveness and challenges inherent in these strategies.

The question to be asked, however, is whether the mitigating strategies proposed will be given full attention in terms of planning, intervention, implementation and evaluation. To answer this question, different stakeholders have been interviewed in an attempt to address all the issues relating to HIV/AIDS in the armed forces.

Finally, the chapter draws conclusions and makes recommendations.

GEOGRAPHIC AND POPULATION OVERVIEW

The country that has come to be known as Botswana covers an area of approximately 582,000 km².⁸ Botswana is landlocked and is bordered to the north by Zambia, to the north-west by Namibia, to the north-east by Zimbabwe and to the east and south by South Africa. Most of Botswana is a generally undulating sand sheet with an altitude of between 900 m and 1,300 m,⁹ and is semi-arid. Large parts of the western semi-arid side are sparsely populated. The south-east is rockier and less flat than the rest, with sandstone and granite hills leading to the Shashe, Limpopo and Marico rivers. This land is more fertile and is endowed with better water resources. The area is therefore suitable for agriculture and is where most of the country's population and major urban centres are concentrated. This region is generally more developed and has the 'bright lights' effect associated with theories of urbanisation. As will be shown later in the discussion, the geographic juxtaposition of Botswana and the settlement patterns have had an effect on the spread of the disease within the country and in the region.

Botswana's population has trebled since independence in 1966, but the growth rate slowed between 1990 and 2000 to an annual rate of 2.5%.¹⁰ In 1991, half the population was below the age of 20.¹¹ According to latest estimates, the population of Botswana currently stands at 1.7 million.¹²

Given that population growth depends on fertility (birth) and mortality (death) rates, and on migration, it is evident that HIV/AIDS has brought with it intractable demographic implications for the country's population. Among others, the pandemic has had the effect of altering the age structure of the population. In the absence of HIV/AIDS, the age structure of most developing countries, including Botswana, conformed to a broad-based pyramid with high birth rates and life expectancy. For example, United States (US) Census Bureau estimates indicate that Botswana's life expectancy has declined to 45 years from a projected 61 years in 1996 as a result of the HIV/AIDS pandemic.¹³ However, with the pandemic, there are indications that these figures have been altered significantly.

Due to a drop in fertility rates, and the premature death of children and adults from AIDS, the annual population growth rate decreased from an estimated 2.6/1,000 to 1.6/1,000.¹⁴ As a consequence, a new population structure is emerging; one that is more chimney like. Estimates for the country explicitly take into account the effects of excess mortality due to AIDS, which can result in lower life expectancy, higher

infant mortality and overall death rates, and lower population and growth rates, as well as changes in the distribution of the population by age and sex compared with what would otherwise have been expected.

HIV/AIDS: A NATIONAL OVERVIEW

HISTORY

The first HIV/AIDS case in Botswana was diagnosed in 1985¹⁵ at the copper mining town of Selibe Phikwe. As this was the first case, the victim was initially investigated for diseases such as tuberculosis (TB) and other opportunistic infections. The treatment given for these presumed conditions was not effective, leading doctors to investigate for HIV/AIDS, which had already been discovered in other parts of Africa. Even after the first case was diagnosed, the disease was to remain ‘just another disease’ that raised no eyebrows until the reported number of cases had risen to 350 in June 1992.¹⁶

The prevalence of HIV among sexually active adults was estimated to be 9% in April 1992.¹⁷ Computer-generated models estimated the total number of people living with AIDS then at about 2,400. As research on the disease increased, smaller ad hoc surveys using different non-standardised methods were conducted between 1989 and 1991. These surveys revealed, *inter alia*, that HIV seroprevalence among pregnant women was between 4% and 8%.¹⁸

In 1998, Ahmed and Brunborg observed that the “prevalence of AIDS in Botswana is one of the lowest in Africa but there is great potential for its quick spread in the population”.¹⁹ Today, almost eight years later, the reverse is true about prevalence rates in the country, confirming the prediction of the potential for the rapid spread of the disease.

It is evident that the rate of infection has risen exponentially over the years. HIV/AIDS is now both a crisis and a catastrophe, affecting individuals, families, communities, public and private organisations, and national bodies. Botswana now has one of the world’s highest HIV/AIDS prevalence rates, and the country’s present pandemic is one of the most severe in sub-Saharan Africa. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that at present some 350,000 (or 20.6%) of Botswana’s population are living with HIV/AIDS.²⁰ Furthermore, UNAIDS estimates that Botswana has one of the highest proportions of adults between the ages of 15 and 49 living with HIV/AIDS.²¹ Sentinel site survey data gathered from pregnant women attending antenatal clinics

between 2000 and 2003 indicated that the prevalence rates are highest for women between the ages of 25 and 29.²² Data gathered from voluntary counselling and testing (VCT) centres in 2003 indicated that women were likely to contract HIV at a younger age than men.

Prevalence rates are alarmingly high. The annual sentinel surveys of pregnant women in all the 22 health districts of the country indicate that prevalence has been rising steeply. In 1992 prevalence was 18%. By 2000 it had risen to 38.5%.²³ Some of the factors contributing to the exponential increase in the spread of the disease include cultural myths associated with the disease and the accompanying policy response.

Initially, the disease was associated with foreigners, homosexuals and prostitutes. It took considerable time for people to accept its presence in their midst. Traditionally in many African societies discussing sex has been taboo. Given that HIV/AIDS is sexually transmitted, it was therefore difficult to bring it into the domain of public discussion and therefore to guide policy and programmes in the right direction.

These rates are in per capita terms very high and they have serious implications for economic development and national demographics. As a result, the impact on health infrastructure and services has been immense. AIDS-related medical ward admissions have increased several-fold. For instance, up to October 2002, 60% of all medical ward admissions in the country were due to HIV/AIDS-related conditions, with some ward percentages from these conditions running as high as 95%.²⁴ Bed occupancy in major referral hospitals was as high as 133%.

HIV/AIDS-related deaths have been increasing over the years: UNAIDS estimates that in 2003 a total of 33,000 men, women and children died of HIV/AIDS in Botswana. This was an estimated increase of 7,000 compared with the 2001 figures.²⁵ By the same token, indications by the National AIDS Coordinating Agency (NACA) also suggest a gradual increase in mortality. Life expectancy is only 39 years, while it would have been 72 if it were not for AIDS.

One of the challenges brought about by the pandemic is the problem of orphans resulting from loss of parents due to HIV/AIDS-related deaths. There are around 60,000 registered orphans in the country, but it is feared that Botswana will have about 200,000 orphans in 2010 if the current situation is not reversed.²⁶

These statistics and the sentiments referred to are a graphic reflection of the magnitude of the HIV/AIDS pandemic on Botswana and of the associated challenges. The country's national policy on HIV/AIDS (1993) further captures the concern succinctly, namely:

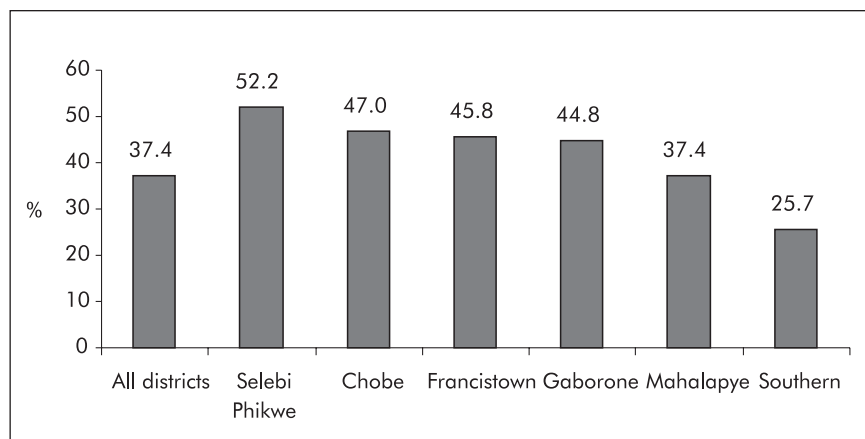
HIV/AIDS is one of the most important current global socio-economic and development problems . . . The range and projected magnitude of the socio-economic impact of HIV/AIDS indicate that the epidemic should now be regarded as a national crisis and receive from each government ministry and each sector of society the attention that such crisis deserves.²⁷

The gravity of the problem is illustrated by the following graphs, which summarise the position in 2003/04, almost ten years later.

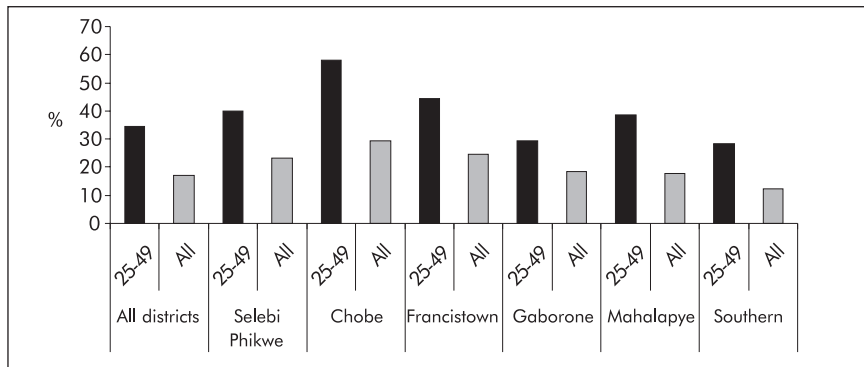
Figure 1 depicts HIV prevalence using data collected from antenatal patients in the country's health districts. The average for all districts was 37.4%, with all the districts having double-digit prevalence rates. It is to be noted, however, that the average for the cities and urban centres, including districts like Chobe, was higher than the rural average. Chobe, though having an estimated population of only 21,230,²⁸ is a major tourist centre, which could account for its high prevalence rate. Francistown is a major transit route along the A1 highway linking Botswana with the northern countries of the sub-region. This could also account for its high prevalence rate.

Figure 2 shows that HIV prevalence is highest in the most sexually active 15–49-year age bracket, with the total average estimated at 35%.

Figure 1: Antenatal HIV prevalence in Botswana



Source: Botswana 2003 Second Generation HIV/AIDS Surveillance, A Technical Report, National Aids Coordinating Agency, December 2003.

Figure 2: Population HIV prevalence in Botswana

Source: Botswana Aids Impact Survey – II: Preliminary Results, Central Statistics Office, press release, 16 December 2004.

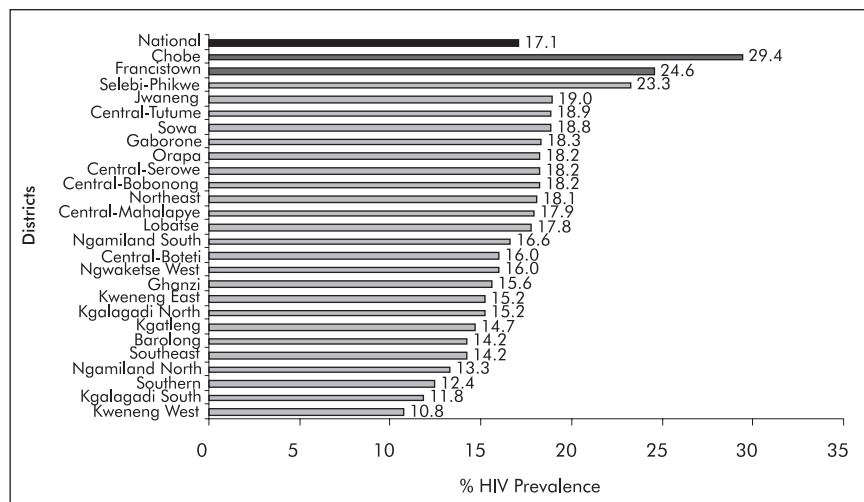
As in Figure 1, Chobe, Francistown, and Selibe Phikwe have the highest prevalence rates. The northern part of the country, where tourism is the main economic activity, accounts for the highest concentration of military forces deployed against poaching, especially on the borders of neighbouring countries.

Figure 3 also depicts high prevalence rates in Chobe, Francistown, Selibe Phikwe and Gaborone, where there are high concentrations of military personnel (military camps are also located here).

Some studies have shown that the rate of HIV infection is often much higher in the armed forces than in the rest of the population.²⁹ This, it is argued, is linked to rates of sexually transmitted infections (STIs) among military personnel that are two to five times higher than those of civilian populations, thus increasing their risk of HIV infection. With such high prevalence rates, these areas are both high-risk areas for new infections and reinfections. However, without empirical data on HIV infection rates in the military in Botswana—as indicated elsewhere in the discussion—it is difficult to establish the relationship between military barracks and the high incidence levels in those areas. This is an important variable for policy formation. The challenge therefore lies in establishing this relationship with empirical data and responding accordingly.

SOME KEY DETERMINANTS OF THE HIV/AIDS PANDEMIC

Some factors attributable to the spread of the disease are worth

Figure 3: HIV/AIDS prevalence in selected districts in Botswana

Source: Botswana Aids Impact Survey – II, NACA, 2004, excerpted from press briefing notes on the National HIV Prevention Conference, 20-22 September 2005.

examining here. These interdependent factors tend to drive the spread of the disease in Botswana. They are grouped under five broad headings and they also include Botswana's position as a transit point for regional trade.

STIGMA AND DENIAL

According to the 2002 *Sentinel Surveillance Report*, it is estimated that over 35% of adults aged between 15 and 49 are HIV-positive, with most of them ignorant of their status.³⁰ Part of the challenge of reversing this trend lies in stigma and denial associated with the disease. Stigma and denial, it is argued, create an environment which maintains the potential for increased infection, as well as limiting the ability of people to live positively and responsibly with HIV and AIDS.³¹ Infection increases because stigma and discrimination continue to be major barriers to improving access to HIV/AIDS-related health care services. Discrimination against those infected is also believed to enforce their desire to hide their infection, thus forgoing a number of opportunities such as counselling, support and even medical care, including antiretroviral (ARV) therapy.

Much has been done in educating the public on HIV/AIDS through various means. Despite this, stigma and denial remain the most outstanding impediments to combating the pandemic. No treatment programme can be effective if it does not reduce the stigmatisation of people with HIV, which inhibits many of them from seeking help.

SOCIO-CULTURAL DETERMINANTS

Socio-cultural factors include the socially reinforced subordination of women. This underpins their weakness and vulnerability in matters of sexuality and economic empowerment when compared to their male counterparts. The sexual networking³² by men is also crucial here and underscores the subordination of women in Botswana.

Access to drugs and alcohol by the youth has been shown to increase the indulgence in casual and unprotected sex, which aggravates the spread of the disease.

SOCIO-ECONOMIC DETERMINANTS

Among others, wealth and consumption patterns have been noted for making a contribution to the spread of the disease. For instance, people with high disposable incomes are generally at risk due to their ability to exploit situations of relative inequality or to exert unfair advantage in the pursuit of sex.

Poverty has also been identified as a major contributor to the spread: it renders people unable to pay for their daily needs, and this often compels them to adopt high-risk survival strategies to make ends meet. The proportion of households living below the poverty line in Botswana is estimated at 22%, spread between rural and urban areas. The majority of this category, however, is located in the rural areas.³³ It can be deduced from these trends that poverty levels are high and, by implication, make a major contribution to the spread of the pandemic.

DEMOGRAPHIC MOBILITY

Tswana economic activity has traditionally been based on movement between the village, fields or *masimo*, and the cattle post. Over the past two decades, however, Botswana's rapid economic growth has led to accelerated urbanisation, which has significantly altered the previous pattern.

The development of relatively good road and transport systems has increased urban–rural mobility. The great majority of the population live along or near the main transport routes and in the main towns and villages, where national infection levels are exceptionally high.³⁴ Most of those living in towns and cities have continued to maintain their strong ties with rural villages, creating a complex network that contributes to the spread of the disease in a significant way.

Furthermore, the rural agricultural economy relies on pastoral and arable farming. Naturally, these economic activities promote the movement of rural people, and contribute further to the spread of the disease.

TRANSIT POINT FOR REGIONAL TRADE

Several studies have tracked the spread of HIV along major trucking routes, underlining the role of truck drivers in spreading the virus to other areas. As indicated earlier, Botswana's geographical juxtaposition is equally important in understanding the dynamics of the spread of HIV/AIDS.

As a landlocked country with fairly well-developed transport systems, Botswana is a transit hub for South Africa, Zimbabwe, Namibia and Zambia, all of which share the high prevalence rates that characterise the pandemic in Southern Africa.³⁵

Truck drivers have networks of sexual partners that include wives, girlfriends, and sex workers dotted along their routes. Opportunities for the spread of HIV are increased given the fact that these drivers spend most of their time away from their families.

Trade movement, both in the formal and informal sectors, also contributes to the spread of HIV. As a result, Botswana experiences the movement of large numbers of people both in the formal and informal trade sectors. For example, high adult HIV prevalence in Francistown—the country's northern and second largest city—estimated at 43% in 1996, was linked with Zambian and Zimbabwean traders, mainly female.³⁶

Refugees and internally displaced persons also add to the dynamics of the spread. Armed conflicts and socio-economic instability in the Southern African region have produced streams of refugees and internally displaced persons from countries such as Angola, the Democratic Republic of the Congo (DRC) and Zimbabwe.³⁷ Economic hardships in neighbouring Zimbabwe, and the resultant mass mobility of the citizens, are also likely to account for cross-border infections.

NATIONAL RESPONSE TO HIV/AIDS: AN OVERVIEW

HIV/AIDS STRATEGIC PLAN

In response to the pandemic, several initiatives have been put into place. In 1986 the government set up the so-called Minimum Programme under the epidemiology unit of the Ministry of Health. A short-term plan was then developed in 1987. This focused on increasing national public awareness of HIV. In 1987 the National AIDS Control Programme, which created the short-term plan (medical response), was launched.

The short-term plan was then followed by the Medium Term Plan (MTP) for the Prevention and Control of HIV/AIDS from 1989 to 1993. The MTP provided policy and strategic guidelines for action since the inception of the National Aids Control Programme. The MTP outlined the role of the health sector and the Ministry of Health, with the support and assistance of other sectors and non-governmental organisations (NGOs) for HIV/AIDS prevention, care and support. The MTPII was subsequently adopted in 1997 to step up efforts in the fight against the pandemic. Its two main goals were to reduce HIV infection and transmission, as well as to reduce the impact of HIV and AIDS at all levels of society in the country.

In 1998 Botswana became the first country in Africa to provide therapeutic prevention of mother-to-child transmission of HIV.³⁸ In 2002 the government took a step further and established an HIV/AIDS National Strategic Framework. In the words of President Mogae, the framework constitutes a:

common determination to turn the tide of the HIV/AIDS pandemic that has cast a shadow over the future of our country . . . and requires the sustained support and action of development partners, civil society, the private sector, and above all, the people of Botswana.³⁹

As a result, several HIV/AIDS initiatives and programmes are now taking place in Botswana at various levels. One of the highest-profile joint initiatives of the government and development partners is the African Comprehensive HIV/AIDS Partnerships (ACHAP). ACHAP is a collaborative effort between the government of Botswana, the Bill and Melinda Gates Foundation and the Merck Company Foundation. ACHAP was established in July 2000 with the aim of supporting the goals of the Botswana government in decreasing the incidence of HIV, and significantly increasing the rate of diagnosis and treatment by rapidly advancing

prevention programmes, health-care access, patient management and HIV/AIDS treatment.

There are a number of NGOs and community-based organisations (CBOs) dealing with HIV/AIDS. These include the Botswana Network of People Living with HIV/AIDS, the Botswana Network of AIDS Service Organisations, the Botswana Council of Non-Governmental Organisations, the Botswana Women's NGO Coalition, and the Botswana Network on Ethics, Law and HIV/AIDS.

Overall, these efforts show the government's commitment to an aggressive, comprehensive and expanded multi-sector and multi-level response to fight the pandemic and to curb its impact on society. Intrinsic in this effort is the recognition and understanding that the complexity of the pandemic in Botswana requires a national response that provides leadership and ensures the active involvement of local, national and international stakeholders, as well as clear definitions of roles and responsibilities.⁴⁰

POLICY RESPONSE

Policy provides an operating framework for implementation as well as a useful guide for domestic and international resource allocation and support. In recognition of this, and in line with the United Nations (UN) Declaration on the Commitment on HIV/AIDS, Botswana has a National HIV/AIDS Policy. The policy spells out the rights of individuals regarding HIV/AIDS within the constitution and other laws of the country. It also outlines the national response to the epidemic.

This policy was developed in 1992 and was revised in 1998 to keep abreast of developments. It describes the roles of national leaders, government ministries, the private sector, NGOs and CBOs, as well as people living with HIV/AIDS and individual community members.⁴¹ It also outlines matters pertaining to HIV testing, confidentiality, HIV/AIDS and employment, and it applies an international human rights approach for addressing stigma and discrimination.⁴² The policy provides, *inter alia*, for the following:

- Workers infected with HIV who are healthy should be treated in the same way as any other worker, with regard, for example, to training and promotion.
- Workers with HIV-related illnesses should be treated in the same way

as any worker with an illness. These workers should be retained in employment as long as they are medically fit to work.

- The government should develop a prototype policy regarding HIV and workers, consistent with national policy. This policy should be communicated to all those concerned, monitored for implementation, evaluated for effectiveness and periodically reviewed in the light of emerging information about HIV/AIDS.⁴³

There is therefore a clear indication that since the first AIDS case was reported in Botswana in 1985, government, private sector and civil society entities, together with the people and development partners of Botswana, have been and are responding to the HIV/AIDS pandemic in a serious and concerted manner. Behind the process is a strong government leadership, with President Mogae in the forefront of the fight against the disease.⁴⁴

Arguably, HIV/AIDS in Botswana has been prioritised as a national emergency by the government, and for many years has received the attention and support of the president and his cabinet.⁴⁵

Botswana's response to the pandemic can, overall, be seen in three major phases.

- In 1987–89 the focus was primarily on screening blood to eliminate the risk of transmission through blood transfusion. This phase included the screening, supply and use of disposable needles and syringes. It later became evident that this initiative was too narrowly focused and did not address other aspects of prevention. It did, however, minimise the spread of the disease through blood transfusions and was a breakthrough in the development of other interventions.
- The National AIDS Control Programme was set up in 1987 with the help of the World Health Organisation (WHO). The programme focused on increasing national public awareness of HIV and on training health workers in the clinical management of AIDS cases.⁴⁶ To this end, an AIDS/STD unit was set up in 1992 to coordinate the programme.
- The subsequent 1992–97 phase included the introduction of information, education and communication (IEC) programmes. This approach was, however, still too narrowly focused.

EFFECTIVENESS OF THE NATIONAL POLICY RESPONSE

It has been argued that implementation of the National HIV/AIDS Policy has been successful, albeit with many challenges.⁴⁷ On the bright side, the policy has managed to bring together an array of stakeholders in the fight against HIV/AIDS. These range from private-sector employers, CSOs and government organisations as an integral part of the multi-sector response. Furthermore, the government has created comprehensive international links, and formed effective working relationships with development partners including the Harvard Institute, the United Nations Development Programme (UNDP), the WHO, the Swedish International Development Agency (SIDA), SADC, and the ACHAP. The provision of free ARV therapy to the public, the nationwide programme for the prevention of mother-to-child transmission, the community home-based care programme, the orphan and vulnerable children programme and the VCT programme have been cited as some of the major achievements of the policy.⁴⁸

Some observers have noted that Botswana's response to HIV/AIDS relates well to the national reality of the disease on the ground.⁴⁹ There is no doubt that the policy has broken a lot of ground, first in providing the framework for fighting the pandemic and thus institutionalising the fight. Second, the policy has been instrumental in mobilising national resources in the fight against the disease. The policy effort has legitimised the government's response and demonstrated its seriousness in fighting the pandemic. Out of this symbolism and commitment, the government has, as we have shown, been able to attract international support in the fight against the disease. The initial commitment and the momentum that followed have been able to place Botswana well ahead of several countries in sub-Saharan Africa in fighting the pandemic.

In combination, preventive, treatment and care, and support strategies are aimed at reversing the adverse effects of HIV/AIDS on the national demographics, such as the decline in life expectancy. The pay-offs are, however, not yet clear.

There are also several challenges facing the war against the pandemic. Section 3 of the Botswana Constitution confers on "every person in Botswana" fundamental rights and freedoms without regard to race, place of origin, political opinion, colour, sex or creed. Furthermore, an examination of the legislation protecting HIV/AIDS-infected people reveals shortcomings. Analysts have challenged the policy for being weak in combating violations of employee rights in the workplace on the basis of employees' HIV status, especially in the private sector. In the

Botswana Building Society (BBS) case, in which an unskilled employee of the BBS sought recourse for unfair dismissal on the basis of his HIV status, the Industrial Court held that courts have to apply law not policy.⁵⁰

INSTITUTIONAL RESPONSE

Further commitment in the fight against HIV/AIDS is formalised through the National AIDS Council (NAC), which is chaired by the president with the assistance of the minister of health. The NAC is the highest national coordinating body responsible for policy oversight and guidance over the expanded national response to HIV/AIDS.

The National Policy on HIV is the government's main and leading policy document on HIV/AIDS. The document came into effect in 1993 through a presidential directive and has evolved significantly since. Key among these developments has been the shift from viewing HIV/AIDS as a purely medical problem to seeing it as a far-reaching issue with physiological, social, economic and cultural dimensions.⁵¹ This is in line with similar developments in the rest of the world. With this realisation, the national response also changed to a coordinated and multi-sector one involving other stakeholders. Thus the NACA was established to coordinate multi-sector efforts in the fight against the disease.

OTHER RESPONSES

ARV THERAPY: IMPLEMENTATION AND CHALLENGES

Botswana was one of the first countries in Africa to provide ARV drugs to its HIV-positive people through a programme known as *Masa*, the Setswana word for 'new dawn'. The programme was rolled out in 2002 at four major centres, with the first ARV drugs provided in Gaborone in January of the same year. By 2004, 23 sites had been launched countrywide.

Like a new dawn, *Masa* is an embodiment of hope in the fight against the disease. Expansion of the number of ARV sites has drastically improved access to drugs. As a result, patients can be processed and treated rapidly, allowing more patients to be enrolled in a given time. The waiting time for a person to be enrolled in the ARV programme has decreased from 24 weeks to one day.⁵² Both the increase in the number of ARV sites and the decrease in waiting time account, in part, for the

increase in the number of patients enrolled in the programme. In addition, the treatment has reduced the number of hospital admissions.⁵³ This programme has further institutionalised yet another phase of the war against HIV/AIDS. The programme is supported by a patient education campaign, as part of which a number of videos were designed to educate people about the impact on their lives of HIV/AIDS and ARV therapy. The campaign focuses on the importance of knowing one's status, and the need always to use a condom when having sex. In addition, the hope is also reinforced that ARV therapy and one's personal responsibility to adhere to the therapy regimen for the rest of one's life will improve quality of life.

Botswana launched its national ARV rollout in mid January 2003 when 4,425 patients were enrolled, of whom only 3,515 actually received treatment. Dispensing centres were dotted throughout the country although concentrated in the urban areas of Gaborone, Francistown, Serowe and Maun.⁵⁴

Two major areas of concern emerged associated with the rollout. The first was the lack of capacity, skilled and adequately trained human resources in the institutions and, second, the projected cost—estimated at US\$24.5 million for treating 19,000 people in 2002. Exacerbating the financial situation was an additional 20,000 people waiting to be admitted on the programme each year.⁵⁵

In May 2004, a Masa programme—aimed at offering ARVs to deserving cases in Botswana—was launched, targeting an estimated 300,000 HIV-positive people. From this national estimate, 36% or 110,000 HIV-infected people met the criteria to qualify for treatment.⁵⁶ However, given the limited capacity available, the programme planned to enrol only 19,000 people in the first year. Owing to capacity constraints, an executive decision was taken to give priority to those people suffering with TB, mothers and their spouses, babies and patients with a CD4 count of less than 200 and/or those showing marked AIDS-defining illnesses.

When enrolment began the figure captured rose slightly as a result of the pressures, to stand at 24,000 of those who actually enrolled. Of these, 14,000 or 60% were able to access ARVs immediately.⁵⁷ To their credit, the group then demonstrated a particularly high rate of adherence, put at over 90%, partly explained as a result of the intensive counselling patients received prior to accessing the drug regimen. The country's success in distributing ARVs, especially measured at Princess Marina Hospital located in the capital, Gaborone, makes this by far the

largest single provider of ARV therapy in Africa. At this hospital, over 4,500 patients receive ARV medicines regularly.

Worthy of note here is that, of the total government-financed HIV/AIDS expenditure for the financial year 2002/2003 (US\$55.5 million), it was expected that a substantial amount would be dedicated to ARV treatment. These levels of expenditure underline the government's commitment to the war on the pandemic.

THE HIV/AIDS BUDGET

In 1990 when HIV/AIDS was in its early stages and was an epidemic rather than a pandemic, total health expenditure in Botswana stood at 3% of GDP.⁵⁸ By 2000 it had increased to 6% of GDP. In like manner, public health spending doubled from 1.7% to 3.8% of GDP, similar to the mean for upper-middle-income countries.⁵⁹ The same report estimates total health expenditure in per capita terms at US\$191 in 2000. In 1999/2000, government HIV/AIDS expenditure was US\$9.5 million. Furthermore, this increased at an average annual rate of 162% (nominal) between 1999/2000 and 2002/2003. These drastic upsurges in expenditure depict the gravity of the pandemic and the tenacity with which it is being fought. In 2000/01 core HIV/AIDS expenditure amounted to 0.27% of GDP or US\$9.05 per capita, translating to actual expenditure of US\$43.94 per person living with HIV/AIDS. The expanded HIV/AIDS expenditure of US\$29.7 per capita represented an investment and attention that is by far the highest in the Southern African region.⁶⁰ However, it is significant to note that this budget covers all the government ministries and departments, including the military.

There is no doubt that there is a high level of the government funding for health and HIV/AIDS in Botswana. This financial commitment has dramatically improved access to health-care facilities. The population live an average of 15 km from a health-care facility. High financial resources have allowed for breakthroughs in infrastructure distribution. Botswana receives financial assistance from the US under the President's Emergency Plan for HIV/AIDS Relief. Support includes training programmes, stigma-reduction activities and assistance to NGOs involved in the HIV/AIDS effort. Even with foreign assistance, the cost of running these programmes is very high and reduces the expenditure available for other important human development activities. Development expenditure on HIV/AIDS programmes doubled from close to US\$40 million in the 2002/03 financial year to slightly above

US\$80 million in the subsequent financial year.⁶¹ This represents a massive scaling up of funds allocated to the HIV/AIDS epidemic by the government.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

In 1999 Botswana became one of the first countries in the region to roll out a national prevention of mother-to-child transmission programme. This was the first programme to distribute the ARV drug AZT in Botswana. The programme provides counselling and testing for pregnant mothers. It also provides short courses for ARV therapy to help prevent transmission from mother to child. The programme is available at all health-care centres in the country, including military facilities, and is accessible to families and dependants of service personnel.

Related to this is the Orphan Care Programme, through which orphans are provided with food, clothing and other items to help their care-givers cope with the impact of HIV/AIDS.

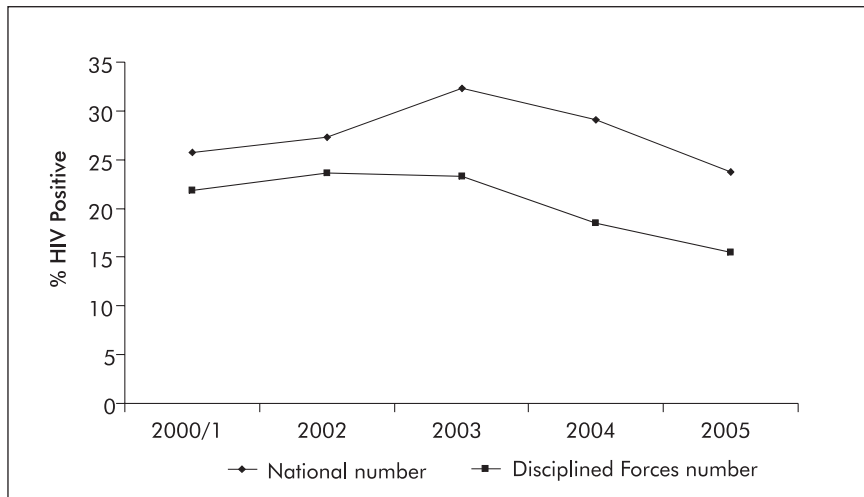
INFORMATION, EDUCATION AND COMMUNICATION

Botswana has made major strides in a number of HIV/AIDS-related interventions. Education and prevention remain the cornerstone of the country's national HIV/AIDS strategy. Some programmes have now been in operation for several years. These include behaviour-change interventions and communications, VCT centres, and radio and television programmes and advertisements. The establishment of VCT centres in the larger centres has been a major breakthrough in the fight against the disease. The Tebelopele VCT centre has been successful with over 60,000 people being tested so far. Figure 4 (*over page*) shows the impact of concerted campaigns both nationally and on the disciplined forces (which include the armed forces).

The figure shows the reduction in the levels of infection due to behavioural-change campaigns and other interventions. It also highlights the marked decline in the number of infections in the disciplined forces, indicating a major shift in behaviour. While the figure does not show that the effect of the pandemic is declining, it does not support the assumptions and perceptions held in some quarters of society that the prevalence of HIV in the disciplined forces is higher than the national average.

Despite these initiatives, there have been major setbacks, including the key problem of accessibility. For example, during testing, it takes a long

Figure 4: HIV prevalence – Tebelopele VCT centre, 2000–2005



Source: Tebelopele Voluntary Counselling and Testing Centre, September 2005.

time for one counsellor to do both pre- and post-test counselling. VCTs can therefore not handle mass voluntary testing campaigns due to capacity limitations.

Furthermore, there are problems of voluntary testing associated with stigma and discrimination, as well as the ability to cope with the post-testing stress. Availability of trained counsellors and social workers to handle the behavioural aspects of dealing with the disease is a major shortcoming.

Access to certain media services has also been insufficient. For a long time the government relied on radio and the print media for public education. Until the late 1990s, when private radio stations were introduced, Radio Botswana was the only public radio. Equally important was the opening of a national television station five years ago. This has made a major difference in the public education campaign against the disease. Television has widened news coverage and accessibility and has contributed significantly to increased public education, not only on HIV/AIDS-related issues but beyond. Programmes include *Remmogo* and *Talk Back*, in which youth, particularly those at high school, share information and experiences on various subjects, including HIV/AIDS and peer education.

CHALLENGES TO THE OVERALL NATIONAL RESPONSE

The first decades of the disease have revealed successes in some areas of the fight against HIV/AIDS and challenges in others. While there have been major breakthroughs in information dissemination, indications are that there are greater challenges in other preventive schemes. One such critical area is that of behaviour change. Others include stigma and discrimination. Stigma is still attached to sexually transmitted diseases and many people are afraid to be voluntarily tested for HIV. Routine testing is seen as one way of removing this stigma.

Botswana has succeeded in a number of different HIV/AIDS-related interventions. The country has many different HIV/AIDS education and prevention initiatives and strategies, and prevention remains the cornerstone of the latest national HIV/AIDS strategy. One of the success areas has been a slight decline in the past few years in HIV incidence among pregnant women.

All in all, Botswana's initiatives in the fight against HIV/AIDS go a long way towards showing what political commitment and a well-coordinated effort supported with immense resources can do to alleviate the HIV/AIDS situation. Observers have noted that the efforts in improving the health infrastructure, reducing infection and making sure that more people have access to essential drugs have borne positive results.⁶²

On the downside, there is evidence of multiple programmes being pursued by various players. Although the NACA is the overall custodian of these efforts, there are problems of coordination. The NACA has no statutory power to control the plethora of programmes. Instead, it relies on the goodwill of the various players to furnish them with updates of their initiatives.

HIV/AIDS IN THE MILITARY

This section examines HIV/AIDS mitigation strategies put in place to combat the disease in the military. It is worth repeating the truism that a country's defence and security sector is a crucial asset for both state and human security. The need to examine how the military copes with HIV/AIDS gains relevance due to the vulnerability of the military to infections, given the nature of their duties and attitudinal variables in their culture.

In addition, as indicated earlier, defence and security represent a major population component. This makes the military an important area of the research and policy debate—more particularly its efforts on the

one hand to cope with the disease, and on the other hand to meet its primary mission.

HISTORIC DEVELOPMENT OF HIV/AIDS IN THE BDF

Although no exact information is available on the infection rates in Africa's militaries, it is estimated that militaries throughout sub-Saharan Africa are now reporting averages in the 20–40% HIV-seropositivity range within their ranks, but as high as 50–60% in countries where the virus has been present for more than ten years.⁶³

As with other African armed forces, information on Botswana's military and the first HIV infections is not readily available. One of the main challenges facing any research effort on the military in Botswana is that this area has so far been under-researched. Given this research limitation, and the sensitivity surrounding HIV/AIDS—especially in the early years of its discovery—it is difficult to determine with precision when the first cases of infection were detected in Botswana's military. However, using a deductive approach, it is safe to assume that the discovery of the disease among members of the BDF may be somewhat related to that of the rest of the population: the military is a microcosm within the larger national society.

Cases of infection and symptoms of the disease were observed in the BDF as early as the 1990s.⁶⁴ As with the rest of society, there were challenges to the acceptance of the presence of the disease by uniformed personnel.

Aspects of testing and living with HIV/AIDS affected the development of the disease in the early years. Increasing prevalence became evident from the late-1990s, when the need to introduce mitigation measures was accepted. As the national and military situations worsened, the political and military leadership introduced HIV/AIDS-mitigating strategies that included a policy on HIV/AIDS, awareness campaigns, testing, counselling and treatment. Unit HIV/AIDS committees were also established.

FACTORS CONTRIBUTING TO THE SPREAD

DEMOGRAPHIC MOBILITY

The military is generally a highly mobile society due to the nature of the job. The extent of this mobility is governed by the country's large area and the need to protect its borders. Covering an area of approximately

582,000 km², Botswana's borders stretch the resources of the BDF. Deployment along the borders and other operational engagements, such as military training exercises, naturally oblige the BDF to rotate its human assets all over the country. These factors have had significant implications on the spread of the disease and its management. Mobility—arising from military personnel being on the move over a long period of time—is thus believed to play a role in the spread of HIV/AIDS in the armed forces.⁶⁵

RISK-TAKING ETHOS AND OTHER ATTITUDINAL FACTORS

Military personnel are especially vulnerable due to objective factors such as their relative youth and their attitudes. The armed forces inculcate, purposefully through their training, behaviour such as bravery and courage.

Courage and the willingness to take risks are critical in combat situations, but in non-combat situations they may increase soldiers' willingness to engage in risky behaviour, such as sex without condoms, or even commercial sex. The high value placed on aggression may make soldiers prone to pursuing sex with multiple partners as a type of conquest. Other attitudes are learnt informally through the culture and are encouraged through peer pressure.⁶⁶

A SALARIED POPULATION AND THE 'MAGIC OF THE UNIFORM'

As noted earlier, the military in Botswana represents considerable percentages of both the national population and the public sector. Military personnel usually have a comparative advantage over the rest of society in terms of good salaries and other employment benefits. Naturally this makes them the subject of envy for many. They often become an attraction to the opposite sex. The power of the purse, combined with high-risk behaviour such as bravery, tends—with the mobility issue—to increase the risk of military personnel contracting and spreading the disease.

CURRENT SITUATION

The current situation regarding HIV/AIDS in the BDF is not exactly known given the statistical shortcomings and the lack of research, documentation and analysis. No attempt has been made to quantify the

gravity of the disease through a specific scientific investigation. However, the situation can be summarised as being serious in the sense that the disease is ravaging the ranks of the military, as it is the rest of the nation.

It is reasonable to estimate the prevalence as the same as the national rate, which, given the size of the BDF, would indicate a high number of infected personnel.

The 1993 *Men and Sex Report*⁶⁷ identified particular characteristics in the demographic differences between the two groups sampled, which were males in educational institutions and males in the uniformed forces in Botswana. The minimum age in the uniformed forces was 19. Modal age was found to be 22 years, while the mean age was 29.7 years. This demographic profile underscores the importance of the military, as part of the uniformed forces, and as a major component in the analysis of the impact of HIV/AIDS on the economy and the security of the nation. The bulk of the active force falls within the most-affected age bracket, and constitutes a substantial proportion of the high-risk population. Aggressive measures should therefore be taken to reduce the infection rate.

One of the most pronounced consequences of HIV/AIDS over the years has been the spiralling number of personnel on long sick leave. Bed occupancy rates in military health facilities attributed to HIV/AIDS-related illnesses have increased significantly. This has reduced the number of deployable personnel at any given time and there has been an accompanying loss of man-hours. Operational readiness is compromised in the process.

Although, as indicated earlier, it is difficult to prove this statement with empirical data, it is evident that long illnesses now lead to the largest component of the total number of deaths in the BDF. Indeed, Maj Gen BK Oitsile of the BDF has been quoted as saying that 60% of deaths in the military are due to HIV/AIDS-related conditions.⁶⁸

The disease has seriously affected the BDF's ability to deploy the required number of soldiers for operational and training activities. These include professional development training outside Botswana, which is partly sponsored by the US government's International Military Education and Training programme. According to the US Department of Defence, 116 BDF officers were trained in US military academies between 1992 and 1997, but no figures for this programme are available after 1997.⁶⁹ Eligibility for this training includes an HIV-negative test. As Botswana requires foreign military assistance, its policy of voluntary testing needs to be replaced by the compulsory testing expected by the US and other donor countries. Issues of merit and intelligence are

therefore compromised as health issues take precedence. Those unwilling to undergo testing are left out, with a resulting constraint on the BDF's training and development efforts. It is clear, therefore, that HIV/AIDS is limiting the pool of healthy and trainable human assets. The BDF is having to grapple with the reality of this deviation from the National HIV/AIDS Policy.⁷⁰

STRATEGIC RESPONSE

The commitment of the military command is unwavering in the fight against HIV/AIDS—so much so that other stakeholders have commended the BDF High Command for its commitment and dedication to the fight against the pandemic. Reflecting on the need to maximise the campaign, Lt Gen Fisher noted that:

AIDS in the military, as well as in the national environment, is no longer an academic issue; it is a reality that has to be tackled with all the vigour and effort commensurate with its ramifications.⁷¹

A further manifestation of these efforts is that the command has used every available opportunity to drum the HIV/AIDS message into the troops. In addition to other avenues, the commander's annual tour of camps has been an important platform for such an exchange. In 2004, the commander led a campaign to encourage officers and men of the BDF to undergo voluntary testing. At the time of the campaign, Tebelopele officials set up counselling and testing facilities in BDF camps and installations where BDF personnel could be tested. The response was good and there has been an increase in the level of voluntary testing. All these efforts are a clear indication of the military's commitment to fighting the disease. An advisory committee on HIV/AIDS has been created in order to help policy efforts at the strategic level. The committee includes representation from the Social Welfare, Chaplaincy, corps of Health Services, Legal Services and Personnel branches of the BDF. The committee meets from time to time to deliberate mainly on operational and policy issues related to HIV/AIDS.

HIV/AIDS POLICY IN THE MILITARY

In accordance with the national HIV/AIDS policy and the BDF's vision of ensuring a healthy defence force with a low HIV prevalence, the BDF

developed an HIV/AIDS policy document in 1994. Some of its more important provisions are as follows:

- HIV-positive soldiers and officers shall receive the same treatment and be deployed in the same way as those who are HIV-negative.
- There will be no involuntary discharge of HIV/AIDS personnel except on the grounds of performance levels being below the retention level.
- Voluntary testing and care services are extended to military health-care beneficiaries, including the BDF's civilian employees.
- The policy provides for 'need to know' confidentiality.⁷²

The policy has made breakthroughs in efforts to institutionalise and legitimise the fight against the pandemic. As a by-product of the policy, the BDF was able, as early as 1995, to establish HIV/AIDS committees in all its combat, combat support, logistics and service support units in order to strengthen the campaign against the disease.

The committees were instrumental in institutionalising the campaign against HIV/AIDS. These structures are closer to the troops and are able to encourage their involvement in the fight against the pandemic. The committees train and educate unit members on HIV/AIDS-related issues. In addition they do peer counselling. Peer educators have been particularly crucial in providing support to HIV-infected persons, and in dealing with other health and social problems. Furthermore, the BDF has been able to train HIV/AIDS counsellors and peer educators. In addition, officers have been trained at seminars and short courses.

In 1997, a comprehensive HIV/AIDS programme was developed in order to implement the policy programme. A start was made in 2003 to review the HIV/AIDS policy to see how well it was achieving its goals. This review process has, however, been suspended pending a review of the national policy.

Overall, the BDF policy is seen as a major breakthrough in institutionalising the fight against HIV/AIDS. It has also demonstrated the concern of the command structure to respond adequately to the pandemic. On the negative side, the policy has, however, been challenged for being outdated. When it was drafted, it was intended to respond to HIV-infected persons only. ARV therapy, which was then a new development, was also not adopted at the inception. It is vital that the

policy should deal with how best to maintain and encourage HIV-positive personnel to remain in the force and receive counselling and treatment. The policy does not define its targets and it was drawn up in the absence of a needs analysis by the military community.⁷³ It is also important to note the critical relevance of the family unit in the life of soldiers.

The military community has the advantage of having readily available and easily accessible medical services in its camps and installations. This is a positive organisational attribute in the fight against HIV/AIDS, and should be used to its maximum potential. The fact that there are new dynamics underlines the need for continuous policy reviews. These new dynamics attest to the magnitude of the problem and indicate the required response.

MEDICAL SUPPORT AND HIV/AIDS VICTIMS IN THE MILITARY

All BDF camps and installations have medical facilities that provide comprehensive health care. As such, the infrastructure in place is adequate to respond to the HIV/AIDS pandemic and other health care needs. However, in line with other armed forces in the region, the BDF has an insufficient supply of health service personnel to manage the HIV/AIDS pandemic. There is no special dispensation for determining which, if any, HIV/AIDS victims in the military should be given sheltered employment or which should be boarded out medically. The general Medical Board conditions apply: whatever their debilitating illnesses, service personnel who fall below the retention standards due to their physical status are boarded out on medical grounds. HIV/AIDS is categorised together with all other debilitating illnesses.

CHALLENGES

Among the challenges are the differences between the national and the military HIV/AIDS policies—and perhaps also the recruitment policy. As Dandeker notes:

The military is unique in the nature and the extent of the demands it places on its personnel. They are obliged to train to kill and to sacrifice self, to participate in a military community where one works, lives and socialises with other service personnel, and when necessary, to respond to a 24-hour commitment with risk of separation from family at short notice.⁷⁴

It is revealing to unpack this statement for our analysis. At one end, it underlines the fact that the military is unique and must be seen and understood as such. It has its own unique roles, which may be diametrically opposed to those of other sectors of the economy. Among others, is the issue of mandatory pre-employment testing. For the military, failure to undergo pre-employment testing, which includes HIV testing, may be detrimental to both the potential employee and the organisation.

Armed forces have reasons, directly influenced by the nature of the job, why they cannot enlist HIV-positive applicants. These reasons may clash with the national policy. Recruiting personnel with pre-existing medical conditions would be costly to the organisation and would also negatively affect individual and team performance due to the rigours of training. In short, the BDF would not get a return on its investment from HIV-positive recruits. Instead, HIV-positive recruits would be more likely to deteriorate, compromising their health in the process. The military regards its members as soldiers first, regardless of their specialisation, and thus subjects them to basic training as a matter of principle.

For in-service members, the policy on the administration of personnel infected with HIV provides that unless under stipulated conditions, testing for HIV shall be voluntary, but is encouraged.⁷⁵ Special conditions apply in cases of foreign training, deployment in peacekeeping operations and similar circumstances. Live-virus immunisations could be life threatening to individuals in cases where they have to receive such immunisations, as may be required for peacekeeping operations. In combat situations, applicants would not be able to be battlefield blood donors to their colleagues.

Armed forces would not be able to predict when an applicant would progress to the AIDS stage, a risk factor in itself. It must be understood that while it may be obligatory to support and treat in-service personnel with HIV, the same resources may not be readily available for trainees. The argument for discrimination must be seen in this context. In this regard, therefore, it is imperative that the political and military leadership meet each other somewhere on this critical aspect in order to avoid policy ambiguities.

Perhaps it is even appropriate that the BDF should adopt a clear stance on the issue of pre-employment testing—as is the case with other militaries in the region, and there is need to cultivate a civil–military relationship that accommodates this policy difference. In our view, it is important that the BDF should make it clear to everyone that HIV

testing is a prerequisite for enlistment and therefore an intrinsic component of recruitment policy. Such a policy stance would create a number of breakthroughs.

The current practice poses a dilemma for doctors. If a patient were tested for HIV without his knowledge, the doctor might fear an ethical breach if he disclosed the patient's status. A clear statement that HIV testing is a prerequisite for recruitment would create a doctor-patient relationship free from considerations of medical ethics. Infections would then be easy to monitor. This would then enable the BDF to keep track of infections among those who have tested and have been informed of their results. Those testing positive would be able to be counselled and to register for ARV therapy.

HIV/AIDS STRUCTURES AND PROGRAMMES

As elsewhere, the HIV/AIDS pandemic has led to an unprecedented demand in the military for both clinical/medical and social support services. This demand has had to be met with commensurate tenacity and vigour. As a result, a comprehensive organisational structure and wide-ranging programmes have been put in place to meet both the clinical and social aspects of the pandemic.

HIV/AIDS COORDINATING OFFICE

At the helm of the BDF's overall HIV/AIDS efforts is its HIV/AIDS Coordinating Office. This was created in 2001 primarily to coordinate the implementation of HIV/AIDS programmes and to advise the BDF command on related policy issues. The office is also responsible for HIV/AIDS education programmes. The establishment of the Coordinating Office was a crucial move in the fight against the disease. Since its creation, the office has been able to sensitise the military community about the pandemic, its effects, methods of transmission and other related issues.

There is evidence that the office has made a valuable contribution to the efforts to fight the pandemic. It has been able to consolidate the previous efforts of the BDF's Social Welfare Office in rolling out HIV/AIDS prevention programmes. It has also been the link between the efforts of the military and other players in the war against the pandemic. The office has both institutionalised and legitimised the BDF's efforts against the pandemic within and beyond the military community.

In an interview with the authors of this chapter, the executive director of Tebelopele commended the BDF's efforts in fighting the pandemic, noting that the collaboration between Tebelopele and the BDF had led to new, smart partnerships in the fight against the disease.⁷⁶ A challenge, however, has been the office's shortage of staff, which has reduced its available time to deal with policy and other strategic issues. The HIV/AIDS Coordinating Office has no budget of its own, but draws funds from the NACA, the US Office of Defence Cooperation and other stakeholders. This limits the extent to which the office can stretch its programmes.

SOCIAL WELFARE OFFICE AND CHAPLAINCY

Other BDF support structures include the Social Welfare Office and the Chaplaincy. The former offers basic counselling and pre- and post-HIV test counselling for both uniformed and non-uniformed members of the BDF, as well as for their spouses and dependants. This office was at first responsible for overseeing the implementation of HIV/AIDS programmes in the BDF.

Initially, the military community was not very receptive to the office's primary role of providing counselling services. The additional role of overseeing HIV/AIDS efforts further marginalised the office from mainstream military organisations. In the early years of the pandemic, HIV/AIDS activities were seen as an avenue for dodging primary military duties. In a nutshell, there was resistance. With time, however, the office gained recognition.

As the HIV/AIDS workload increased, it was realised that the Social Welfare Office was not adequately equipped to handle HIV/AIDS issues, including counselling. The HIV/AIDS Coordinating Office was therefore created to take over the implementation efforts.

The Chaplaincy offers mainly pastoral counselling, but now also offers aspects of HIV/AIDS counselling due to the demand for such services. It is to be noted that with the advent of HIV/AIDS, the demand for chaplaincy has increased significantly. The intervention of the Chaplaincy has been particularly valuable in the conduct of funeral services as the death toll from HIV/AIDS-related illnesses has increased over the years.

Other efforts related to the management of the pandemic include the training of peer educators and counsellors, motivational talks on HIV/AIDS by the BDF command, seminars targeting uniformed and

non-uniformed members, and family devotional days. Devotional prayers are held at all BDF camps and installations on Mondays and Fridays, and HIV/AIDS-related messages are communicated to members of the military as a contribution to behavioural change. The strength of this mode of education is that it is able to reach many members of the military.

CLINICAL RESPONSES

Clinical structures have also been established to help in the management of HIV/AIDS. Such structures include prevention of mother-to-child transmission, laboratory facilities for processing samples, and ARV treatment sites.

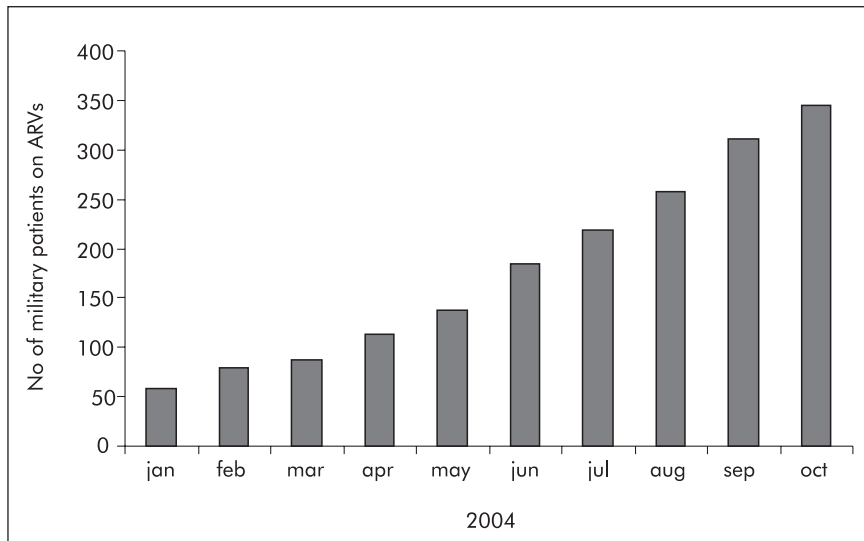
ARV PROGRAMME

The ARV programme was rolled out in 2003 at the BDF's Bephatswa airbase. The programme was later extended to Francistown in May 2004 and subsequently to the Sir Seretse Khama Barracks in March 2005. The programme draws drug supplies from the national pool and is able to provide up to three months' requirements for all the sites. For stable patients going on operational tours, arrangements are made to supply them for a two-month period of deployment. A medical orderly with the deployed troops is responsible for monitoring patients and liaising with the base medical officer on the condition of patients.

Troops on UN peacekeeping missions adhere to the provisions of the mandates on pre-deployment HIV testing.

Overall, the programme has represented a major breakthrough in the fight against HIV/AIDS. By prolonging lives, ARV therapy has brought hope to military personnel and their families. It has significantly reversed the high number of deaths due to HIV/AIDS.⁷⁷ The existence of ARV therapy has also encouraged those who had hitherto wallowed in fear to come out of their cocoons and undergo voluntary testing in order, if appropriate, to benefit from ARV therapy. Furthermore, it has allowed for better tracking of patients and comprehensive statistics of those living with the disease.

Another effect has been to change behaviour. The increase in the number of those submitting to testing and enrolling in the ARV programme indicates that many more members of the military are accepting their status and tackling their disease constructively. The ARV

Figure 5: Military patients on ARVs, January–October 2004

Source: Excerpted from a presentation made by the BDF at the Fourth Annual HIV/AIDS Strategic Planning and Policy Development Course, 11-17 December 2004, San Antonio, Texas, US.

treatment has also helped to reduce the number of consultations and re-admissions in hospitals. These had previously been a major problem posed by the pandemic.⁷⁸

Equally important is the fact that there has been a significant reduction in the rate of new infections.

Figure 5 depicts the military community's response to ARV therapy between January and October 2004 and shows a positive response to the early availability of the therapy. The number of patients on the programme has continued to increase.

COLLABORATION WITH OTHER STAKEHOLDERS

The Office of Defence Cooperation at the US Embassy is one of the major collaborating partners with the BDF in the fight against HIV/AIDS. It provides both technical and financial assistance, and has been instrumental in the establishment of the ARV programme in the BDF, contributing offices, a vehicle and finances for information, education and communication (IEC) campaigns.

NATIONAL RESPONSE TO SADC GUIDELINES

The 2003–07 SADC HIV Strategic Framework and Programme of Action provides guidelines on the way SADC has proposed that its members should respond to HIV/AIDS. The challenge lies in the extent to which these guidelines can be implemented by Botswana, both nationally and within the military establishment. There are also, of course, the differences previously referred to between the country's national and military policies.

As an example of other countries' responses, the Zambian military command has, in line with the country's political leadership, accepted pre-employment testing as part of its recruitment policy. By contrast, Botswana still has to reconcile its military and national HIV/AIDS policies.

A CRITICAL EVALUATION OF MITIGATION STRATEGIES

THE POSITIVE SIDE

Generally, the BDF's response to HIV/AIDS has been hailed as constructive and well organised.⁷⁹ Military mitigation strategies have been applauded for being well organised. This, it is argued, is directly related to the organisation of the disciplined forces generally, and the military in particular.

The fact that the military is a well-organised society is in itself a strength that could be exploited in efforts to fight the pandemic. Military personnel are easy to mobilise and to be given whatever message one has for them. Their strong peer influence is equally a plus and could help public education on HIV/AIDS. Their sense of belonging and community can be used as a breakthrough in mitigating the effects of the pandemic. As a result, the military community has been one of the more accessible sectors of the population in efforts to fight the pandemic. This is the opposite of the perception that this community is closed and inaccessible.⁸⁰

Also on the plus side is the fact that the number of people being tested in BDF health facilities has increased significantly between 2003 and 2005. In addition, there were members of the military who had enrolled for ARV programmes in government hospitals before such programmes were made available in the military community. Although statistics are not readily available, it is clear that there has been a positive response to ARV therapy, indicating a major behavioural change towards the management of the pandemic.

The military as an agent of positive change

The armed forces have three major political advantages compared with civilian organisations: a marked superiority in organisation; a highly emotionalised symbolic status; and a monopoly of arms.⁸¹ The first two attributes make the armed forces valuable potential agents for change. They could become major movers in the fight against the pandemic. One of the ways in which the BDF is involved in the fight against the pandemic is through its Men Sector programme, which is a part of the NAC.

The Men Sector committee is a sector-specific forum—currently chaired by the BDF—that brings together male-dominated organisations in the fight against the disease. For instance, the first World AIDS Day commemorations in 2000–01 were spearheaded by this sector, with themes including ‘Men make the difference’ and ‘I care. Do you?’

In addition, Botswana’s military regional structures are part of the district multi-sectoral HIV/AIDS committees. These are HIV/AIDS structures in the political districts of the country. Here the military’s organisational prowess is equally visible, creating the perception in society generally that the military is heavily engaged in efforts to fight the pandemic, both within and outside their own organisation.⁸² The military do not have independent HIV/AIDS programmes. Instead, they follow national programmes. However, given their organisational strength, they are able to mobilise resources and thus energise efforts better than their civilian counterparts. This could lead to a motivational role where the rest of society follows in the footsteps of the military.

THE DOWNSIDE

Programme focus

On the downside, programmes have been blamed for being narrowly focused on the soldier, and leaving out the family and the broader military community. For instance, some of the respondents noted with concern the weakness of public education campaigns in targeting families and other members of the military community. This is despite early efforts to reach out to the families through family fun days. These have died a natural death, however, leaving those previously targeted without support.

The issue of stigma stands out vividly as a major setback to efforts in fighting the disease. Notwithstanding the fact that there is an observable

increase in the number of those coming forward for voluntary testing, there are indications that the stigma issue persists.⁸³

While respondents commended the efforts of the BDF in educating officers and men about HIV/AIDS, there was concern over the inability of the programmes to reach the members' dependants and families, who are also an important constituent of the military community. Respondents underlined the importance of family support for soldiers. Taking the family on board would thus enhance the strategies by reaching out to a wider base.

The role of the male in the family was equally noted. Being male-dominated, the military community has a significant effect on issues of paternity and sexuality. As a consequence, their appreciation of the dynamics of the pandemic naturally has serious implications for the management of the disease beyond its impact on individual officers and soldiers. Going by the statistics of the 1993 *Men and Sex* survey referred to earlier, 67.5% of men in the forces were fathers. Although these figures may have changed significantly since then, they show, in a very strong manner, the extent to which men are important in matters of family, sexuality and HIV/AIDS.

In the interviews, the conspicuous inability of mitigation strategies to reach out to the entire military community, especially women and children, was a recurring concern. Respondents lamented the failure of public education programmes, and VCT efforts to reach out to the families and dependants of military personnel. Instead the focus is mainly on the uniformed cadre. This, respondents argued, had a major impact on the success of the mitigation strategies. A new approach to the problem was required.

ARV therapy

Another area was the stigmatisation that respondents said was linked to the manner in which drugs are administered. Owing to cost and security considerations, ARV drugs are administered from a specially designated place separate from the main hospital/clinic dispensary. This arrangement is seen by some as discriminatory and as perpetuating the HIV stigma. Stigma and denial may potentially deny beneficiaries access to ARV drugs, undermining efforts to fight the pandemic. Although it cannot be quantified, evidence from the interviews supports these indications. As a consequence, a considerable number of the military prefer to access drugs elsewhere.

Prior to the establishment of the ARV management sites, it was difficult to track the number of AIDS-related deaths in the BDF. This was because of a setup that did not include proper documentation and tracking of patients. The management sites were also not able to follow up patients who had been transferred to other treatment facilities. Some patients have died while on home-based care because stigma and denial had led them to prefer private treatment.

There is also a growing concern on the impact of ARV therapy on other prevention programmes.

Some observers note that since the introduction of ARVs the focus has shifted towards ARVs and away from public education about the disease.⁸⁴

As a result, those not directly impacted by HIV/AIDS five or so years ago may have joined the vulnerable population and may therefore need to be educated on the disease and its effects. The importance of an aggressive and continuing education programme therefore becomes obvious.

IEC and sustained behavioural change

In a study to explore the literacy level of members of the BDF on HIV/AIDS, Molate concludes that the majority of the officers sampled exhibited a high level of knowledge on HIV/AIDS and its prevention.⁸⁵ This, in our view, is a sign of a significant behavioural change by military officers. The finding is another indication that gains are being made in the fight against the disease, and that public education efforts are paying off.

A sustained behavioural change is, however, needed, especially in view of the statement in the study that “. . . there is a significant proportion whose attitude and behaviour need more information and education across all levels of prevention”.⁸⁶

Some of the observations raised in the interviews noted with concern the lack of commitment by a number of members of the officer corps in participating actively in mitigation efforts to combat the pandemic. For instance, the visibility of the officers is said to be minimal in structures such as unit HIV/AIDS committees, as well as in seminars and related forums organised to intensify public education. These negative attributes are a stumbling block in the war against the pandemic. The officer corps of any military is a crucial force multiplier in driving change and influencing behaviour.

CHALLENGES

THE NEED FOR RESEARCH AND INFORMATION DOCUMENTATION

As indicated earlier, there is a greater hurdle that still needs to be overcome: documenting the magnitude of the pandemic in all its manifestations—clinical, socio-economic and otherwise. This would help reshape both policy and programme development. This critical function is conspicuously absent in the efforts so far undertaken.

The BDF is therefore having to manage a problem about whose magnitude it is ignorant. In the absence of research and empirical data, it is difficult to establish whether infection rates are stabilising, increasing or dropping.

It is also difficult to establish if there is any connection between high HIV prevalence in operational and urban centres such as Chobe, Selibe Phikwe, Francistown and Gaborone with high concentrations of military personnel.

The organisation needs to be able to track the development of the pandemic with the best technology available. This would allow it to shape its policy on operational aspects and human resource management. This would in turn lead to new methods of combating the pandemic. Losses of personnel would also be easier to trace.

Despite all the positive strides made over the years, no impact assessment surveys have been undertaken to determine the extent of the prevalence of HIV/AIDS in the military community, let alone the level of understanding of preventive and mitigating measures such as condom distribution and use and, more recently, the ARV programme. This is a daunting challenge for the military leadership.

POLICY REVIEW

Aspects of ARV therapy are other areas that need addressing. There are critical issues to be attended to in the management of therapy and the protocols of its administration. The involvement of other stakeholders and partners in the war against the disease is equally vital.

REACHING OUT TO THE ENTIRE MILITARY COMMUNITY

Intensifying public education to reach out to the entire military community is essential. While servicing a male-dominated community, policy and programmes should include the dependants of members wherever this is

possible. Issues of sexuality and HIV/AIDS are of vital concern for the stability or otherwise of the family, both now and in the future.

NEED TO SUSTAIN PUBLIC EDUCATION TO EFFECT BEHAVIOURAL CHANGE

Real prevention is complex. There is no ‘magical bullet’ or readily available single way of fighting the pandemic. Instead, prevention must be multi-sectoral and must take a long-term view.

ADDRESSING THE SHORTAGE OF HEALTH-CARE PERSONNEL

Owing to its peculiarity, the military has sector-specific risks and vulnerabilities that need to be investigated and given specific attention. It is therefore critical to train more health-care personnel to meet the demands of the pandemic.

STRENGTHENING THE LEADERSHIP ROLE

The role of the leadership in efforts to mitigate the effects of the pandemic has been cited as equally important. The effectiveness of these responses depends, to a large extent, on the personal interest of the commanding officers and the officer corps in each unit, their perceptions of the pandemic and their appreciation of the potential effects of HIV/AIDS on those they command.⁸⁷

RECOMMENDATIONS

NEED FOR A POLICY REVIEW AND EVALUATION

There is a need for the current HIV/AIDS policy to be reviewed in line with the present condition of the HIV/AIDS pandemic. Evaluation is essential for the success of HIV prevention programmes, policies and strategies as it provides useful feedback on the success of mitigation strategies.

RESEARCH AND DOCUMENTATION

It is imperative that the military should undertake research on the extent of the HIV/AIDS pandemic on its officers and men. This would allow prevalence rates to be put into perspective and would also provide detailed information on condom distribution and usage, as well as on

issues of stigma and denial. Given the perceived sensitivity of such an exercise, it would be prudent to use the services of internal stakeholders who would then analyse the information and make it available on a need-to-know basis.

INTENSIFYING COMMUNITY OUTREACH

The need to recognise and involve families and dependants at the grassroots level is an imperative in the war against the pandemic. Given the various constituencies of the military community, comprehensive and all-inclusive outreach initiatives would achieve the maximum impact on the target population.

INCREASED PARTICIPATION OF THE OFFICER CORPS

One of the recurring concerns from the respondents is the lack of strong participation and visibility by the officer corps in efforts to fight the pandemic. There is therefore a need to strengthen this critical missing link to add robustness in this regard. HIV/AIDS should not be seen as a problem for the non-commissioned officers.

STAFFING THE HIV/AIDS COORDINATING OFFICE

Empowering this office by appropriate staffing would allow the office to improve its management of the various programmes required to combat the pandemic.

SYNCHRONISING EFFORTS OF VARIOUS STAKEHOLDERS

It is evident that the efforts of the major stakeholders in the fight against the pandemic are not well coordinated. Proper coordination of all efforts is therefore imperative so as to avoid duplication and in order to achieve a more concerted effort. The BDF's Health Services, Social Welfare and Chaplaincy corps should have clear-cut responsibilities in the management of HIV/AIDS programmes in order to facilitate a multi-sectoral approach to HIV/AIDS-related issues.

EXTENDING ARV SERVICES TO OTHER INSTALLATIONS

Given the effect of ARVs in prolonging the lives of those infected with

the virus, and therefore encouraging VCT, it is important for ARV services to be made more widely available so as to reach the maximum number of people.

GREATER COLLABORATION WITH OTHER STAKEHOLDERS

While the efforts by both the BDF command and its collaboration with the Tebelopele VCT centre and other stakeholders are commendable for reaching out to BDF camps and installations to deliver counselling and testing services, there is need to intensify the campaigns in order to reach more personnel whose duties deny them access to these services.

CONCLUSION

This chapter has examined the mitigation strategies against the HIV/AIDS pandemic in Botswana at national and military levels. It has examined the evolution of the pandemic in the country and has identified major responses, ranging from institutional and policy initiatives to programmes aimed at mitigating the pandemic. The chapter has also underlined achievements made at the national level, noting the comprehensive multi-sector institutional framework, the strong political commitment and the foreign assistance and collaboration in the war against HIV/AIDS.

On the downside, there are policy gaps that need to be closed in areas such as human rights and HIV/AIDS. Overall, the response shows a commitment led by the political leadership in taking the war against HIV/AIDS to greater heights through a multi-sector approach. The financial, human and material resources committed to fighting the disease are a major cost to the government, and their sustainability will for a long time restrict other development efforts in the country. With this commitment, however, plus support from international partners, it is evident that the country will be able to sustain the present level of effort for some time. However, the national prevalence rate is still very high. More still needs to be done in evaluating the impact of the mitigation strategies put in place thus far and in deciding how best they can be improved.

There are indications of a serious commitment to the fight against the disease at both the military and national levels. The military's superior quality of organisation and its highly emotionalised symbolic status provide it with an opportunity to consolidate the present gains. Military

personnel are easy to mobilise and programmes are therefore able to reach them more easily. The military could in turn convert its superiority in organisation into energies for positive behavioural change in the national war against the pandemic.

The success of the VCT sessions taken to the barracks by Tebelopele attest to this. The response has been overwhelming. Equally vital is the fact that there has been a major behavioural change indicated, *inter alia*, by the response to VCT and enrolment in the ARV programme. However, there are challenges still to be overcome. Key among these is the need to apply a comprehensive and holistic approach to the war by integrating other sectors of the military community, which are equally valuable for the success of the efforts so far undertaken. The family unit remains an important factor in the war against the pandemic and has to be targeted by the available programmes.

Similarly, the military should put in place a comprehensive data management system that will improve the management of ARV therapy and other programmes. Research on HIV/AIDS in the military is conspicuously absent and must be given the attention it deserves. In the absence of empirical data, the BDF is managing a problem whose magnitude is unknown to it.

In order to enhance a holistic approach to managing the pandemic in the military, it is also imperative for all internal stakeholders within the BDF to synchronise their efforts.

Owing to a strong organisational ethic, much could be gained through a more collaborative and concerted effort by all players, from the Social Welfare Office to the Chaplaincy and the medical side.

Overall, both at national and military levels, major strides have been made in institutionalising the mitigation strategies and legitimising them, as well as impacting on behavioural change for the better; however, more still needs to be done.

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- 70 This concern on the need to reconcile national HIV/AIDS policy with the military HIV/AIDS policy was expressed, among others, by Lt Col MR Gaborone. Gaborone is Staff Officer, Manpower Planning at the BDF headquarters and often deals with these practical issues.

- 71 Maj Gen LM Fisher, Chief of Staff, Botswana Defence Force, quoted in the *UNAIDS Best Practice Collection*, op cit, p 5.
- 72 PO Molate, op cit, p76.
- 73 Ibid, pp 76-77.
- 74 C Dandeker, Flexible forces for the twenty-first century, *Facing Uncertainty* Report No.1, Karstad, Department of Leadership, Swedish National Defence College, 1999, p 85.
- 75 *Botswana Defence Force policy on the administration of personnel infected with Human Immunodeficiency Virus (HIV)*, unpublished document, Botswana Defence Force Headquarters, Gaborone, May 1994, p 6.
- 76 Interview with the authors on 15 September 2005, Gaborone.
- 77 One of the respondents, a chaplain assistant and a member of the unit HIV/AIDS Committee, noted with relief the difference in the number of HIV/AIDS-related deaths before ARV therapy was introduced and after. Chaplains and their assistants are responsible, *inter alia*, for conducting funeral services for members of the BDF and are reliable sources to attest to these trends.
- 78 These insights were shared by one of the respondents, a medical doctor, in an interview with the authors.
- 79 R Molosiwa, executive director of Tebelopele Voluntary Counselling and Testing Centre in an interview with the authors at his office in Gaborone, 15 September 2005.
- 80 Ibid.
- 81 SE Finer, *The man on horseback*, Pall Mall Press, London, 1962, p 6.
- 82 This perception was expressed by a number of respondents including the Tebelopele Voluntary Counselling and Testing Centre executive.
- 83 This came out in a number of interviews with members of the BDF across the board, both officers and juniors. Some even noted that the special arrangement for distributing ARV therapy is inherently discriminatory and perpetuates the stigma of the disease.
- 84 Several respondents underlined the potential threat of this paradigm shift to undo the overall success attained in fighting the pandemic so far.
- 85 PO Molate, op cit.
- 86 Ibid.
- 87 Response during interviews regarding the effectiveness of the HIV/AIDS management programmes was varied; some saw it as effective in given areas but not so in others. Interviews were held with the following:
 - Lt Col MR Gaborone, Staff Officer Manpower Planning, BDF Headquarters, Sir Seretse Khama Barracks (SSKB), 22 July 2005.
 - Maj R Phetogo, HIV/AIDS Coordinator, BDF, SSKB, 29 August 2005.
 - Maj MK Mojela, Director, Social Welfare, SSKB Clinic, 30 August 2005.
 - Col MN Alidi, Director, Legal Services, BDF Headquarters, 31 August 2005.
 - Maria Kegaisamang, ARV Programme Coordinator, SSKB Clinic, 31 August 2005.

- L Cpl TB Tina and Cpl O Esi, SSKB, 31 August 2005.
- Maj H Rakgantshwane, Coordinator, VIP Squadron HIV/AIDS Committee, SSKB, 1 September 2005.
- Maj D Mapitse, Director of Chaplaincy, BDF Headquarters, 4 September 2005.
- W O H Bahuma, Force Sergeant Major, 6 September 2005.
- W O B Bosekeng, Chairperson, SSKB HIV/AIDS Executive Committee, 1 September 2005.
- P Molete, member of the SSKB HIV/AIDS Executive Committee, 2 September 2005.
- Maj A Mandiwana, Medical Officer, Thebephatswa Airbase Hospital, 8 September 2005.
- M Tselayakgosi, Programme Manager, NACA, 8 September 2005.
- Capt KR Mpaleng, Chairperson, HIV/AIDS Committee, Band Wing, 8 September 2005.
- Brig G Peke, Assistant Chief of Staff, Personnel, BDF Headquarters, 9 September 2005.
- Capt OP Molate, 9 September 2005.
- R Molosiwa, Executive Director, Tebelopele Voluntary Counselling and Testing Centre, 15 September 2005.

HIV/AIDS in the Umbuto Swaziland Defence Force

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INTRODUCTION

Swaziland, like most sub-Saharan countries, continues to face the challenges imposed by the advance of HIV/AIDS. The pandemic is of concern not only because of the physical destruction it inflicts on individuals, but also because it undermines almost all aspects of human existence in Swaziland. Since its advent, human resources have been depleted, state capacity to deliver services has been damaged, communities are under continuous stress, and the number of vulnerable children continues to rise. The Swazi social fabric has been greatly undermined as no sector has been untouched by the impact of HIV/AIDS.

For researchers, HIV/AIDS has posed the challenge of knowing the extent to which the pandemic has affected different sectors of Swazi society. A large body of literature has emerged addressing some of the research concerns surrounding the havoc in Swaziland caused by the pandemic.¹ In spite of the numerous works on HIV/AIDS in Swaziland, research gaps are still glaring. For instance, up to now no comprehensive study has been produced that analyses the HIV/AIDS situation in the Umbuto Swaziland Defence Force (USDF). This is in spite of the fact that the military is a high-risk sector both within itself and in its relationships with local, regional, continental and global communities.

This chapter analyses the HIV/AIDS situation in the USDF, with particular emphasis on the manner in which the Swaziland military has reacted to the general advent of HIV/AIDS. The chapter first presents

the national HIV/AIDS situation, with particular reference to the manner in which Swaziland has responded to the challenge of HIV/AIDS. We consider this crucial because it contextualises the situation in the military and because what the USDF does is largely and fundamentally informed by what is happening at the national level. The chapter then proceeds to an analysis of the HIV/AIDS situation within the USDF. Owing to the limited research that has been done in this sector, the work in this chapter is but the first cut and therefore cannot be comprehensive.

GEOGRAPHIC AND DEMOGRAPHIC PROFILES OF SWAZILAND

Swaziland is a small land-locked country located in the south-eastern part of Africa and bordered by South Africa and Mozambique. The total area of the country is about 17,363 km², and its borders extend for 535 km. The country is divided into four ecological and topographic regions, Highveld, Middleveld, Lowveld and the Lubombo Plateau. The country is divided into four administrative regions: Hhohho in the north, Manzini in the centre, Lubombo in the east, and Shiselweni in the south. The official languages of the country are siSwati and English. Some 40.6% of the population is under 14 years old, 55.6% is in the 15–65-year range and 3.8% is over 65 years. The population growth rate is estimated at 0.25%, while life expectancy has been reduced from an average of 54 years to about 35 years, partly due to the HIV/AIDS pandemic. The literacy rate, which refers to those who have completed primary education, is estimated at 81.6%.²

HIV/AIDS SITUATION IN SWAZILAND

The HIV/AIDS epidemic is the greatest challenge to humankind in the 21st century, and especially those in sub-Saharan Africa. According to evidence gathered by the Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa in 2001, this region was the most severely affected in the world. The HIV/AIDS situation in Swaziland continues to be widespread. Prevalence rates are both high and increasing. The pandemic represents a severe threat to the overall development of the country.

Swaziland has one of the world's four highest HIV/AIDS prevalence rates.³ A 2001 report by Tobias⁴ estimated that 25.5% of the population of Swaziland was then infected with HIV.

The first reported case of HIV in Swaziland was in 1987. Since then the disease has spread very quickly through the population. Most data on HIV/AIDS prevalence in Swaziland is derived from national sentinel surveillance surveys designed as an epidemiological means of tracking the epidemic. Since 1992, these surveys have been conducted on three population groups, namely: those attending antenatal clinics (ANCs); patients with sexually transmitted infections (STIs); and tuberculosis (TB) patients. However, the latest available report (2002) covered only pregnant women attending ANCs. It is therefore difficult to find consistency in the correlation of the statistics, although it is clear that there is still a health problem of crisis proportions.

In addition to being tested for HIV/AIDS, the women were also tested for syphilis and various types of hepatitis. This report found that of 2,787 blood samples tested at ANCs, 38.6% were found to be HIV positive (*see Table 1*). This extrapolates to an 890% increase in prevalence since 1992, when the first of these surveys was undertaken. What this also signified is the fact that any counter-measures undertaken until then had failed to stem the rising tide of the affected population.

Table 1: HIV prevalence rates for antenatal clinic patients, 1992–2002

	1992	1994	1996	1998	2000	2002
HIV	3.9%	16.1%	26.0%	31.6%	34.2%	38.6%

Source: Report on the 8th HIV Sentinel Survey, Mbabane, 2002, p 6.

The report also indicates that the Shiselweni region recorded the highest HIV infection rates, rising from 27% in 2000 to 37.9% in 2002. Evidence of some degree of stabilisation was noticed in the Manzini region, located in the centre of the country, from 41% in 2000 to 41.2% in 2002. This trend has continued to hold true with the 2006 *Global Aids Report* placing the prevalence rate in Swaziland at 42%.

Generally, available evidence shows that the major mode of HIV transmission in sub-Saharan Africa occurs through heterosexual sex, with unsafe injections and blood transfusions accounting for a small fraction of HIV transmissions. What remains unrecorded, and therefore falling outside the body of major research initiatives, is the unspoken homosexual dimension of the problem among the population. Strong

cultural inhibitions continue to make homosexuality a taboo discussion in Swaziland.

A report by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 2002 found that young women have higher HIV prevalence rates than men in the same age group. The implication from this finding suggests that increasingly younger women are having sex with older men, resulting in a possible inter-generational driver of the infection from men to women. This UNAIDS finding is true for Swaziland as, according to the 2002 sentinel survey, 87% of women below the age of 30 formed the majority of those infected with HIV. This implies that nine out of ten women in this age group were infected with HIV. Infection rates among young women aged 15–19 attending ANCs were found to be 32.5%, which means that three out of ten of these women were infected with HIV.⁵

The above statistics, indicating a growing increase in prevalence rates, are a cause of major concern in the country because the epidemic is reversing all the development gains realised over the past years. HIV/AIDS has become the major cause of death in the country, obliterating thousands of lives, particularly the young and economically productive members of the Swazi population, thereby undermining the country's social and economic security. As is the case in some other countries in the region, HIV/AIDS has become "the single most important phenomenon that will shape future demographic, health and development trends . . .".⁶

As mentioned, Swaziland has one of the highest HIV/AIDS prevalence rates in the world as well as in the Southern African region, in which population mobility is an established factor. Over the past decade the prevalence rate has steadily risen and, according to the so far unpublished 2004 sentinel survey, the prevalence rate is estimated at about 42%. This evidence has serious implications for regional strategies to combat HIV/AIDS in one country as a vector of transmission and recipients of available drugs in neighbouring states.

NATIONAL RESPONSES TO HIV/AIDS

A national HIV/AIDS response programme has been in place for more than a decade involving government, non-governmental organisations (NGOs) and international agencies. However, it has become evident that despite the national response interventions to inform the public about the epidemic, there is still a gap between knowledge of HIV/AIDS and

changes in sexual behaviour. HIV prevalence rates have not begun to reach a plateau but continue to spread rapidly. There still remains an urgent need to expand HIV/AIDS responses in Swaziland because most of the current efforts have hardly managed to restrain the spread of HIV. This is in spite of the fact that numerous interventions have been made. For instance, at the official opening of Parliament in February 1999, King Mswati III declared HIV/AIDS a national disaster requiring emergency interventions. The king has continued to make similar comments every year when supporting his Red Cross charity organisation.

The government of Swaziland responded to the emerging HIV/AIDS challenge by establishing the National AIDS Prevention and Control Programme (NAPCP) within the Ministry of Health and Social Welfare, in collaboration with the World Health Organisation's (WHO's) Global Programme on AIDS (GPA). The aim of the programme was to develop and coordinate a national response to the AIDS epidemic. The response was initially guided by the development of short- (1987–88) and medium-term (1990–97) plans, using the GPA recommended guidelines.⁷ The various plans covered the following intervention areas:

- Development of infrastructure for the effective prevention and control of HIV/AIDS.
- Setting up of advisory bodies.
- Screening of all donated blood.
- Development of technical guidelines.
- Public awareness of HIV/AIDS.
- Establishment of surveillance activities, including laboratory services.
- Training of health-care workers on HIV/AIDS.

This programme opened the AIDS Information and Support Centre in Manzini, Swaziland. This includes a hot line and offers training, counselling and public information. The result of this was a raised awareness level of HIV/AIDS among the Swazi people.

With the evolution of knowledge about the spread of HIV and its association with other STIs, the management of HIV/AIDS and STIs was

merged into the Swaziland National AIDS/STI Programme (SNAP). With the support and guidance of the WHO GPA, a number of interventions were initiated,⁸ including:

- information, education and communication (IEC) programmes on the spread of HIV;
- condom promotion and distribution;
- donated blood screening; and
- the establishment of support centres.

The Swaziland government recognises that HIV/AIDS is not only a health problem, but also a development problem that has social, economic and cultural implications. In 1998, a new HIV and AIDS policy was developed and approved by cabinet. The policy identified the need for a decentralised and multi-sector approach to the national response. It focused on three components: prevention; care and support; and impact mitigation.

King Mswati has continued his personal support for the fight against the spread of HIV/AIDS. One of his major interventions was a fund-raising tour of the United States (US) for a project called the Royal Initiative to Combat AIDS (RICA).

Through this project, the king appealed to American musicians, entertainers and artists to record an album called 'Songs for Life', the proceeds of which would go towards setting up a fund to help the fight against HIV/AIDS in Swaziland and in the Southern African Development Community (SADC) region generally. The success of the project has so far not been evaluated.

Since 1999, the Swaziland government has intensified the national response to HIV/AIDS. A cabinet committee on HIV/AIDS and a Crisis Management and Technical Committee (CMTC) were launched. The cabinet committee was formed specifically to supervise the work of the CMTC and to report to cabinet on a regular basis with comments and recommendations.

In September 2000, the CMTC developed a 2000–05 National Strategic Plan for HIV/AIDS that was approved by cabinet. In November 2001, the Ministry of Health and Social Welfare published a policy document on HIV/AIDS and STI prevention and control.⁹ The specific objectives of the policy were to:

- maintain a sustained political commitment at all levels for HIV/AIDS prevention and control;
- expand the national response to the HIV/AIDS epidemic by strengthening and maintaining a multi-sector approach;
- improve coordination of HIV/AIDS prevention and control activities at all levels;
- ensure that the general public has access to appropriate IEC programmes on HIV/AIDS and STIs;
- increase the capacity of women, youth and other vulnerable or disadvantaged groups (for example, disabled persons, sex workers and street children) to protect themselves against HIV/AIDS and STIs;
- ensure that HIV testing is used to maximise prevention and care;
- provide comprehensive health-care and social support for people with HIV/AIDS and their families;
- safeguard the human rights of people living with HIV/AIDS; and
- promote HIV/AIDS-related research and surveillance activities.

The government has also moved from the single-sector approach used before 1999. This viewed HIV/AIDS as a health issue only, for which the Ministry of Health addressed the epidemic through SNAP. A multi-sector approach involving a number of stakeholders has since been adopted. HIV/AIDS has also been included in the country's development plans and national budget.

In December 2001, the National Emergency Response Committee on HIV/AIDS (NERCHA) was created, replacing the CMTC and placed under the Office of the Prime Minister, with the task of converting the CMTC's national strategic plan for HIV/AIDS into an action plan. NERCHA is also mandated to coordinate and mobilise resources for an expanded and coordinated response in the country, as well as to foster a wider and multi-sector involvement of the stakeholders. The NERCHA committee has now been given council status by an act of parliament.¹⁰ The key objectives of the council are to coordinate and facilitate the:¹¹

- achievement of preventive behaviour towards the transmission and contracting of HIV/AIDS;
- provision of comprehensive and appropriate care and support for people infected and affected by HIV/AIDS;
- minimisation of the impact of HIV/AIDS on society;
- monitoring and evaluation of services as well as measuring the impact of HIV/AIDS on the Swazi people;
- mobilisation of financial and technical resources, including the management and allocation of these to implementing agencies; and
- periodic review and updating of HIV/AIDS-related policies and guidelines.

The functions of the council are to:

- oversee the coordination of the national HIV/AIDS response;
- establish and activate a national HIV/AIDS directorate;
- provide guidance to the directorate on its action plans and otherwise;
- review and approve the directorate's action plans;
- review the directorate's monthly progress and financial reports;
- review and adopt, as appropriate, the directorate's HIV/AIDS-related policies and recommendations;
- approve the directorate's budget;
- submit the directorate's annual audited accounts to cabinet within six months of the end of the financial year;
- approve the directorate's recommended funding allocations to implementing agencies;

- submit monthly progress reports and the reports of the directorate to the Prime Minister's Office for onward transmission to cabinet; and
- advise the prime minister and cabinet on all issues pertaining to HIV/AIDS.

The Ministry of Health and Social Welfare has developed specific health-sector responses and policies on critical issues such as the prevention of mother-to-child transmission (PMTCT), the provision of antiretrovirals (ARVs) and voluntary counselling and testing (VCT). These are awaiting approval. The ministry is also improving the availability of care and treatment of opportunistic infections by scaling up VCT and antiretroviral therapy (ART) in the country. There are also active organisations for people with or affected by HIV/AIDS, and various HIV/AIDS programmes for all stakeholders, including employers, workers, donors, the government and NGOs.

Several NGOs, community-based organisations (CBOs) and other partners have come up with various programmes to address the HIV/AIDS epidemic, including education, counselling and support services on HIV/AIDS. Swaziland has recently received a grant of over 500 million euros from the Global Fund to assist the country in its efforts to expand its response in the war against HIV/AIDS.

In 1999, Indlovukazi, the Swazi queen mother, launched the Khulisa Umntfwana project to fight teenage pregnancy and combat the spread of HIV/AIDS. In 2001, King Mswati targeted surveillance on the spread of HIV/AIDS among the youth.

The above outline indicates that HIV/AIDS has reached a crisis level in Swaziland. Different social formations and institutions are constantly at risk. Much as there is an elaborate response at national level, there is an urgent need for each sector to devise strategies for combating the epidemic, and so fulfil their mandate and contribute to the socio-economic development of the country. It is against this conceptual background that sectors such as the military should have their HIV/AIDS situations analysed, and should make appropriate responses to the challenge. What the USDF has done and continues to do about its HIV/AIDS situation will be informed by the national response.

EVALUATION

The Swaziland government has formulated appropriate policies and strategic interventions that bring together NGOs, the private sector,

CBOs and other stakeholders in combating HIV/AIDS. Swaziland has a strong traditional structure that links the country through *Tinkhundla* (constituencies) and chiefdoms to the homestead level. This structure allows prompt access to stakeholders involved in HIV/AIDS-related activities at community level. There are, however, certain challenges that have limited the success of these interventions.

NATIONAL CHALLENGES ON HIV/AIDS

The challenges faced by the country in the fight against HIV/AIDS are many, ranging from policy implementation and resource constraints to behavioural and cultural practices. At the national level some of the more prominent challenges include the following:

- The process of policy development is extremely slow. The majority of national and sector policies related to HIV/AIDS are still in draft form—sometimes years after they were first developed.
- A considerable decrease in government budget allocations to the health and social welfare sectors and the growing fiscal deficit have hampered the government's ability to fund HIV/AIDS programmes at a sustainable level. The burden of financing HIV/AIDS programmes is therefore likely to be borne largely by donors and other development partners.
- Some of the HIV/AIDS intervention priorities are driven by the sources of funds rather than by the stage of the epidemic and available epidemiological and research information in the country. There are inadequate policies and legislation for the protection of the rights of people living with or affected by HIV/AIDS from stigmatisation and discrimination. Counselling services provided to people living with HIV/AIDS are limited to pre- and post-HIV test counselling. There is no continuous counselling within the community, where stigma and discrimination are common. There is also inadequate protection of women from culturally driven vulnerability to HIV infection.

Most of the challenges faced by Swazi society are influenced by certain cultural practices that make behaviour change difficult to achieve. The challenges faced by the military are therefore by no means unique to the USDF, but its members are highly influenced by them and their vulnerability is strongly derived from them.

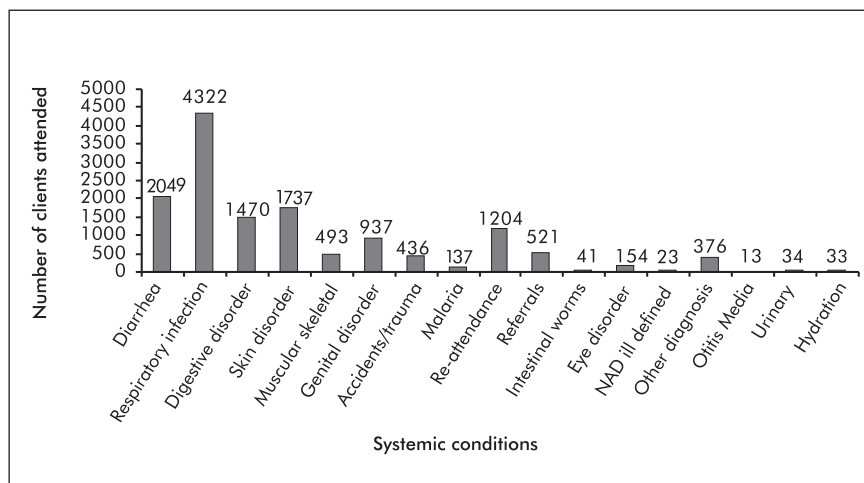
THE USDF AND THE HIV/AIDS CHALLENGE

By 1999, barely 12 years after the discovery of the first HIV/AIDS victims, the pandemic had reached crisis proportions and was officially declared a national disaster deserving priority status. The emphasis then was on recognising the broad implications of HIV/AIDS as the infection related to and impacted on the various sectors of Swazi society, including the military, and on coming up with sector-specific alleviation strategies. To this end, the government mobilised all sectors to contribute towards the national effort in order to fight the pandemic. Taking its direction from King Mswati, the USDF has responded seriously to the challenge and has restructured itself in order to be better prepared to face the challenges within all ranks of its personnel and at various levels.

RECRUITING: RENEWAL OF HUMAN RESOURCES

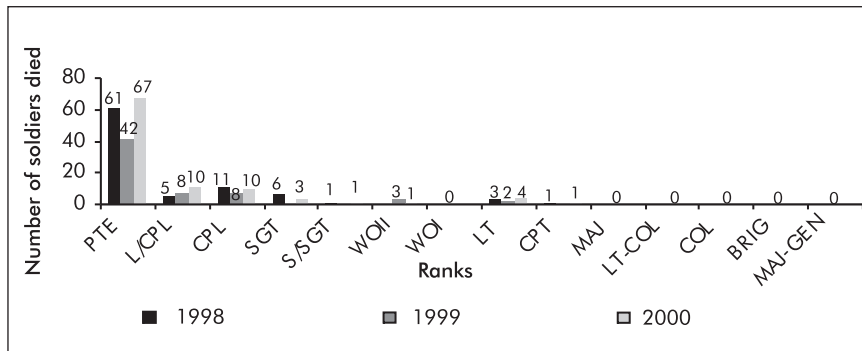
While financial limitations continued to be prohibitive, the USDF recognised that young productive soldiers occupying critical and skilled operational and supervisory roles are affected by such opportunistic infections as pulmonary tuberculosis, chronic dermatitis, chronic or carposis sarcoma, herpes zoster, chronic diarrhoea, lymphadenopathy, STIs, etc. (see Figure 1) and needed to be protected.

Figure 1: Occurrence of diseases in the military



Source: USDF Annual Medical Report for 2002.

Figure 2: Deaths in the military, 1998–2000



If this were not done, the chronic illnesses of such essential personnel would, once they were in service, compromise their combat readiness. The seriousness of the situation was exacerbated by the humane approach that guided commanders not to replace seriously sick soldiers and only to do so when they actually died. In other words, units were, and have been, forced to keep sick persons on their books in the forlorn hope that they might recover and return to duty.

In conjunction with the manpower losses in the military units has been the recognition by the USDF that the situation is not limited to soldiers but to their immediate family dependants.

There have therefore been attempts to extend their mandate to try to alleviate the plight of dependants who have experienced trauma and widespread emotional, social and financial difficulties as orphans, widows and widowers.

Chronic illnesses have also resulted in deaths (*see Figure 2*) that have undermined the efficiency and organisational stability of the military.

The USDF has not conducted a sero-prevalence survey to detect the impact of HIV/AIDS or the effect of HIV programmes that have been in place since 2002. This is in spite of all the effort on strengthened preventive programmes, care and support to the infected and affected, the availability of VCT and impact mitigation. The military continues to suffer the loss of young productive soldiers, both males and females, and especially in the lower ranks and below the age of 45. Life expectancy has continued to decline.

Monthly reports still indicate a high number of young soldiers suffering from opportunistic chronic infections, either bedridden at home or hospitalised in government hospitals. Medical records for 2003

indicate that respiratory or chest problems, chronic diarrhoea, skin disorders and STIs are the four leading problems in USDF clinics.

Annual medical records for 2003 and 2004 show a slight increase in the four main problems. Respiratory tract infections increased from 23% to 27% of all patients attending USDF clinics. Diarrhoea conditions increased from 10.3% to 12%, and the incidence of STIs increased from 5% to 9.3%.

A study on knowledge, attitude and practice was conducted in 2005 among army personnel. The findings on knowledge indicated that 99% of those interviewed were fully aware of the importance of condom use, but only 54% were practising safe sex through using a condom. It appears that the main problem is still behaviour change in the light of numerous interventions that have been put into place.

While the prevalence of AIDS among young men and women in the general population has been reported as 42%, a 2005 USDF activity showed a different finding. In that year, the army received 1,099 applications from potential recruits. When the medical corps carried out its normal tests, which include HIV/AIDS prevalence, the result was unexpectedly favourable in that only 237 (or 21.5%) of the applicants were diagnosed as HIV-positive and certified unfit for military training.

This concrete example demonstrates a number of policy-related complexities. The first is that there is no clear policy to guide the military on the traditional approach to recruiting. Arguments have been raised regarding discrimination and the violation of human rights by refusing potential recruits access to the armed forces through medical screening.

However, according to a public health officer, Maj Mutasa of the Zimbabwe Defence Force, a colleague, Dr Mudambo, has completed research on the impact of military training on HIV/AIDS-positive recruits in which he discovered that the training regime radically reduced their CD4 levels culminating in death within 90 days.¹² Taking Mudambo's research findings into account, the basic choice left for HIV/AIDS-positive youths intending to undergo military training is survival outside the military or the likelihood of death in the military in 90 days.

The second observation from this unique view into the workings of the military is that while recruits taken on are known to be HIV-negative, it is not clear whether and how the integrity of their status can be maintained. Should the onus fall on the individual as well as on the military itself, and even the state in the broader sense? Should there be mechanisms, incentives, policies, the capacity to continue testing, or

even penalties for individuals who later fail to maintain their health status? Stated differently, it is evident that once recruits join the military after passing their HIV/AIDS tests, the responsibility for maintaining their status rests both on the individuals and on the military institution. In the absence of comprehensive policies on these issues, the military has been forced to take ad hoc decisions.

Another more recent debate is whether particular posts in the military should be designated as HIV/AIDS-free, and, if so, what incentives or legal backing might be put in place to allow the institution to deliver on its primary mandate of providing national security. To summarise, it is clear that the challenge to the USDF is how to strengthen its HIV preventive programmes in order to maintain the negative status of most of its soldiers.

The pandemic both jeopardises security and also increases health costs, because more drugs, medical equipment and medical staff are being demanded by the current situation. The army has no hospital to accommodate its patients but has to refer them to government hospitals for further management. The military is limited to providing out-patient care, psycho-social support through counselling, and nutrition assistance.

Households continue to feel the various impacts of AIDS when their bread-winners fall sick. They bear the burden of taking care of their sick after their discharge from hospital. Orphans and widows are often left behind when a soldier dies—although statistics for these are not available because the affected persons are scattered around the country. CBOs are expected to mitigate the impact of these deaths, while the legal system is available for the distribution of deceased estates to known widows and orphans.

FACTORS THAT INFLUENCE THE SPREAD OF HIV

HIV/AIDS has been perpetuated in the military by several factors, including the following.

POOR CONDOM USAGE

A USDF survey in 2001 found that knowledge of condom use was above 97% but that actual condom usage among respondents was only 57%.¹³ These levels are very much in line with the results of the previously quoted survey on this subject. This survey showed that the incidence of

unsafe sex continued to be a problem within the military. While no research has been undertaken to determine the reasons for low condom usage, the problem appears to be an attitudinal one—which persists also among the general Swazi population.

SEXUALLY TRANSMITTED INFECTIONS

Evidence from military medical records indicates that STIs have always been among the four most frequent problems in the USDF. This is significant because of the medical evidence that the presence of STIs increases the transmission of HIV by a factor of five to ten. The combination of STIs and HIV/AIDS continues to be a problem in the Swazi military.

SEX FOR MONEY

Swazi soldiers, as is the case with other soldiers in Africa and other parts of the world, are constantly in contact with poor communities. The soldiers enjoy a steady income, which attracts members of the communities in which they live.

A 2000 report brought to the attention of USDF commanders noted that young civilian unemployed women in poverty-stricken areas were agreeing to sex with members of the USDF without the use of condoms and in exchange for food. This phenomenon faces most poor African countries, including Swaziland, that have been ravaged by drought, floods or lack of infrastructure and that have experienced widespread food insecurity.

Similar conditions may be extrapolated to peacekeeping missions, where military camps and their surroundings become islands of stability and food as well as sexual networks. Policy responses developed for isolated USDF units are therefore similarly relevant for peacekeeping operations in conflict zones, where both soldiers and civilian women have a high vulnerability to HIV/AIDS exposure.

FREQUENT DEPLOYMENT

Soldiers can be classified as mobile workers because they are frequently deployed from one part of the country to another. During this time they are not only away from their families but they may also be without their normal social peer support. In such situations, there are more

opportunities for young soldiers of a sexually active age to abandon responsible behaviour. Such mobility makes them vulnerable to HIV/AIDS as they are separated from their families and their regular sex partners. Soldiers posted to peripheral parts of the country are therefore placed at risk within the country.

Another dimension of this issue generally escapes attention. This is that the military are now required to think beyond the operational threats that require the deployment of units for particular tasks in different parts of the country, or even abroad. The military hierarchy must now also consider the sexual dimension of the theatre of operations and of various home bases with similar conditions. Commanders thus have new responsibilities—which may or may not violate individuals' rights—that include the imposition of more stringent restrictions on the activities of both on- and off-duty soldiers.

MILITARY RESPONSE TO HIV/AIDS

During the 21st session of the SADC Inter-state Defence and Security Committee (ISDSC), the Defence Subcommittee encouraged individual member states to develop comprehensive military-specific HIV/AIDS policies appropriate to each country's military. The USDF responded by launching an HIV/AIDS programme in February 2001 with funding assistance from the United States Department of Defence.

During the launch, the commander of the USDF, Maj Gen SS Dlamini, expressed the need for preventive programmes to contain and reduce the transmission of HIV and STIs among army personnel and their families. In his speech, Dlamini referred to the USDF's HIV/AIDS programme as a "war for life". During the launch of the 2002 World AIDS Day, Dlamini further observed that, in terms of equity, an important step in the defence against HIV/AIDS was the creation of a non-stigmatised and non-discriminatory environment in the USDF, and the provision of care and support to personnel and family members living with the virus.

Military training is designed to mould individuals into tough soldiers who can endure extremely stressful conditions during their tours of duty. Militaries are therefore interested in recruiting, rigorously training and retaining battle-ready and omni-deployable men and women.

In addition to the earlier point made about AIDS sufferers in the military, it has been argued that rigorous military training tends to precipitate full-blown AIDS in the case of HIV-positive persons at much

faster rate than normal.¹⁴ It has therefore been suggested that in carrying out their recruitment processes, defence forces should complete a general medical assessment for each candidate, including HIV status. In this way, policies that bar the HIV-positive recruits from enlisting will be a way of preventing the unnecessary progression of the status of these recruits from HIV-positive to full-blown AIDS.

In recognition of the serious nature of the HIV/AIDS pandemic, the leadership of the USDF embarked on a programme of formulating a policy that would project strategies for combating HIV/AIDS in the military. The policy was intended to provide guidelines on the prevention of HIV/AIDS, and care and support for infected and affected USDF personnel. The critical objectives were to:

- increase the capacity of the USDF to protect its personnel against HIV/AIDS and STIs;
- improve the management of USDF HIV/AIDS programmes and to monitor their implementation and effects;
- safeguard the human rights of USDF personnel living with HIV/AIDS;
- ensure that USDF personnel have access to appropriate IEC programmes on HIV/AIDS and STIs; and
- provide comprehensive health-care and social support for USDF members living with HIV/AIDS.

Through this policy, the USDF has put into place strategies for reducing the spread of HIV/AIDS in the military. It developed this policy in the awareness that the increase in the incidence of HIV can be reduced by an intensification of prevention efforts. Some of the more important strategies of the USDF that are now in place include the following:

EDUCATION

Education is a critical intervention in the prevention drive. The USDF has embarked on both formal and informal education activities at unit level. Relevant structures for peer education have been put in place and there is easy access to IEC programmes. Also of major importance is that HIV/AIDS/STI education has been incorporated into the curriculum for

new recruits. The main aim of these educational programmes is to increase awareness and knowledge and to translate these into behaviour change.

VOLUNTARY COUNSELLING AND TESTING

Another key component of prevention is psycho-social preparation before and after testing through counselling in a favourable environment and with guaranteed confidentiality. The vision is that VCT “will help USDF personnel to learn about how HIV is transmitted, to practise safer sex, to get an HIV test and, depending on the results, to take steps to avoid being infected or to avoid infecting others”.¹⁵ Spouses should also have access to VCT.

The policy states that HIV testing may be conducted for different purposes. The testing is in line with national policy and remains voluntary. Testing is strictly not used for discriminatory purposes. Due to some particular aspects of the military, mandatory testing is required in the following areas:

Blood donations

USDF policy here follows the national guidelines established by the Ministry of Health and Social Welfare.

Screening of recruits

As an entry requirement, all candidates shall undergo a medical examination that includes blood tests for any chronic diseases. HIV testing in this regard will be no exception but will be conducted with the knowledge and consent of the candidates. Only candidates who test HIV-negative will be allowed to join the military.

Pilots, aircraft engineers and air traffic controllers

The annual medical examinations of these categories of personnel will include HIV screening. Personnel testing positive will be relieved of their present duties and will be nominated for other duties.

Foreign military training

Candidates selected for training in countries that have mandatory HIV

screening can refuse to be trained for foreign deployment with no penalties in the advancement of their domestic careers.

Pre- and post-deployment HIV testing

In the event that the USDF forms part of a UN or other multilateral peacekeeping contingent, participants will need to consent to undergo both pre- and post-deployment HIV testing.

Local deployment

Free time is allocated to refresh the mind, visit spouses, and access various recreational facilities, including volleyball, soccer and running.

Care and support

An essential part of the response to the epidemic is home-based services. The USDF care-giving programme works in partnership with the government and NGOs. The care-giving programme includes sub-unit care-givers responsible for treating all military personnel for opportunistic infections and STIs.

The government allocates budgets for medical drugs for the USDF. Referrals can be made to government hospitals where the need arises. AIDS patients and their spouses are provided with ART at no cost to themselves.

HIV-positive and AIDS patients will continue to perform tasks for which they have been trained. They should be deployed within Swaziland and not be discharged unless they fail to meet performance standards. Retirement on medical grounds will be made only with the approval of the Medical Board and only on a soldier's failure to perform. Post-retirement care is offered at government or defence clinics at no cost to the military personnel concerned. Units are responsible for food parcels for AIDS patients under home care.

An important component of the care-giving programme is home-based care. Government hospitals become so full that some patients need to be cared for at home by their relatives. The USDF care-giving programme works in partnership with government and NGO agencies in an endeavour to provide such care for its personnel. Every unit is responsible for the establishment and maintenance of a home-based care facility that will:

- enhance continuation of care after discharge from hospital; and
- promote family involvement and support family members to care for their patients.

Another important component is improved nutrition at household level. This is because HIV/AIDS and food security are closely linked. An HIV-affected household increasingly risks food insecurity and malnutrition through decline in work and income. The inclusion of nutrition as a core part of the USDF's HIV care package is therefore essential. Nutritional deficits make people with HIV/AIDS more susceptible to a variety of diseases and infections. For this reason, soldiers' rations are provided.

Also crucial at the level of care-giving is psycho-social support. Counselling and spiritual support for both infected and affected personnel are part of the package. Mitigating the devastating impact of AIDS on the lives of personnel, their social interaction and their income are good and sufficient reasons for providing such support. Involvement of people living with HIV/AIDS is critical in the provision of psychological care. Chaplains take the lead in providing spiritual support to infected and affected people.

Christianity has been integrated into the support and care programme. Christianity teaches abstinence—which is a good method of preventing the spread of the virus to youth or unmarried members. There is a formal group called Christian Military Fellowship, which accepts that testing is a subject when counselling young couples preparing for marriage. Church leaders in the military were the first to be made HIV spiritual counsellors, and they counsel people to adopt a constructive attitude towards HIV/AIDS. Christian counsellors visit patients in hospitals and at home. While they pray for their patients, they may find it difficult to involve themselves with the subject of condom usage because they may feel that it is outside their scope to preach sexual immorality. They are, of course, able to emphasise the virtue of faithfulness for married couples as extramarital sexual partnerships may destroy the family and bring HIV/AIDS into the marriage, thus spreading the infection.

MONITORING AND EVALUATION

In order to assess the impact of interventions, the USDF needs to conduct surveys to determine HIV prevalence rates for its personnel. It is unfortunate that these have not yet been carried out, the reason being

that funds have not been available. As a result, the military has had to rely on national surveys to estimate prevalence rates and to predict their impact.

Other monitoring and evaluation tools to measure impact have been behavioural surveillance surveys and indicators, such as medical records for STIs and opportunistic infections.

It was a 2001 behavioural surveillance survey that indicated the finding already quoted that more than 97% of those surveyed knew about the role of condoms in the prevention of HIV transmission, but that only 57% of them used condoms. And it was a more recent knowledge, attitude and practices study that revealed slightly different percentages for the same two variables (99% and 54% respectively). This study indicates that a behavioural change is still not a reality in spite of the awareness and prevention programmes. An evaluation of STI medical records confirms this. This was an evaluation of STI cases handled at USDF clinics. It showed that STIs were the fourth most numerous illnesses recorded and treated.

Bearing in mind the close relationship between STIs and HIV/AIDS as the heterosexual vector in the process, greater efforts need to be made to influence more fundamental behavioural change. This is significant due to the previously reported influence of an STI in increasing the transmission of HIV by a factor of five to ten.

The Defence Policy is being executed, though there are gaps here and there. One good achievement has been the development of IEC material that makes use of playing cards with HIV/AIDS/STI messages. These cards have been distributed to all units. Educational talks and workshops are conducted, and peer educator counsellors have been trained—though there are not yet enough of them. VCT centres have been established where clients have been tested and counselled. All selected candidate recruits undergo physical examination for chronic diseases—including HIV—and doctors report on all abnormalities. All candidates certified unfit for military training are not allowed entry into the military, but information on the numbers who retain their negative status remains the greatest challenge. Behaviour changes, too, are difficult to achieve. Condoms are placed at strategic places, with supplies needing frequent replenishment.

It may be appreciated that the HIV policy protects soldiers from being charged for refusing to undergo HIV tests demanded by foreign countries. It is, however, true that HIV will still have an impact on a soldier's career development. This is because he cannot be promoted if his curriculum vitae is unsatisfactory.

Soldiers who are found to be HIV-positive are not discharged but remain in the military and perform their normal duties until they fail to meet performance standards. AIDS patients are treated just like other patients and there is no discrimination.

ARV therapy is initiated at no cost following the protocols set by the Ministry of Health and Social Welfare, and patients are monitored at government hospitals and public health centres in all the regions. The USDF has no hospital and provides only outpatient care. Treatment of opportunistic infections and STIs remains on track and reports are submitted monthly to the Ministry of Health and Social Welfare. The government allocates budgets for drugs and medical supplies, but it has become clear that the situation demands more than is available; while home-based care aims at continuing and enhancing care after discharge from hospital. Here, too, the work is being limited by a shortage of resources, and there are some gaps.

It is difficult to monitor the welfare of orphans and widows as the distribution of deceased estates is administered at the Master of the High Court. There is an assumption that orphans and widows are being looked after at community level. From the USDF's perspective, the greatest challenge may be the achievement of a behavioural change. It is, certainly, the challenge demanding the highest priority if the capability of the armed forces is not to decline further.

USDF HIV/AIDS CHALLENGES

MULTIPLE PARTNERS

Having multiple partners of the opposite sex has been a practice long cultivated by many Swazi men. It is something that has traditionally been encouraged by Swazi culture. It emanates from the view that before a young man gets married he should choose a wife from among several girlfriends. The aim was to gauge a man's prowess in getting the attention of as many ladies as possible. Most men engage in this practice before they marry, and some continue with it even after marriage. This has been the case because Swazi culture does not necessarily encourage faithfulness among men. Only women are expected to be faithful to their partners. We now know that in this era of HIV/AIDS, faithfulness by one spouse and promiscuity by the other increases the exposure risk.

The continuation of this practice among USDF men today poses several challenges. The major challenge with this cultural norm that

guides marriages is that some partners do not practise safe sex or may have extramarital partners. In such situations soldiers have become vulnerable to HIV/AIDS as they are unable to control the behaviour of their numerous partners.

A comprehensive response to this challenge is required. It should be one that is linked to societal norms, culture and practices. Without this higher intervention, actions taken at the institutional level are unlikely to have any significant impact.

Another challenge is that people today are no longer able to 'hold back'; relationships now mean sexual penetration as soon as people fall in love. Also, there is not enough education about how to date without having sex.

The strategies employed traditionally are no longer taught to the youth, including the moral teaching of engaging in penetrative sex only at the appropriate time. Girls are no longer emotionally and physically strong enough to refuse penetration before marriage. They are no longer taught how to deal with peer pressure and consequently engage in penetrative sex at inappropriate times.

GENDER RELATIONS

What informs gender relations most is the distribution of power between partners. Swaziland is a patriarchal society and some of the cultural practices are informed by patriarchal values which prevent women from controlling their bodies or deciding the terms on which they have sex. This is a major challenge in Swazi society as it makes girls and women more vulnerable to HIV/AIDS. The gender imbalance is manifested in many ways, including the following:

- The cultural practices and adages give the impression that men have a right to get whatever they demand from women. Women are then burdened with the responsibility to make sure that they do not fall pregnant before marriage.
- The culture empowers the male to take the dominant role in a relationship.
- Women have no leverage to force their partners to engage in safe sex.

For the purposes of national survival in the era of HIV/AIDS, it is in

everyone's interest that women be empowered to make their own decisions concerning their sexual behaviour, especially on how to protect themselves.

ALCOHOL AND DRUG ABUSE

The abuse of drugs and alcohol is a common habit that creates addiction and exposure to HIV/AIDS. Among soldiers, drug taking and the exchange of stimulants occurs around messes and canteens where many engage in excessive drinking combined with prostitution after hours, ending with sexual relations with or without condoms.

The scenario provides a case of combined elements of drugs, alcohol abuse and unprotected sex, making this an area that needs urgent intervention. As well as more effort at awareness, there could be a more liberal distribution of condoms in the messes and canteens, and more effective policing of the taking and distribution of drugs.

TRADITIONAL MEDICINE VERSUS MODERN MEDICINE

Swazi society, as with many other African societies, still believes in the efficacy of both traditional and modern medicine. Worse, there are significant sections of the society who still believe in witchcraft, citing this as the reason for most ailments. This has resulted in a delay before victims receive effective treatment. In the context of HIV/AIDS, this can mean a considerable delay from the time when the virus has taken effect.

Having said this, HIV interventions are continuing to be taken up by different groups of society, including traditional healers, church elders, community leaders (chiefs) and the youth.

Although only anecdotal so far, the present evidence appears to suggest that traditional medicines have had little impact on the reversal of HIV/AIDS conditions. For the military to remain effective, ways need to be found to overcome the practice of first consulting traditional herbalists and even attributing sicknesses to witchcraft. Civic and religious leaders need to persuade Swazi society to begin to change its perceptions and beliefs—this as one of the comprehensive counter-measure against HIV/AIDS.

CONCLUSION

In common with most sub-Saharan countries, Swaziland is faced with a serious HIV/AIDS challenge. The prevalence is continuing to rise in spite

of numerous interventions. The Swaziland government has shown a strong commitment to the fight against HIV/AIDS.

This has come in the form of committing resources to fighting the pandemic, and enacting necessary policy measures to create an environment conducive to the implementation of interventions on prevention, care and mitigation.

Much as the leadership of the country has shown itself to be serious about winning the war against HIV/AIDS, numerous challenges are being encountered—of which behavioural change is perhaps the most significant.

No research yet has provided a clear picture on how impediments to behavioural change can be overcome. Some commentators have argued that a cultural approach can address the situation. In the case of Swaziland, such an approach would require an identification of the strong points of Swazi culture that could be used as strategies for fighting the pandemic.

The HIV/AIDS situation in the USDF seems to correlate closely to the situation at the national level. Evidence indicates that the USDF is losing large numbers of skilled personnel throughout the ranks due to HIV and AIDS-related diseases. There is no doubt that the impact of the epidemic will have to be arrested if the country's security efforts are not to be undermined. This is because most of those dying are in their prime years.

The leadership of the USDF has realised the danger posed by the pandemic on the military, and it has taken decisive action to stabilise the impact. The USDF HIV/AIDS policy outlines strategies for addressing the pandemic in the armed forces. These strategies are mainly in the areas of prevention, care and mitigation.

A positive element of the policy is that it looks beyond the individual soldier into the family and community. This is very important because the military does not exist in isolation but is constantly in touch with the families and community members of its personnel.

Compared to other sectors within the country, the USDF has taken a strong stance against all aspects of HIV/AIDS. It is hoped that other sectors of Swazi society will learn from this good example and will reform their structures along USDF lines.

In spite of the many successes that have been achieved, challenges are still numerous. From an armed forces perspective, ultimate success will depend on the extent to which the USDF proves able to meet the challenge of HIV/AIDS.

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HIV/AIDS in the armed forces: Policy and mitigating strategies in Zambia

Anne Namakando Phiri and Lawson Simapuka

GEOGRAPHY AND THE PEOPLE

Zambia is a land-locked country situated in south-central Africa. It covers an area of 752,620 km² and lies some 1,400 m above sea level. Zambia shares borders with the Democratic Republic of the Congo (DRC) and Tanzania to the north; Malawi and Mozambique to the east; Zimbabwe and Botswana to the south; Namibia to the south-west; and Angola to the west.

Zambia has 73 tribes with 105 different dialects. The Bemba, Kaonde, Lozi, Lunda, Luvale, Nyanja and Tonga are the major tribal groupings, each with different cultural and traditional diversity. These cultural differences have tremendous impact on health delivery and outcomes.

Prior to political independence from Britain on 24 October 1964, Zambia was known as Northern Rhodesia and formed part of the Federation of Rhodesia and Nyasaland. Southern Rhodesia and Nyasaland were today's Zimbabwe and Malawi.

Administratively, Zambia is divided into nine provinces and 72 districts. The provinces are Northern, Southern, Eastern, North-Western, Western, and Central as well as Lusaka, Luapula and Copperbelt. The Northern Province is the largest with a surface area of 147,862 km², while Lusaka is the smallest province with a surface area of 21,896 km², but also the most densely populated. Lusaka's density increased from 31.6 persons per km² in 1980 to 45.1 in 1990 and to 65.4 in 2000. The second most densely populated province is the Copperbelt Province with a density of 52.9 persons per km². In addition

to being the most densely populated provinces, Lusaka and the Copperbelt are also the most urbanised. The North-Western Province has the least density with only 4.9 persons per km². The urban population grew from 29% of the total population in 1969 to nearly 40% in 1990.

Zambia has a population of 10.3 million, of whom 5.1 million are male and 5.2 million are female.¹ Zambia's population is relatively young and the structure is typical of a developing world population pyramid. Available data indicates the following population breakdown:

- 0–5 years: 15%
- 6–14 years: 25%
- 15–24 years: 27%
- 25–59 years: 29% (this is the most productive age group)
- 60 years +: 4%

Copperbelt has the highest population followed by Lusaka, Northern, Southern, and Eastern provinces. North-Western Province has the lowest population followed by Western Province.² The population growth rate has always been very high, but between the last two censuses of 1990 and 2000 the annual population growth rate declined from 3.1% to 2.9%.³

According to the Central Statistical Office (CSO) Report, the decline in the population growth rate has affected all the provinces, except for Lusaka, Northern and Luapula. The population in districts in proximity to international borders grew by much higher rates. The higher population growth rates are a result of other factors, such as spontaneous settlement by populations from neighbouring countries.

Zambia and its neighbouring countries have a long history of spontaneous settlement of populations along the border areas depending on variations of the weather and political and socio-economic situations on either side of the international boundaries. Given the strife in Angola and the DRC, there would be a strong motivation for people from those countries to settle spontaneously in Zambian villages along the borders.⁴

Zambia is part of the African plateau, which gives it a moderately cool, mild climate. There are three distinct seasons: cool and dry, hot and dry, and hot and wet. The minimum daily temperatures are in the 8–15°C range in the cool and dry season, while maximum temperatures are in the 27–35°C range in the hot and dry season. The coldest month is July, while the hottest is October. Annual rainfall ranges from 600 mm in the south to 1,500 mm in the north. The rainy season is November–April.

The country is drained by three river basins, the Zambezi, the Luapula/Chambeshi and the Tanganyika. Zambia has five main rivers—Zambezi, Kafue, Luangwa, Luapula and Chambeshi. The country also has several lakes—including Mweru, Mweru-wa-ntipa, Bangweulu, Tanganyika—as well as the Kariba and Ithezi-thezi man-made lakes. Other water features include the Victoria Falls, which is one of the Seven Wonders of the World. Some 80% of all the water in the Southern African Development Community (SADC) region is in Zambia. Most of the vegetation is classified as well-wooded savannah, dominated by the Miombo woodlands.

Zambia's rich biodiversity remains largely unexplored, unexploited or lost to socio-economic activities. Zambia is also endowed with abundant natural resources and various minerals and precious stones such as copper, aquamarine, emeralds, zinc, lead, diamonds and cobalt. Copper is Zambia's major export and foreign currency earner. The fall of the copper price on the world market is one of the contributing factors to Zambia's current economic misery.

After independence, the first Zambian government found itself with considerable financial resources at its disposal. The government embarked on a major programme of developing the social, physical and economic infrastructure. Education was made compulsory, and health services were provided free of charge. But over the years Zambia's economy has declined, so that there are now high poverty levels. Gross national product continues to show a downward trend. The collapse of incomes and loss of employment have been identified as some of the major causes of poverty in Zambia. National savings have also fallen over the years to levels that are inadequate to fund desirable investment.⁵

According to the *Zambian Poverty Reduction Strategy Paper*,⁶ the existing huge debt burden has accounted for the loss of 10% of gross domestic product. Inadequate expenditure on economic and social services has contributed to the deterioration of the country's stock of human and economic capital, and this in turn has constrained growth.

The prevailing socio-economic changes have not only had serious consequences for the health and quality of life of most Zambians, but they have had an impact on social, political and cultural determinants of the country's health and quality of life.

According to the 1998 *Zambia's Living Conditions Survey*, the manifestations of poverty have grown to such an extent that Zambia can be said to be experiencing a social crisis. It has been estimated that about

two-thirds of the Zambian people are living below the poverty line, and that more than 30% of Zambians spend 85% or more of their income on food, making them vulnerable to any income disruption.

PROJECT OBJECTIVES AND METHODOLOGY

The HIV/AIDS project in the military was carried out in five Southern African countries, namely Botswana, Swaziland, Tanzania, Zambia and Zimbabwe.

The objectives of the research project documented in this report are twofold, namely to:

- provide a deeper understanding of how the Southern African region's armed forces have responded to the HIV/AIDS pandemic through documenting the different national responses. The hope is to provide such case studies as examples to those countries still grappling with the formulation of public policy that is appropriate to the pandemic; and
- create a select body of researchers who will develop special interest and skills, working in the area of HIV/AIDS in the armed forces. The hope is to facilitate a professional group around whose members the debate on and solutions to HIV/AIDS in the region's armed forces can be further integrated.

The project is divided into two phases. The first phase of the project was mainly desk research. This phase looked at policy options on HIV/AIDS in the military in Southern Africa. The aim of the review was to determine how the existing policy framework addresses the impact of HIV/AIDS in the military.

Data was collected from primary and secondary sources. Other than a literature review, the researchers conducted interviews with some stakeholders. The study did not look at medical or epidemiological issues that arise as a result of HIV/AIDS; the area of interest was policy options that would benefit the ordinary officer or soldier in the armed forces.

For the Zambian chapter, the following sources were examined to ascertain whether they addressed human rights, labour issues and HIV/AIDS in the military:

- Zambian Constitution.
- Defence Act.

- Draft National HIV/AIDS Policy Framework.
- Draft Defence HIV/AIDS Policy document. This was reviewed in relation to:
 - recruitment policy;
 - training policy;
 - personnel advancement policy;
 - utilisation and advancement policy; and
 - counselling, treatment, medical retirement and post-retirement and medically boarded personnel.

Other than document analysis, social, cultural, religious, ethnic and historical traits were examined to try to isolate some traits that have implications for the management of the pandemic. These included issues of culture relating to social formation, sexual practices, faith, religion, and idiosyncrasies of polygamy and wife inheritance.

HIV/AIDS NATIONAL OVERVIEW

Zambia has one of the highest prevalence rates of HIV in the world. HIV was first reported in Zambia in 1984. Initially, the concentration of HIV/AIDS cases was in urban areas, but it soon became clear that all parts of the country were affected.

Since then the scourge has moved on, with the 15–49-year age group most affected. HIV transmission is mainly heterosexual. In 2002 sero-prevalence rate for HIV-1 was 16%.⁷ Up to about 71% of those suffering from sexually transmitted infections (STIs) are found to be HIV-positive, and approximately 27% of pregnant women are infected with HIV.⁸

Of babies born to HIV-positive mothers, 39.5% are infected with the virus.

There is substantial evidence suggesting that women are more affected than men. The number of HIV-positive women increases with age. The percentages are: 6.6% in the 15–19-year age group; 16.3% in the 20–24-year age group; and 23.3% in the 25–49-year age group. In men, HIV prevalence is less than 5% for the less than 25-year age group; and 18% in the 25–49-year age group. The comparative prevalence in the 15–49-year age group is 12.6% males against 17.8% females. The provinces with higher than national average HIV prevalence rates are Lusaka (22%), Copperbelt (20%) and Southern (18%).

The World Health Organisation (WHO) reported some 920,000 AIDS cases in Zambia at the end of 2002. However the unofficial

estimate by the end of 2002 was 1.1 million. The official estimates indicate that one million people are living with HIV infection, with at least 690,000 individuals having already died from AIDS-related illnesses since the pandemic began, resulting in 570,000 orphans.⁹

THE TRANSMISSION OF HIV/AIDS

HIV infection is primarily through heterosexual contact and perinatal (mother-to-child) transmission during pregnancy, at birth and while breastfeeding. Another recognised mode of transmission is through contaminated blood and blood products. Other modes of transmission include the re-use of needles and sharp instruments, as well as male homosexual sex.

FACTORS THAT PERPETUATE THE TRANSMISSION OF HIV

SOCIAL-CULTURAL BELIEFS AND PRACTICES

Social-cultural beliefs, which subordinate women in society, make them more vulnerable to contracting HIV infection. Cultural practices such as dry sex and the tradition of widow/widower cleansing (whereby the living spouse is cleansed by having unprotected sexual contact with a relative of the deceased) also facilitate the transmission of HIV.

Women lack control over their lives and are taught from early childhood to be obedient and submissive to males, particularly males who command power such as fathers, uncles, husbands, elder brothers or guardians. In a sexual relationship, females are expected to please their male partners, even at the expense of their own pleasure and well being. Dominance of male interests and lack of self-assertiveness on the part of women put them at greater risk.

A woman is taught never to refuse sex with her husband, regardless of the number of sexual partners her husband may have or her husband's unwillingness to use condoms; even in situations where he may be suspected of having HIV or other STIs.

Some women continue the practice of dry sex, which increases their vulnerability to infection through bruising and laceration of the genital organs of both partners.

Women have limited access to means of production such as land, credit, skills, capital, technology and information. As a result, most women are economically dependent on men. Women's weak economic

position contributes to their inability to negotiate for safer sex and leaves many of them having to engage in commercial and survival sex.

There are no organised services in Zambia to deal with people involved in commercial sex work. Girls from poor families are sometimes forced into early marriages or sexual arrangements in exchange for money or school equipment and thus become vulnerable to HIV infection.

The high prevalence of untreated STIs, sex with multiple partners and sexual activities at an early age render young girls vulnerable to HIV. According to the 1992 Zambia Demographic Health Survey, the median age of first intercourse is 16.3 years for women. Women with secondary education were found to begin sexual activity two years later than those with no education.

MOBILITY OF GROUPS

Specific groups are more vulnerable due to their mobility. These include refugees, long-distance truckers, migrant workers, cross-border traders, fish traders and security guards.

PRISON CONFINEMENT

Approximately 13,000 men and women are in Zambian prisons. Their vulnerability to HIV stems from unprotected sex, frequently from rape, the high prevalence of STIs and a very low and inconsistent use of condoms. (The law currently prohibits the distribution of condoms in prisons.) There is substantial evidence suggesting that penetrative and unprotected anal intercourse does occur in prisons. There are also delays in prisoners seeking access to medical services, thus delaying the diagnosis and treatment of STIs.

POVERTY

The relationship between HIV/AIDS and poverty is complex. The manifestations of HIV/AIDS lead to poverty, and the state of poverty directly or indirectly creates vulnerability to HIV/AIDS.

HIV/AIDS leads to poverty by eliminating the productive sector of society (15–45-year age group). More than 70% of Zambians fall below the poverty line and 90% of these are women.

HIV/AIDS has added urgency to the problem as it has greatly

worsened the poverty situation of the Zambian people. The cost of HIV/AIDS care is high as the disease is chronic. Households responsible for one or more persons with AIDS have to make extraordinary financial sacrifices to pay for care, treatment and funerals.

The high and unplanned expenditure strains health-care and household budgets, and accelerates both the poverty situation and the country's economic decline.

With 16% HIV national infection rates, Zambia is likely to lose a large share of its workforce, thus reducing the number of people able to pay taxes or provide family care.

INADEQUATE AND INAPPROPRIATE INFORMATION, EDUCATION AND COMMUNICATION

Some of the increased level of HIV infection must be due to the dissemination of information that is often not audience-specific or based on evidence. In addition, the communication methods are usually directives. People with different levels of ability or disability are often not catered for.

SILENCE, STIGMA AND DISCRIMINATION

Another reason for the continuing high prevalence of HIV/AIDS is the 'S-factor' (silence, stigma, shame), which leads to discrimination, denial and blaming others, thereby delaying action. Discussion of sex matters between parents and their children has been taboo, although this practice is slowly changing.

ZAMBIAN GOVERNMENT'S RESPONSES TO THE PANDEMIC

The Zambian government has responded to the pandemic with a series of planned interventions. A national response began with the establishment of a National AIDS Surveillance Programme in 1986, with assistance from the WHO. National management structures to spearhead effective responses to HIV/AIDS were also put in place but the programme remained cautious about discussing the crisis openly in public.

In 1987, as more evidence became available, the government prepared a national response to the crisis. Short- and medium-term plans were devised and launched. These plans were intended mainly to protect

blood transfusion services and promote public awareness of the HIV/AIDS threat.

The first medium-term programme (MTP) covered 1988–92 and prioritised eight areas, namely:

- tuberculosis (TB) and leprosy;
- information, education and communication (IEC);
- counselling;
- laboratory support;
- epidemiology and research;
- STIs and clinical care;
- programme management; and
- home-based care.

The wider dimensions of the crisis and the search for quick and direct solutions forced the government to strengthen its MTP by incorporating multi-sector responses.

The second MTP covered the period 1994–98. AIDS, TB and STIs were integrated and emphasis was placed on inter-sector approaches. Access to STI care, promoting the use of condoms, TB control and mitigation policies were stressed.

The second MTP was followed by the Zambia National HIV/AIDS Strategic Framework which covered the years 2001–2003. The framework established the National HIV/AIDS/STI/Tuberculosis Council and a corresponding Secretariat. The purpose of these institutions was to provide national and technical leadership in the fight against HIV/AIDS. A cabinet committee was appointed to provide political guidance.

The National AIDS Programme developed a core epidemiological surveillance and research system that includes national sentinel surveillance in antenatal clinics, local population-based surveys (with saliva-based HIV testing), hospital notification of AIDS cases, and small-scale research studies. Self-reported data on sexual behaviour and condom use are available from the national 1992 and 1996 Zambia Demographic Health Surveys.

To monitor the programmes, a mechanism for monitoring impact indicators through sentinel surveillance systems, population-based surveys, demographic and health surveys, and sexual behaviour surveys has been put in place. A programme management information system has been developed to facilitate the collection and analysis of information, including process and impact indicators.

In April 2004 Zambia adopted a Draft National Policy on HIV/AIDS/STI/TB. While the draft has still to be ratified by parliament, some parts of the policy are already being implemented. The policy covers most of the ministries. The Zambia Defence Force (ZDF) has a separate policy on HIV/AIDS.

POLICY ON HIV/AIDS

The policy on HIV/AIDS encompasses STIs and TB: STIs facilitate the transmission of HIV infection, while TB complicates the management of HIV/AIDS.

HIV INFECTION IN THE WORKPLACE

In April 2005 the Medical Council of Zambia adopted a set of principles and recommendations on HIV infection and health care in workplaces. These are intended to serve as a guide for organisations, employers and employees.

PRINCIPLES OF OCCUPATIONAL HEALTH

Before the issue of HIV infection in the workplace is addressed, health providers must take into account the following:

- Any component of an occupational health service programme may be considered essential if it is directed towards the protection or improvement of the health of the worker and is unlikely to be available in an adequate form from another source.
- A health surveillance programme should result in the effective prevention or treatment of disease or provide evidence about qualification for workers' compensation benefits.
- Pre-employment medical examinations or periodic health surveillance of employees, or both, are justified when employees are exposed to special hazards associated with their employment, when mandated by law or when the safety of the general public is an issue. HIV testing should be included as a routine component of medical examinations and there should be no discrimination against an employee based on his or her HIV status. However, the results of the HIV test should not

be communicated to the prospective employer. The person who has been examined should be advised to take appropriate action according to the results of the test.

- When evaluating the employee's ability to work, an employer should consider a disability or other condition significant only if the condition might adversely affect the worker's actual job performance or create a safety hazard to other employees and the general public.

EMPLOYMENT OF PEOPLE WITH HIV INFECTION OR AIDS

With the development of more effective treatments for HIV infection and related diseases, some workers with the infection now continue productive careers for many years. In general there is therefore no reason for an HIV-positive person to be restricted from any job in a field not related to health care. If people with HIV infection are physically and mentally well enough to perform their jobs effectively, they should be permitted to do so. Reasonable alternative working arrangements should be made if fitness for work is affected by an HIV-related illness.

Workers with HIV infection have the right to be protected against discrimination in the workplace. For example, there is no basis for insisting on separate washrooms for HIV-positive workers. Occasionally an employee infected with HIV may have a concurrent communicable disease such as TB. Once such conditions have been adequately treated the employee should be allowed to return to work.

EVALUATION

The policy on HIV/AIDS has been formulated and is now before parliament pending ratification. However, some parts of the draft policy have already been implemented and are being funded by the government and collaborating partners. Zambia has declared HIV/AIDS a national emergency in a bid to start manufacturing generic AIDS drugs under the World Trade Organisation (WTO). The government has since contracted a company (FACO) to manufacture generic drugs locally. This company is currently awaiting WHO certification. Voluntary counselling and testing (VCT) and antiretroviral therapy (ART) management centres have been established throughout the country.

The government started its ARV rollout only in 2004, with the intention of including 100,000 people in this programme by the end of

2005. More than 200,000 Zambians need to be on antiretrovirals (ARVs) but in 2005 only 26,000 people were receiving this therapy.

In the United Nations (UN) secretary-general's report to the General Assembly on HIV/AIDS in June 2005, Zambia was not one of the three African countries mentioned where more than 25% of those eligible for treatment were actually receiving it. (The three African countries were Botswana, Namibia and Uganda. Namibia started its rollout in August 2003, while Botswana and Uganda are in their fourth and seventh year respectively.) Zambia needs to quadruple its rollout of ARVs in order to achieve its 2005 target.

The government intends to finance its ARV programme through internal and external HIV/AIDS funding sources.

While the government had been providing ARVs through a cost-sharing scheme, with patients being required to contribute US\$8 each towards the medicines, it declared that from July 2005 it would provide free ARVs at all government hospitals.

Laboratories for monitoring HIV/AIDS using haematological, biochemical and immunological indices (CD4 count) have been established countrywide, while virological indices (viral load) are monitored in the virology reference laboratories at the University Teaching Hospital in Lusaka and at the Tropical Diseases Research Centre in Ndola.

With the help of non-governmental organisations (NGOs), churches and the private sector, the Zambian government has been able to carry out sensitisation seminars and workshops throughout the country.

While the vision and objectives of the government are clear, a lack of skilled health personnel, a shortage of materials for laboratory use and an erratic supply of ARVs threaten the effective management of HIV/AIDS patients.

The government has in its policy guidelines committed itself to protect workers from discrimination by virtue of their status. Laws are under way to deal with those who wilfully infect others. There is also a law reform programme to abolish customary and traditional laws that promote the spread of HIV/AIDS.

HIV/AIDS AND THE ZAMBIAN DEFENCE FORCE

The armed forces play a significant role in many societies. In addition to guaranteeing a nation's security, the military are a source of highly skilled and trained manpower. In some countries, high-ranking officers

play a leading role in political life and military personnel are seen as role models in their communities.

By the nature of their work, military personnel are especially vulnerable to HIV/AIDS, and like any other military in our region, the ZDF is one of the high-risk groups for HIV/AIDS.

The first cases of HIV were reported in 1985. Like any other country, the available data indicates that prevalence rates are higher among defence force personnel than in the population as a whole, giving the defence force greater experience of the pandemic.

Since 1983, more military personnel have been lost from AIDS-related conditions than from all the military operations, including the independence struggles. Deaths from HIV/AIDS have restricted troop deployment. The cost of looking after the sick due to HIV/AIDS is enormous. HIV treatment is itself very expensive. The high death rate from HIV/AIDS has led to reduced combat-readiness and national security.

In response to the HIV/AIDS pandemic, the ZDF has introduced programmes aimed at addressing various aspects of the pandemic. These include peer education, condom promotion and sensitisation workshops, which are aimed at reducing the spread of HIV infection and STIs among serving personnel, cadets and recruits. The ZDF has also had to consider human rights questions and the needs of those infected and affected by HIV/AIDS. Mitigating HIV/AIDS in the ZDF requires resources far in excess of those which the government can provide. The government has therefore provided an environment that will encourage the ZDF and collaborating partners to provide support in the fight against HIV/AIDS. Notable among the present collaborators are:

- *PEPFAR Fund*: This is the United States (US) Presidential Initiative Fund against HIV/AIDS.
- *ZANARA Project*: This is the World Bank Fund to Zambian ministries via the Ministry of Finance.
- *The Global Fund*: This operates through the Ministry of Finance and the Central Board of Health.

RISK FACTORS ASSOCIATED WITH THE MILITARY

Many words or names are used to describe members of the armed forces. Some call them soldiers, airmen, men or women in uniform, or members

of the defence force or armed forces. In reality, uniformed personnel are no different from the other members of the communities in which they live or which they serve. These men and women in uniform are human beings and as such are affected by the same HIV risk factors as everyone else. However, several factors place uniformed personnel at higher risk of contracting HIV and STIs than other segments of the population. These factors include the following:

- *Age:* The majority of military personnel are young and sexually active (in the 20–30-year age group). As the military environment encourages risk-taking, young men and women in uniform may take part in risky sexual behaviour, such as sex without using condoms.
- *High mobility:* Military personnel frequently travel away from home and mix with the civilian population both in peace and war time. This places members of the defence force at greater risk of contracting HIV and other STIs than the general population. Frequent travels take them away from their regular sexual partners. While some sexual activities may be consensual, in some instances they take the form of rape.
- *Financial superiority:* In some areas where these men and women serve, they are better paid than their civilian counterparts, giving them power and influence over their potential partners, which gives them easy access to sex.
- *Military uniform:* The military uniform is highly attractive and those who wear it are admired by civilian women and men.
- *Environment:* The conditions under which uniformed personnel live and work are often stressful and expose them to HIV and other STIs. Isolation and the knowledge that they could at any time be placed in the firing line can cause high stress in men and women in uniform, and the resultant desire to look for comfort in alcohol or casual sex.
- *Male chauvinism:* Militaries are enclosed societies where masculine values dominate. This may predispose service personnel to illicit sex.
- *Exchanging sex partners:* It is not unusual for different members of the military to have sex with the same partners, especially on operations or under the influence of alcohol. In militaries where research has

been done, high prevalence rates of HIV infection have been reported in civilian populations living near military installations or associated with the movements of the service personnel. Service personnel often have a limited choice of partners in some areas where they have been deployed. This may force personnel from the same unit to share available partners over a period of time. Even if only a small number of the military personnel or their partners were infected initially, unprotected sex and the sharing of partners leads to the spread of HIV and other STIs.

EFFECTS OF HIV/AIDS ON NATIONAL SECURITY

THREAT TO NATIONAL SECURITY

HIV/AIDS is a security threat as it compromises national security. The high rates of illness and death associated with HIV/AIDS reduce military readiness. This was reaffirmed by the Zambian Air Force commander in the *Daily Mail* of 9 August 2005 when he appeared before the Parliamentary Select Committee on Defence.

REDUCED RECRUITMENT POOL

As HIV/AIDS affects the civilian population as well, the human resource pool for recruitment by the military is reduced.

REDUCED MACROECONOMIC GROWTH

The loss of skilled human resources and the necessary switching of overall expenditure from investment to consumption reduce macroeconomic growth. The loss of man-hours through absenteeism—with large numbers of personnel attending funerals and going on prolonged sick leave—leads to decreased production. The loss of colleagues through death also lowers morale, which in turn has a negative effect on production.

INCREASED RECRUITMENT COSTS

The high illness and death rates associated with HIV/AIDS increase recruitment costs as more frequent recruitment is necessary to replace those who have died or who can no longer work.

INCREASED HEALTH COSTS

The high levels of illness from opportunistic diseases associated with HIV/AIDS increase medical and insurance costs through disability payments.

It is envisaged that as we understand more of the way the virus behaves, interacts with other diseases and manifests itself, and of how people learn to live with HIV/AIDS and how households and communities respond, feelings of hopelessness will be converted into optimism, empowerment and ultimately positive action.

THE ZDF'S RESPONSE TO HIV/AIDS

HIV/AIDS is no longer a health issue; but as health professionals, the ZDF has taken the lead by responding to the pandemic through the Defence Force Medical Services (DFMS) and establishing an HIV/AIDS programme in 1993. The HIV/AIDS coordinator is a member of the National AIDS Council. Despite the government's directive on forming HIV/AIDS programmes at places of work, the DFMS has had great difficulty in accessing resources to help in the fight against HIV/AIDS. The government policy at that time did provide for sourcing funds outside military circles. The cost of fighting HIV/AIDS requires resources on a scale that most governments in our region cannot raise on their own. As the Defence Act has not been amended for some time, it does not cover HIV/AIDS issues. Guidance is, however, now available on how to proceed on such issues as dealing with the intentional infection of others with HIV, which is punishable.

NATURAL REMEDY CENTRE

In order to mitigate the effects of the HIV/AIDS among its personnel, the DFMS opened a natural remedy centre in 1999, with the assistance of the British government. The aim of the centre is to manage HIV/AIDS patients by the use of potent natural remedies, hydrotherapy, physiotherapy and diet. Patients are usually admitted for a period of six weeks and followed up for a period of 12 weeks after discharge. The recovery rate (that is, the amelioration of symptoms and signs) of patients admitted to the centre was claimed at 80% at discharge. There is no available post-discharge data, as an evaluation of the programme is currently in progress. The cost of the tests required to monitor these patients at the centre has also been a restricting factor.

FEE PAYING SCHEME

Considering the high cost of managing and treating opportunistic infections, the ZDF has proposed the introduction of a fee-paying scheme for its personnel to replace the free medical service it now offers to its personnel and their dependants. This would reduce the influx of admissions to military hospitals as an alternative to government hospitals, which charge fees. There is also a belief that treatment at military hospitals is better than the treatment available at government institutions. This proposal is proving difficult to implement.

POLICY ON HIV/AIDS IN THE ZDF

A draft ZDF HIV policy was introduced only in May 2002. This policy is still awaiting ratification by the Defence Council. The vision, guiding principles, objectives and other elements of the draft policy are outlined below:

VISION, GUIDING PRINCIPLES AND OBJECTIVES

To have a combat-ready defence force free from HIV and AIDS.

AIM

The aim of the policy is to provide guidelines for dealing with HIV/AIDS. The situation should be dealt with humanely but without compromising combat-readiness.

GENERAL GUIDING PRINCIPLES

- HIV/AIDS is not only a serious public health or socio-economic problem affecting the defence force but also a national security problem that requires concerted effort by the DFMS as well as other departments and corps in the force.
- Provision of treatment, care and support is essential for reducing the social impact on all members of the defence force and their immediate families, and ultimately the nation.
- Provision of appropriate IEC material is central to effecting behavioural change to prevent and control HIV/AIDS.

- The formulation of a legal framework appropriate to the overall attainment of the vision should be initiated.

OBJECTIVES

The objectives of the policy are to:

- reduce sickness and death resulting from HIV/AIDS;
- recruit cadets and others who are HIV-negative, and to guard their HIV-negative status jealously so as to have a combat-ready defence force;
- provide appropriate treatment, care and support to the infected and affected;
- encourage and promote research into HIV/AIDS prevention and treatment;
- cushion the socio-economic impact on orphans, widows and widowers;
- provide a legal framework that will adequately cover the implementation of HIV prevention, care and support programmes;
- develop appropriate IEC material for all members of the ZDF; and
- encourage collaboration in the fight against HIV/AIDS between military and civilian establishments.

MEDICAL ASSESSMENTS

- All service personnel undergo a general medical assessment of fitness at annual intervals and whenever it becomes necessary.
- HIV testing is generally not carried out as part of the annual medical assessment.
- VCT is encouraged for members and their partners.
- HIV testing may, in consultation with the respective service

commanders, be conducted on service personnel going for courses abroad for more than two years.

- HIV testing is conducted on service personnel travelling to host countries requiring the test.
- HIV testing is conducted on personnel proceeding on UN missions. A positive test, however, does not bar one from proceeding on a mission, as long as one meets the set medical assessment criteria.
- HIV testing is carried out on any service personnel at any time for medical, legal or administrative reasons.
- Service personnel may be subjected to HIV testing at the discretion of the service command prior to certain appointments, promotions and courses.
- Service personnel such as military pilots, air crew and commandos are subjected to medical assessment according to appropriate standard protocols.
- All individuals with early symptomatic HIV disease, including abnormal blood tests, are excluded from their usual duties.
- Medical assessment results are kept confidential and restricted.
- All personnel found to be HIV-positive will, with their spouses or partners, undergo counselling and be admitted to HIV management programmes.

COMMANDOS

Excessive exercise accelerates the progression from asymptomatic HIV to AIDS.

In order for the ZDF to maintain a crack commando force and to protect HIV-positive members from deteriorating quickly to AIDS due to strenuous exercises, the defence force will:

- subject commandos to an annual medical examination, including an HIV test using the standard clinical protocol;

- redeploy HIV-positive members to less strenuous service in order to allow them to continue working; and
- conduct neurological examinations on members who show signs of neurological changes, paying particular attention to mental alertness and physical endurance.

MILITARY PILOTS AND AIR CREW

For the ZDF to ensure that its pilots maintain the highest standards required to operate sophisticated air transport and combat aircraft, personal fitness is a prerequisite. To this end, the defence force will:

- subject all pilots to annual medical examinations including an HIV test;
- subject HIV-positive pilots to a further independent medical evaluation using the standard clinical protocol in order to assess their suitability to fly;
- conduct epidemiological assessments (as is done with other cases) which may include records of sexual contacts and histories of blood transfusions or donations to determine the potential risks of HIV infection and transmission; and
- ensure that all aircrew members who test positive are evaluated semi-annually, following the standard protocol and the 1993 Centre for Disease Control (CDC) staging system for HIV infection.

INTERPRETATION OF RESULTS AND DISPOSITION OF PILOTS

Results of the prescribed evaluation shall be interpreted and disposed as follows:

- Pilots with the following findings shall be allowed to fly under close medical supervision and in multi-crew roles only:
 - asymptomatic aircrew: CDC clinical stage A1 and some cases of A2;
 - CD4+ cell count >350 cells/mm³;
 - HIV RNA <20,000 copies (RT-PCR); or
 - <10,000 copies (DNA test).

- Pilots falling in the following categories shall be debarred from all forms of flying duties:
 - symptomatic HIV infection;
 - CD4 = T cell count <350 cells/mm³;
 - HIV RNA viral load >20,000 copies/ml (RT-PCR); or
 - >10,000 copies/ml (DNA test).

DURATION OF TOURS OF DUTY

In order to reduce the chances of members being infected with HIV/AIDS during tours of duty, the ZDF will:

- ensure that members of the defence force spend not more than six months on any tour of duty;
- provide adequate protective materials, i.e. gloves, condoms, etc.; and
- provide trained counsellors and chaplains to accompany personnel on any tour of duty.

POLICY ON NEW RECRUITS/OFFICER CADETS

RECRUITMENT

HIV/AIDS guidelines in the ZDF state that recruitment shall always be based on established medical standards of fitness. These take into account the physical and mental fitness as well as the biochemical, haematological and microbiological fitness profiles of individual applicants.

The fitness examination is a comprehensive general and systematic medical assessment for each candidate, including serological tests for hepatitis, syphilis and HIV infection and pregnancy (females). All candidates who do not satisfy the established medical criteria for fitness are excluded from recruitment. Various pre-existing medical conditions will disqualify applicants and these include chronic infections (syphilis, hepatitis, HIV, TB, etc.), chronic degenerative conditions (diabetes, hypertension, heart disease, peptic ulcers, etc.) and mental illnesses.

Available data indicates that HIV/AIDS may occur with an increased frequency among members of the military. Recruitment of already HIV-infected individuals into the military does not, therefore, make any public

health sense. There are various other reasons peculiar to the military for excluding from recruitment individuals who are HIV-positive.

SOME REASONS FOR EXCLUDING HIV-POSITIVE APPLICANTS

HIV infection, like syphilis, hepatitis, TB and other medical conditions, is chronic and progressive. HIV infection should therefore be regarded in the same way as other medical conditions including hypertension, diabetes, asthma, peptic ulcer disease and others that disqualify candidates from recruitment.

- Although the effects of strenuous training on asymptomatic HIV infection are not yet well documented, there is a possibility that HIV infection, like other medical conditions, will be accelerated under strenuous military training conditions. Training of recruits for a prolonged period is without doubt stressful. Training takes place day and night with lack of adequate sleep and rest, and often in cold, wet, hot, dry and dusty conditions. There is often endurance training, with water and food deprivation, leading to mental and physical exhaustion. These conditions predispose recruits to repeated respiratory infections, diarrhoea episodes, skin infections and dehydration. These conditions will undoubtedly unmask various 'silent' medical conditions and might even lead to a medical crisis and eventual death. Reason therefore dictates that all applicants with certain pre-existing medical conditions should be excluded from recruitment.
- Pre-existing medical conditions, including HIV infection, would incur high military and medical costs during and after training. In the case of HIV-positive recruits, this would entail frequent counselling sessions, regular CD4 and viral load estimations and other blood tests, and, inevitably, provision of ARV drugs, prophylactic drugs against opportunistic infections and nutritional supplements. Eventually these individuals would have to be redeployed in selected duties according to the level of their fitness and they would probably require frequent sick leave. There would be a great cost to the government in maintaining HIV-positive recruits. This does not make economic sense.
- HIV-infected individuals who get injured in battle and other operational duties will bleed and might infect other combatants who are obliged to offer first-aid support to the injured.

- HIV-infected individuals could die from live virus immunisations required of combatants. This would mean excluding HIV-infected recruits from receiving live virus vaccines at the expense of contracting diseases during various tours of duty after recruit training.
- HIV-positive individuals will not be able to assist others in battle as blood donors for those who are critically injured.

PROTECTION OF HIV-POSITIVE CANDIDATES

Pre-test group counselling of applicants will be conducted by qualified counsellors at recruitment centres in order to inform applicants about HIV testing and giving of consent so that they can make an informed choice.

Reasons for disqualifying an applicant shall only be revealed to the applicant on a need-to-know basis. In case of an HIV-positive result, one-on-one post-test counselling will be carried out in order to enable the applicant to seek further medical attention.

HIV-positive results for applicants will be kept confidential and will not be disclosed to any other personnel except those who need to know the results for medical, legal and administrative reasons.

SENSITISATION OF RECRUITS AND OTHER TRAINEES

All trainees are sensitised during training on the need to protect themselves against HIV infection in order to remain HIV-negative as future combatants. All trainees are issued with IEC material on HIV/AIDS. Condoms and other barrier methods against HIV infection are provided to trainees without charge. All recruits and trainees continue to be medically monitored during their training, and those found to be unfit are excluded from further training.

Counselling services are made available at all training establishments for recruits and other trainees. The training centre leadership and course instructors are all sensitised on HIV/AIDS, and education on HIV/AIDS is included in the training programmes.

POLICY ON HIV-POSITIVE SERVING PERSONNEL

Existing rules are in force for serving members regarding incapacity, when members of the ZDF are medically unable to continue in the job

in which they are employed. Members who test HIV-positive may, if necessary, be reassigned to duties appropriate to their level of fitness.

HIV-positive individuals having received appropriate counselling have a choice whether to be withdrawn from service and to be retired on medical grounds. In cases of personnel members' mental incapacity, spouses or relatives may choose to have their family member withdrawn from service on medical grounds.

Incapacitated service personnel are referred for a medical board evaluation on the recommendation of health personnel, unit commanders or, in cases of mental incapacity, the personnel members' family or relatives.

A medical board evaluation is conducted according to the existing rules. Service personnel retired on medical grounds continue to receive medical treatment according to existing administrative regulations and resources.

PROTECTION OF HIV-POSITIVE SERVING PERSONNEL

HIV-positive personnel are not stigmatised or discriminated against in their workplaces or barracks. They are encouraged to live constructive lives and they are allowed to take part in all social and military events according to their level of fitness.

Disclosure of a service member's HIV status is to be limited to only those persons who have a medical, legal or administrative need to know about the medical condition in the performance of the member's duties. However, individuals are encouraged to disclose their status. The recipient of such information on the need-to-know basis is obliged to protect such information against unnecessary further disclosure. HIV-positive results cannot be used as the basis for an adverse administrative or disciplinary action.

Information obtained from service members in an epidemiologic assessment, research or clinical interviews cannot be used in evidence against that member in a court martial, non-judicial punishment, involuntary administrative discharge procedure or line-of-duty determination, or as an unfavourable entry in personal records.

PROTECTION OF HIV-NEGATIVE SERVICE PERSONNEL

HIV-negative service personnel are in the majority and therefore form an important segment of combatants. The ZDF has put measures in

place to protect these combatants from being HIV-infected. This is because these HIV-negative individuals, like any other service personnel, are exposed to the same risk factors for HIV transmission despite receiving adequate prior counselling.

If HIV-infected individuals are not able to complete their term of service, there will be a wasted investment in such individuals. As earlier mentioned, high attrition rates of service personnel due to the effects of HIV infection will lead to frequent recruitment programmes by the government at high cost.

PREVENTIVE MEASURES

Measures taken to prevent further infections include:

- VCT facilities at all levels;
- the provision of appropriate preventive measures, including IEC material, sensitisation workshops and the availability of condoms in workplaces, barracks, training establishments and operational areas;
- the promotion of early diagnosis and proper treatment of STIs; and
- the provision of a living and working environment that reduces the vulnerability of members and spouses to HIV infection.

OTHER MEASURES

Other measure taken concerning HIV-positive service members in order to protect HIV-negative service personnel include the following:

- HIV-positive individuals are encouraged to live constructive lives and to take active roles in the fight against HIV/AIDS as peer educators, psycho-social counsellors and the like.
- HIV-positive individuals may not donate blood, body fluids or other tissues to others.
- HIV-positive members are, after counselling, encouraged or obliged to inform health workers and unit commanders about their HIV status. In this way, they will be able to be adequately provided for in

all respects; and measures can be taken to protect health workers and fellow combatants in case of injury during military exercises and operations.

- Service personnel and dependants who are HIV-positive, and who wilfully and knowingly pass on the HIV infection to others through sex or other means, are liable to face disciplinary action and possible prosecution.
- HIV-positive service members are encouraged to disclose their HIV status on moral grounds to their spouses, partners and those to whom they are engaged through a trained counsellor, to allow their partners to make an informed choice.
- Service members intending to marry are counselled and are encouraged to undergo HIV testing to establish their immune status and that of their partners’.

CIVILIAN EMPLOYEES IN THE MILITARY

Civilian employees in the military are non-combatants. However, both the ZDF and these civilians have an obligation to fight against the spread of HIV infection in the workplace and in their residential areas. However:

- no HIV testing is conducted when civilians are recruited, except at their own request during medical examinations;
- counselling services on a voluntary basis are made available to all civilian employees in the workplace;
- sensitisation on HIV/AIDS, IEC material, condoms and other preventive measures are made available to civilians;
- like military personnel, HIV-positive civilian workers are not stigmatised or discriminated against in their workplaces or residential areas, and are redeployed according to their levels of fitness;
- chronically ill civilians are referred for medical board evaluation at public health (Ministry of Health) institutions; and

- civilians may take part in peer education, counselling, ARV management, home-based care and related activities.

POLICY ON RETIRED HIV-POSITIVE PERSONNEL

Members retired on medical grounds will continue to receive medication. Care for partners, children, widows, widowers and orphans will be provided within the resources available.

OTHER PROGRAMMES TO CONTROL HIV/AIDS

With the help of collaborating partners, the ZDF has been able to bring awareness of the dangers of HIV/AIDS to employees through health education and the promotion of preventive and behavioural change activities.

These are conducted through sensitisation campaigns and workshops, drama presentations and the distribution of IEC material. Each military base has home-based care and VCT centres.

A mobile drama group visits defence units to carry out sensitisation campaigns.

Condom promotion is an ongoing process. Condoms are supplied as part of the military kit when troops are going on operations. Condoms are placed in all toilets and on bar counters at all barracks. The ZDF has also produced some IEC material in the form of videos and audio tapes, CDs, pins, chitenje material, T-shirts and caps.

TRAINING OF PERSONNEL

In order to ensure that the HIV/AIDS programme is efficient and sustainable, the ZDF has trained and appointed the following personnel in all its units:

- psycho-social counsellors;
- peer educators;
- ARV managers;
- STI managers;
- home-based care givers;
- lab assistants;
- train-the-trainer counsellors; and
- train-the-trainer peer educators and counsellor supervisors.

OVC PROGRAMME

The ZDF is in the process of setting up an orphans and other vulnerable children (OVC) programme that will run parallel to the HIV/AIDS programme. This is in recognition of the swelling numbers of orphans and vulnerable persons as a result of HIV/AIDS.

The implications of these increasing numbers of orphans are that these children will grow up without parental care and love. This will deprive them of their basic rights to shelter, food, health and education. Emotional distress is worsened by being separated from other siblings. Also, if the orphans are not well handled, they may constitute a reservoir of criminals.

The ZDF is convinced that despite their traumatic experiences, these orphans can still have safe, healthy and productive childhoods if the communities respond with immediate, coordinated and sustained efforts to protect them and their families.

PROVISION OF ARVs

The ZDF has used highly active antiretroviral therapy (HAART) since 2000 in the management and control of HIV/AIDS and has established ARV management centres at all its barracks. It has made strides in providing free ARV therapy. Each unit has trained paramedic nurses, while a few have medical officers trained in HIV management.

HIV testing in the ZDF is mandatory on recruitment and voluntary in serving personnel. All officers and men are counselled before and after testing. Those who test HIV-positive undergo further medical evaluation. If they meet the criteria, they are advised to start HAART, while those who do not meet the criteria are followed up and reviewed every three months in the HAART clinic. They are counselled and encouraged to live constructive lives. Stable HIV-positive military personnel proceeding on UN duties continue their treatment with the contingent medical officer. Observers and staff officers review this programme from the home base every three months. So far the programme has worked well.

LABORATORY SUPPORT AND ARV MANAGEMENT

The US government has, through its PEPFAR fund, helped with the establishment of a modern laboratory at the referral hospital for monitoring HIV/AIDS patients. However, this aid did not include a

continuing supply of materials, with the result that reagents are frequently not available and clinicians have to depend on less reliable immunological indicators. While this laboratory has strengthened the HAART programme, the ZDF has to secure funds to cover other areas not catered for.

EVALUATION

The ZDF has introduced policies and programmes for recruitment, training, utilisation, counselling, treatment, medical retirement and post-retirement care. These programmes are, however, still being implemented and have not yet been evaluated. The ZDF has pioneered the fight against HIV/AIDS and the DFMS rolled out HAART and realised the extent of the pandemic before the government.

A study carried out in the ZDF revealed that HIV/AIDS is widely perceived as a major cause of chronic ill health. Some 89% of service personnel know about VCT and 69% know of such a centre in their barracks. Some 63% have shown willingness to test voluntarily in the near future, while 92% say it is not embarrassing to buy condoms and 88% believe that using condoms shows care for one's partner. Some 78% know of the modes of transmission of HIV infection and over 95% know that STIs increase the risk of HIV infection.

This is an indication that public health campaigns are being understood. But these messages are yet to be turned into practice, which seems to be the biggest battle in the HIV/AIDS campaign.

More soldiers have now offered themselves for ART management; the ZDF has made strides in providing free ARVs. As from July 2005 the ZDF has been able to access ARVs from the Ministry of Health. The Ministry of Health source has, however, not been very reliable—even in their own hospitals.

The US government has helped with the training of doctors, nurses and paramedical staff in the management of HIV/AIDS.

CONCLUSION

The DFMS has made great strides, within the available resources, to combat HIV/AIDS among service personnel, although much more still remains to be done. Mainstreaming the disease into the daily life of the ZDF has not been easy, as the topic still elicits feelings of fatalism, hopelessness and despair, fear, prejudice and denial of illnesses and

deaths of one's colleagues. In addition, the DFMS is still grappling with the issue of attitudes.

While the majority of ZDF officers and men know about HIV and AIDS, there are major differences between understanding, and attitudes and practice. These issues have to be dealt with as soon as possible as they have negative effects on the fight against the pandemic.

The Zambian government has provided an environment in the ZDF that is conducive for collaboration between the ZDF and donor partners in the fight against HIV/AIDS. It is envisaged that the government will continue to encourage donor and sponsoring partners to provide resources for the fight against HIV/AIDS in the defence force.

The ZDF has embarked on recruiting HIV-negative military personnel; there is continued health education and counselling programmes in order to ensure that recruits and cadets remain HIV-negative. HIV-positive serving personnel are not stigmatised and segregated.

Infected personnel who do not meet the established medical standards of fitness are redeployed for administrative or other non-strenuous duties. Civilian employees are not subjected to HIV testing on recruitment, and guidelines provide for care of civilian employees in the military or any competent civil authority.

ART is made available free to all serving and retired personnel and their families. Nutritional supplements are also made available. The ZDF covers the cost of laboratory monitoring of its personnel on ART.

The policy on HIV/AIDS is comprehensive, but implementation of the policies will require concerted and multi-sector approaches. Implementation may be inhibited by the lack of trained and skilled manpower.

The country as a whole has a shortage of doctors, paramedical staff and nurses, especially as many of its skilled people have left Zambia for better paying jobs in Botswana, South Africa and Western countries. However, on 3 August 2005 the President of Zambia directed the ministries of Health and Education to work with trade unions to find solutions to the brain-drain problem. Without skilled manpower, Zambia will not be able to achieve its Millennium Development Goals for HIV/AIDS.

RECOMMENDATIONS

- Sensitisation of the top leadership in the ZDF is required.

- Intensive education among service personnel on HIV/AIDS, its impact and implications is needed.
- Law reforms are needed that do away with negative cultural and traditional practices such as dry sex and widow/widower cleansing.
- The government should continue encouraging international and other collaborating partners to provide resources for the fight against HIV/AIDS in the ZDF.
- The government should increase its own resources as a contribution towards mitigating the impact of HIV/AIDS, and to sustain some activities being carried out in the ZDF.
- Education and economic empowerment of women and girls is required.
- Couple counselling should be encouraged among service personnel found to be HIV-positive.
- The Defence Act should be amended to deal with serving personnel who wilfully infect others with HIV.
- A policy statement on how to deal with retired service personnel is required.
- Social and recreational facilities in ZDF barracks and operational areas should be increased.
- Basic training in HIV/AIDS should be provided for all medical personnel and auxiliary staff.
- HIV/AIDS should be incorporated in first-aid drills for troops and recruits.
- Separate funding is needed for laboratory support materials and ARVs in order to ensure the constant supply of reagents and ARVs.
- In the absence of medical officers, the government should train more nurses and paramedics in the management of HIV/AIDS.

- Troops require adequate blood supplies during operations.
- Poor families should receive government assistance for their school-going children through the Ministry of Social Welfare and Ministry of Education.
- Social and recreational facilities in prisons should be increased.
- Stiffer penalties are needed for prisoners who perpetrate sodomy while serving their sentences.
- The age of consent for sex should be increased to 18 years old.

NOTES

- 1 Central Statistical Office (CSO), 2000.
- 2 Zambian National Census, 2000.
- 3 Government of the Republic of Zambia, 2000.
- 4 CSO, op cit.
- 5 Zambian Poverty Reduction Strategy Paper, 2002.
- 6 Ibid.
- 7 Zambian Demographic Health Survey, 2001-2002.
- 8 UNAIDS Report, 2002.
- 9 Ibid.

PART II

CIVIL SOCIETY PERSPECTIVES

Implementation of the Tanzanian National Policy on HIV/AIDS in relation to the defence sector

Jonathan Mutayoba Kakulu Lwehabura and
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INTRODUCTION

The Centre for Strategic and International Studies in the United States (US) notes that:

HIV/AIDS affects the institutions that guarantee national security and safeguard the international systems as a whole . . . HIV/AIDS can be so pervasive that it assaults, as surely as prolonged conflict, the essence of the nation state: to secure families, communities, economic and political institutions, [the] military and police force.¹

The Tanzanian defence sector is an important sector as far as national defence is concerned. Tanzania, having an HIV prevalence of about 12% of the adult sexually active population (15–49 years old), is ranked as one of the developing countries facing a serious HIV/AIDS epidemic, with an already noticeable negative impact on people-centred development.²

The World Bank estimated that the average real gross domestic product growth rate for the 1985–2010 period could drop from 3.9% without AIDS to 2.8%–3.3% with AIDS.³ These are serious economic implications for Tanzania. More specifically, the infection is resulting in reduced productivity, a loss of skilled workers and other socio-economic impacts. A rise in the infection prevalence of HIV/AIDS in the defence sector threatens the national defence system as it reduces the availability of much needed human, social and physical capital.

The impact of HIV/AIDS in Tanzania has been felt across all major sectors including the defence sector. HIV/AIDS has caused a significant increase in the sickness rate of adults and children. An increased mortality rate was estimated to have reduced the life expectancy of Tanzanians from the previous 56 years to 47 years by the year 2004.⁴ The increased adult mortality rate has resulted in a rapid increase in the proportion of children under 15 years of age who are orphans. By 2005, it was estimated that some 2.1 million children in the country had no parents compared to a figure of 1.5 million in 1996.⁵

The defence sector has been seriously affected by the HIV/AIDS pandemic since the war with Uganda in 1983.

In the light of the predicament facing the country, the head of state, President Mkapa, declared in his New Year message for 2000 that the HIV/AIDS epidemic “is a national disaster”. He called on the entire nation, including the government, the defence and security organs of the state, political, religious and civil leaders and non-governmental organisations (NGOs) to accept that important new measures were required to fight the long war against HIV/AIDS.⁶

In response to President Mkapa’s call and the continuing spread of the virus, Tanzania, in collaboration with all its development partners, started intensifying the effort to combat the pandemic. HIV/AIDS now ranks among the top government priorities.

The approach being promoted by the government is frankness and openness about HIV/AIDS, and prevention through capacity-building and empowerment of the people, including the defence sector families and individuals, to respond to the challenges and threats posed by the pandemic. This broad national response is guided and directed by the National Multi-Sectoral Strategic Framework (NMSSF) on HIV/AIDS, which is itself based on the November 2001 National HIV/AIDS Policy.⁷

BRIEF ON TANZANIA DEMOGRAPHY

Tanzania is a united republic comprising Tanzania Mainland and Zanzibar. It has a total area of 945,087 km². According to the 2002 census,⁸ Tanzania then had a population of some 34.4 million, with all but slightly less than one million of this population living in Zanzibar. With an annual population growth rate of approximately 1.83%, Tanzania had an estimated population of 36.8 million in 2005.⁹

It is worth noting that the 2005 estimate takes into account the higher death rate due to AIDS. This has resulted in a lower life expectancy at

birth (45.24 years), higher infant mortality (98.4 deaths/1,000 live births), a higher death rate (16.71 deaths/1,000 population), and a lower population growth rate.¹⁰ There is also a change in the distribution of population by age and sex than would otherwise have been expected.¹¹

OUTLINE

This report has been structured to include a short introduction highlighting the reasons that made the Tanzanian president declare a protracted war on the HIV/AIDS pandemic and a short brief of Tanzania demography. The problem statement and relevance of the study have been presented to ascertain why self-knowledge on the pandemic is essential in the battle that ensues.

The aims and objectives of the study have been clearly indicated as a pragmatic guide to the researchers in tracking needed data. Methods deployed in the study have been clearly indicated. Limitations during the study have been indicated to justify areas where data collection was impeded or not well elaborated to meet the needs of researchers.

The findings section dwells more on the national responses to HIV/AIDS, including the establishment of the:

- National AIDS Control Programme (NACP);
- Tanzania Commission for AIDS (TACAIDS);
- promulgation of the National Policy on HIV/AIDS (including an emphasis on the policy's objectives related to the defence sector);
- formulation of the NMSSF on HIV/AIDS (and its implementation in relation to the defence sector); and
- Monitoring and Evaluation Framework for HIV/AIDS. (The section on the defence sector employment policy on recruitment of military staff in relation to HIV prevention [p 145] notes that despite the defence sector being part of the overall implementation of the National Policy where HIV testing is voluntary, the testing of HIV/AIDS for military recruits is mandatory).

For the purpose of care and counselling of people living with HIV/AIDS (PLHA), the military and other security sector services—such as the police,

prisons, national security and intelligence forces—are better off in terms of resource provision than are other sectors of the Tanzanian society.

The report ends with a summary of key issues and recommendations that arose from the study findings. Its conclusion is that both the National Policy on HIV/AIDS and the NMSSF on HIV/AIDS need to be implemented for the pandemic to be counteracted. The report calls on the military to join hands with all Tanzanians in the struggle for survival.

RELEVANCE OF THE STUDY

Tanzania is considered as one of the poorest countries in the world, with more than 51% of its population having an average income falling 16% below the national poverty line and with 36% living on less than US\$1 a day.¹² HIV/AIDS has continued to be a threat to the lives of Tanzanians—men, women and children. The disease has had a tremendous impact on the Tanzanian economy generally as it affects the development process by its impact on households.

The implementation of the National Policy on HIV/AIDS in the defence sector has been taken as a point of special reference due to this sector's influential position in Tanzanian society.

AIMS AND OBJECTIVES OF THE STUDY

The study aims to provide an understanding of how the defence force has responded to the HIV/AIDS pandemic through documenting different national responses. The process relied on documenting shared experiences and policies crafted to combat the HIV/AIDS pandemic since its advent in Tanzania in 1984.¹³ The study focused on:

- reviewing and isolating elements of legislation that relate to HIV/AIDS and the defence sector contained in existing Tanzania National HIV/AIDS Policy documents;
- documenting related defence sector HIV/AIDS policies for recruits;
- evaluating policies adopted for those already in service but found to be suffering from HIV/AIDS;
- critically examining policies in place regarding personnel who have left the defence force but who are victims of the disease; and

- reflecting on particular or unique features and policies—ranging from culture, religious beliefs, ethnicity and other influences on sexual practice—as well as on ways of handling HIV/AIDS-related matters in the defence force, which was the sector covered by this research.

HISTORICAL BACKGROUND AND MAGNITUDE OF THE HIV/AIDS EPIDEMIC: GLOBALLY AND IN AFRICA

The history of HIV/AIDS can be traced back to 1976–79 when unrecognised cases of AIDS in humans appeared in the US.¹⁴ At that time, the Tanzanian military and a large number of militia were engaged in a war against Idi Amin in neighbouring Uganda.

The first three cases of HIV/AIDS in Tanzania were reported in 1983 in the Kagera Region, which borders Uganda.¹⁵ Since then the epidemic has spread among all sectors of Tanzanian society. The military and other security sectors have been severely affected. It is believed that military personnel contracted HIV/AIDS during the 1979–84 wars with Uganda.¹⁶

At first, the disease was not identified. Due to wasting of the patient's body, it was called 'Slim disease' or 'Juliana disease' (referring to the tight blouse that was worn by slender girls in the northern part of Tanzania bordering Uganda). The initial 'discovery' soon spread. Within 20 years (1983–2003) some 151,000 AIDS cases were reported through the health services. However, given the sparse nature of available medical infrastructure in the country, there is a strong possibility that up to 80% of cases were not reported.¹⁷

Since this period, the medical infrastructure of clinics and hospitals has been overwhelmed by AIDS-related cases. Part of the manifestation of the situation above is revealed in community-based mortality reports established by the Ministry of Health, which have shown that HIV/AIDS is the leading cause of adult mortality in both urban and rural areas.¹⁸

Table 1 (*over page*) shows HIV/AIDS estimates for Tanzania from 1996–2006. The figures show that the population infected with HIV/AIDS is expected to increase from 1.6 million in 1996 to 1.9 million in 2006, with the adult prevalence percentage decreasing from 10.5% in 1996 to 9.2% in 2006. New cases are expected to increase from an annual figure of some 143,000 in 1996 to some 189,000 in 2006.

Annual HIV-positive births are expected to decrease from 3.56% in 1996 to 3.17% in 2006. Annual AIDS deaths are expected to increase from 4.23/1,000 in 1996 to 5.01/1,000 in 2006, while adult HIV

incidence is expected to remain approximately static—that is, 1.49% in 2006 compared to 1.50% in 1996.

Table 2 shows the age and gender breakdown of cumulative AIDS cases between 1987 and 2003. The figures show that males generally have a higher prevalence than females in Tanzania, particularly for the

Table 1: HIV/AIDS estimates in population (thousands), 1996–2006

	1996	1998	2000	2002	2004	2006
Total	1,660	1,720	1,750	1,780	1,840	1,910
Males	760	800	810	830	860	900
Females	900	930	940	950	980	1,020
Adult prevalence (%)	10.51	10.21	9.8	9.48	9.29	9.22
New AIDS cases						
Total	142,990	167,510	181,710	187,220	188,140	189,660
Males	70,640	80,170	85,800	887,330	90.45	92,240
Females	72,360	87,340	95,910	98,490	97,690	96,930
Annual HIV+ births						
Total	46,430	46,280	44,960	43,900	43,310	43,350
(%)	3.56	3.47	3.35	3.25	3.19	3.17
Annual AIDS deaths						
Total	128,480	157,250	176,350	185,280	187,350	187,470
Males	64,780	76,260	83,570	87,420	89,300	90,75
Females	63,700	80,980	92,780	97,860	98,040	96,720
Per 1,000	4.23	4.94	5.30	5.35	5.20	5.01
Cumulative AIDS deaths (thousands)						
Total	610	910	1,260	1,620	2,000	2,370
Males	330	470	640	810	990	1,170
Females	280	440	620	810	1,010	1,200
Adult HIV incidence (%)						
	1.50	1.43	1.45	1.48	1.50	1.49
Annual new TB cases						
	100,430	104,240	107,260	110,760	115,350	121,110

Source: URT/MOH/National AIDS Control Programme: HIV/AIDS/STI Surveillance Report No.18, October 2004, p 27.

Table 2: Age and sex-specific case rate of cumulative cases, 1987–2003

Age	MALE				FEMALE			
	Cases	%	Population (2003)	Case rate*	Cases	%	Population (2003)	Case rate*
0-4	2,809	4.3	2,832,886	99.2	2,514	3.6	2,837,999	88.6
5-9	741	1.1	2,572,790	28.8	734	1.1	2,554,935	28.7
10-14	372	0.6	2,228,621	16.7	460	0.7	2,205,799	20.9
15-19	1,065	1.6	1,759,602	60.5	3,186	4.6	1,830,818	174
20-24	4,893	7.5	1,399,702	349.6	11,574	16.7	1,747,362	662.4
25-29	11,335	17.4	1,309,018	865.9	15,952	23.1	1,491,777	1,069.3
30-34	13,473	20.7	1,088,566	1,237.7	13,487	19.5	1,139,713	1,183.4
35-39	10,361	15.9	822,482	1,259.7	8,541	12.4	842,022	1,014.3
40-44	7,225	11.1	668,480	1,080.8	4,509	6.5	677,466	665.6
45-49	4,310	6.6	477,556	902.5	2,332	3.4	506,461	460.1
50-54	2,324	3.6	428,286	542.6	1,158	1.7	455,239	254.4
55-59	1,142	1.8	290,436	393.2	524	0.8	301,929	173.6
60-64	707	1.1	287,582	245.8	316	0.5	318,157	99.3
65+	525	0.8	657,130	79.9	227	0.3	699,027	32.5
Unknown	3,717	5.7			3,598	5.2		
Total	64,999	100	16,823,136	386.4	69,112	100	17,609,106	392.5

*Case rate = cases/100,000 population

Source: URT/MOH/National AIDS Control Programme: HIV/AIDS/STI Surveillance Report No.18, October 2004, p 4.

Table 3: HIV-positive prevalence of the adult sexually active population, 1991–2003

Age	1991	1993	1995	1997	1999	2001	2003
15-19	3.2	3.9	5.3	4.5	5.4	5.9	4.8
20-24	5.0	5.8	5.8	4.9	7.0	8.5	6.3
25-29	6.7	6.1	7.2	7.2	8.8	10.4	8.2
30-34	6.4	6.2	7.7	7.3	10.0	11.2	9.5
35-39	6.1	6.5	7.8	7.4	9.9	12.3	9.9
40-44	4.8	5.1	5.9	6.6	9.9	11.2	9.3
45-49	4.5	4.9	5.8	5.8	8.5	10.6	8.6
50-54	4.4	4.3	3.5	4.8	7.7	9.3	7.2
55+	4.0	5.2	2.5	5.9	5.5	7.6	6.7
Total	5.8	5.9	6.7	6.0	8.7	10.3	8.2

Source: URT/MOH/National AIDS Control Programme: HIV/AIDS/STI Surveillance Report No.18, October 2004, p 14.

age groups 30 years and above. Higher rates for both sexes are in the age group 24–44 years.

Table 3 shows an HIV-positive prevalence of about 12% of the adult sexually active population (15–49-years). This scenario makes Tanzania a country with one of highest incidences of the HIV/AIDS pandemic, with an already noticeable negative impact on the development of the country.

The impact of HIV/AIDS in Tanzania has been felt across all sectors, including the military. HIV/AIDS has caused significant increases in the rates of sickness and death in both adults and children.¹⁹ It was not possible to obtain actual figures from the military both due to a strict compartmentalisation of information and because monitoring and evaluation procedures, which are currently being introduced, were not then available.

Table 4 shows that an estimated 2,080,000 children had no parents by 2005, compared to the figure of 1,480,000 in 1996.

In Tanzania HIV/AIDS has had significant impact on health-care provision. It is now estimated that about half the hospital beds in the country are occupied by HIV/AIDS patients. This has put pressure on the meagre resources allocated for health care. The demand for medicines has increased tremendously. The previous successes of the

Table 4: Estimated cause and type-specific orphans, 1996–2006

Year	Maternal AIDS	Paternal AIDS	Dual AIDS	All AIDS	Total orphans (all causes) (thousands)
1996	255,500	282,780	265,770	272,520	1,480
1997	320,710	338,770	328,100	331,380	1,560
1998	389,020	394,750	392,560	391,210	1,640
1999	457,260	448,680	455,940	450,000	1,720
2000	522,200	498,660	514,660	506,200	1,800
2001	580,880	543,320	565,890	558,310	1,870
2002	631,050	381,620	607,850	604,820	1,940
2003	671,400	613,150	639,590	644,950	1,990
2004	701,640	637,980	661,210	678,410	2,040
2005	722,390	656,550	673,740	705,190	2,080
2006	734,840	669,460	678,860	725,450	2,110

Source: URT/MOH/National AIDS Control Programme: HIV/AIDS/STI Surveillance Report No.18, October 2004, p 29.

national tuberculosis (TB) campaign are being challenged by an increase in the number of TB patients. The economic impact of HIV/AIDS is difficult to assess because it involves multiple variables.

TRENDS IN THE NATIONAL RESPONSE TO HIV/AIDS

ESTABLISHMENT OF THE NATIONAL AIDS CONTROL PROGRAMME (NACP)

In response to the HIV/AIDS pandemic, the government of Tanzania formed, with technical support from the World Health Organisation's Global Programme on AIDS (WHO-GPA), the NACP under the Ministry of Health. The NACP formulated a short-term plan (1985–86) and three subsequent five-year plans (1987–91, 1992–96, and 1998–2002).

Initially HIV/AIDS was perceived as a health problem and the campaign to deal with it involved the health sector only through the NACP. The Tanzania national response comprised the development of strategies to prevent, control and mitigate the impact of the HIV/AIDS pandemic through health education, multi-sector responses and community participation.²⁰ The military became heavily involved because of the increasing HIV/AIDS prevalence in its ranks.

Qualitatively, however, the responses under the NACP have not had much impact. This is because the national response was initially constrained by factors such as inadequate human and financial resources, ineffective coordination mechanisms and inadequate political commitment and leadership.²¹ To overcome these shortcomings, a wider sectoral response was suggested. This included priority areas such as poverty alleviation and improvements in health, education and other social areas. As emphasised in the 2001 Policy on HIV/AIDS document, this response seeks to engage all sectors, including the defence sector, in participating actively in the implementation of HIV/AIDS programmes.²²

ESTABLISHMENT OF THE TANZANIA COMMISSION FOR AIDS (TACAIDS)

A February 2001 Act of Parliament²³ established TACAIDS under the Prime Minister's Office to facilitate and strengthen the expanded response to the pandemic. At this time, it was felt that the special department located in the Ministry of Health had insufficient capacity. As a result, this departmental activity was upgraded to a national programme, TACAIDS.

TACAIDS provides strategic leadership, national focus, the ability to leverage both local and external resources, coordination, and monitoring and evaluation of the national response for all sectors, including the defence sector. TACAIDS is therefore the main guardian of the NMSSF on HIV/AIDS (2003–07). TACAIDS also provides policy motivation for a sectoral approach, without giving the final nuts and bolts of such policies.

Since the establishment of TACAIDS, the defence sector, other security sectors and other civil society organisations (CSOs) have responded by developing or expanding their own HIV/AIDS programmes in line with the National Policy on HIV/AIDS.²⁴ Most of these, however, have not been able to come up with sector-specific policies.

Part of the explanation may lie in the fact that, globally, the threat is new, and yet in the developed world—which provides most of the institutional and governance examples we have borrowed—HIV/AIDS has remained a public health issue. Because this has not necessarily threatened national security or the integrity of military institutions, attention and priority of HIV/AIDS in the military has been relegated to a minor position with detrimental effects on emerging democracies and states, many of which are on the African continent.

PROMULGATION OF THE NATIONAL POLICY ON HIV/AIDS: ELEMENTS THAT RELATE TO THE MILITARY

Tanzania has only one specific national policy on HIV/AIDS that caters for all sectors in terms of adoption and implementation. In November 2001 the government issued the first national policy, with TACAIDS being entrusted to ensure its optimum implementation among various sectors in the country. This policy cuts across disciplinary and institutional sectors to provide a framework for a response. The policy has been adopted and has been translated into an NMSSF.²⁵

The policy has the overall goal of providing a framework for leadership and coordination of the national multi-sector response to the HIV/AIDS pandemic, with due emphasis on the formulation of appropriate interventions by all sectors (including the military), as well as on strengthening the capacity of institutions, communities and individuals to arrest the spread of the pandemic, and the promotion of effective community-based prevention, care and support interventions. The defence sector, like other sectors, has been mandated to translate both the national policy and the NMSSF into a Specific Sector

Implementation Plan (SSIP). Defence sector-related objectives identified by the national policy for adoption in the defence SSIP include:

PREVENTION OF TRANSMISSION OF HIV/AIDS

- Creating and sustaining an increased awareness of HIV/AIDS through targeted advocacy and information, education and communication (IEC) for behaviour change at all levels of the defence sector.

HIV TESTING AND COUNSELLING

- Promoting early diagnosis of HIV infection through both compulsory and voluntary testing, with pre- and post-test counselling.
- Reassuring and encouraging military personnel who are HIV-negative to take appropriate steps not to be infected.
- Assuring that those who are HIV-positive receive the counselling and care they need to cope with their status, to prolong their lives and not to infect others.

CARE FOR PLHA

- Providing counselling and social support services for PLHA and their families.
- Combating stigma and strengthening constructive lifestyles.
- Providing adequate treatment and medical care through an improved health-care system that enhances quality of life. (However, as indicated by one medical practitioner at the Lugalo Military Hospital, fatigue and frequent illnesses are associated with absenteeism from studies and work-places, which in turn increases the cost of health-care and reduces productivity. Her conclusion was that this situation was even more noticeable and serious when it comes to comparing the military with other security sectors. The military does not work in isolation. There is a collaborative approach in fighting the scourge where, for example, the military works hand in hand with different security organs and other sectoral actors, including civil society, both national and international).

- Establishing a system of referral and discharge that links military hospital services to community services in a sustainable and complementary relationship. (For example, the military has its own referral hospital, Lugalo, which is fully staffed and equipped with modern medical equipment and a constant supply of antiretrovirals (ARVs). Owing to the good civil–military relationship that exists, this hospital is also open to civilian patients living close to it.)
- Ensuring the availability of essential drugs for the treatment of opportunistic infections. (The current free availability of highly active antiretroviral treatment [HAART] has given high hopes for the survival of HIV/AIDS victims in the military. A national programme for managing the provision of ARVs has been established. The defence sector has been fully integrated into this programme.)

DEFENCE SECTOR ROLES AND FINANCING

- Strengthening the defence sector in relation to other sectors, including civil society, to ensure that all stakeholders are actively involved in HIV/AIDS work.
- Providing a framework for coordination and collaboration within the defence sector.
- Ensuring a strong and sustained political and government commitment at all levels of leadership accountability in the defence sector.
- Influencing sectoral policies to address HIV/AIDS within the military.
- Establishing a framework for coordinating fundraising activities, budgeting and the mobilisation of human and material resources for activities in HIV/AIDS, both inside and outside Tanzania.
- Encouraging and promoting a spirit of community participation in HIV/AIDS activities.

RESEARCH

- Participating in HIV/AIDS research.

- Establishing an appropriate system to disseminate scientific information emanating from the research while upholding defence sector ethics that govern interventions in HIV/AIDS.

LEGISLATION AND LEGAL ISSUES

- Creating a legal framework by enacting laws on HIV/AIDS.
- Ensuring that human rights issues on HIV/AIDS are adhered to, including:
 - non-discrimination, equal protection and equality before the law;
 - the highest attainable standard of physical and mental health;
 - privacy;
 - freedom to receive and impart information and opinions;
 - an adequate standard of living;
 - social security assistance and welfare;
 - sharing in the benefits of scientific advancement; and
 - freedom from torture and cruelty, and inhumane or degrading treatment or punishment.

POLICIES ADOPTED BY THE MILITARY IN RELATION TO CARE, SUPPORT AND TREATMENT FOR PLHA

HIV/AIDS within the defence sector, particularly uniformed service personnel, is predominantly transmitted through unsafe sexual behaviour. Uniformed service personnel live and work in a range of environments where the circumstances of their recruitment, rank and operational deployment may predispose them to contracting HIV/AIDS.²⁶

The deployment of uniformed service personnel in Uganda during the war with Uganda in 1983 was a vivid example, as some of the military and other uniformed service personnel contracted HIV while not then aware of the danger. The same personnel are now known to have spread the disease in the northern part of Tanzania (Kagera Region) on their return from the war front in 1984. The disease later spread throughout the country and, perhaps, to neighbouring countries in East, Central and Southern Africa. This appears to have been the scenario that originally introduced HIV to Tanzania.

Factors²⁷ that predispose members of the uniformed services to contracting or transmitting HIV include the following:

- They are predominantly young men and women who are sexually active and who often see themselves as invulnerable.
- Their duty schedules and periods of deployment result in separation from their families. Separation from regular partners increases the chances of engaging in sexual relationships with casual partners. Destabilised family units and the increased use of sex workers increase HIV infection rates.
- They have a steady income that often makes service men and women considerably better off than those in surrounding communities, and that often allows them to be perceived by civilians as privileged and in a position of power and authority. They are therefore more likely to have multiple partners and unprotected sex.
- In some cases, where military and other uniformed service camps are surrounded by communities, these communities are dependent on uniformed service personnel for food, clothing, etc. Male chauvinism in these circumstances can lead to condom use that is incorrect or inconsistent, particularly under the influence of alcohol or an intense sexual urge. This happened in the Kagera war, where surrounding environments, including those in Uganda, already had an HIV prevalence.

The study indicated that the care for PLHA in the broad defence and uniformed sector was generally adequate. During open-ended interviews with military medical practitioners at the Lugalo Military Hospital in the Dar es Salaam army headquarters, as well as with TACAIDS and NACP officials, it became evident that the institutional care policy for their personnel was more advanced than it was in other sectors. These respondents generally indicated that in addition to national referral hospitals caring for HIV/AIDS patients, each security sub-sector had a designated department in its hospital for the treatment of HIV/AIDS. Major tasks in these sub-sector departments, they said, included the following:

ADVOCACY

Including:

- strengthening political support and public awareness;

- psychological and behavioural training for staff prior to deployment to help them counsel those affected with HIV/AIDS, encouraging sufferers to live with the disease;
- fighting stigma and discrimination by encouraging positive attitudes towards PLHA;
- safeguarding PLHA's human rights; and
- bringing HIV/AIDS and concerns about the well-being of personnel into the mainstream through integrated and comprehensive plans and implementation. The frameworks for advocacy and stigma and discrimination strategies are shown in figures 1 and 2.

Figure 1: Strategic (results) framework on advocacy

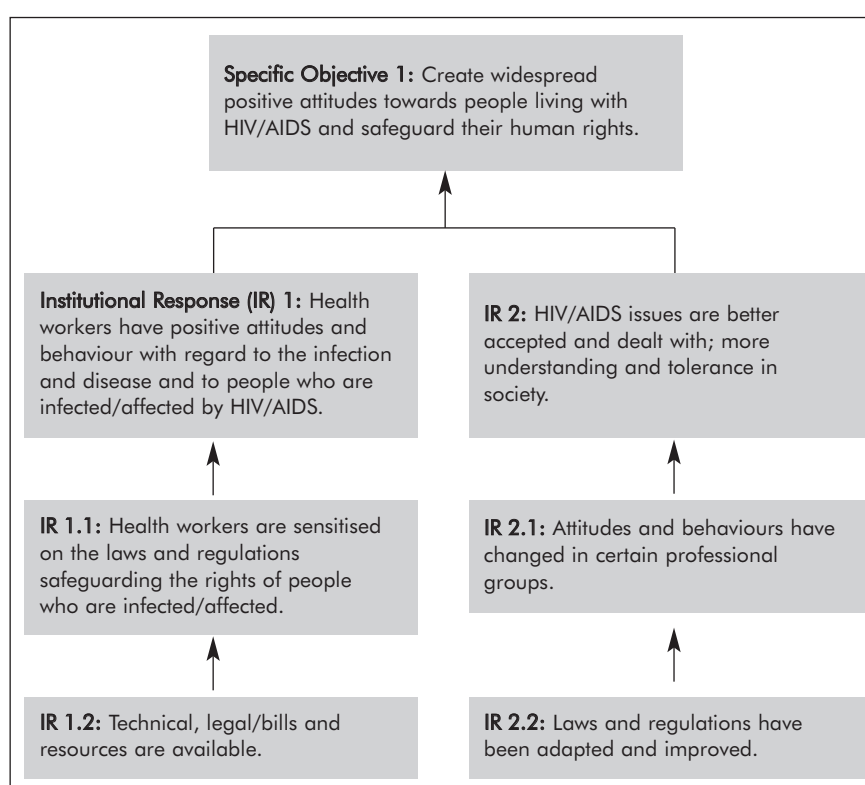
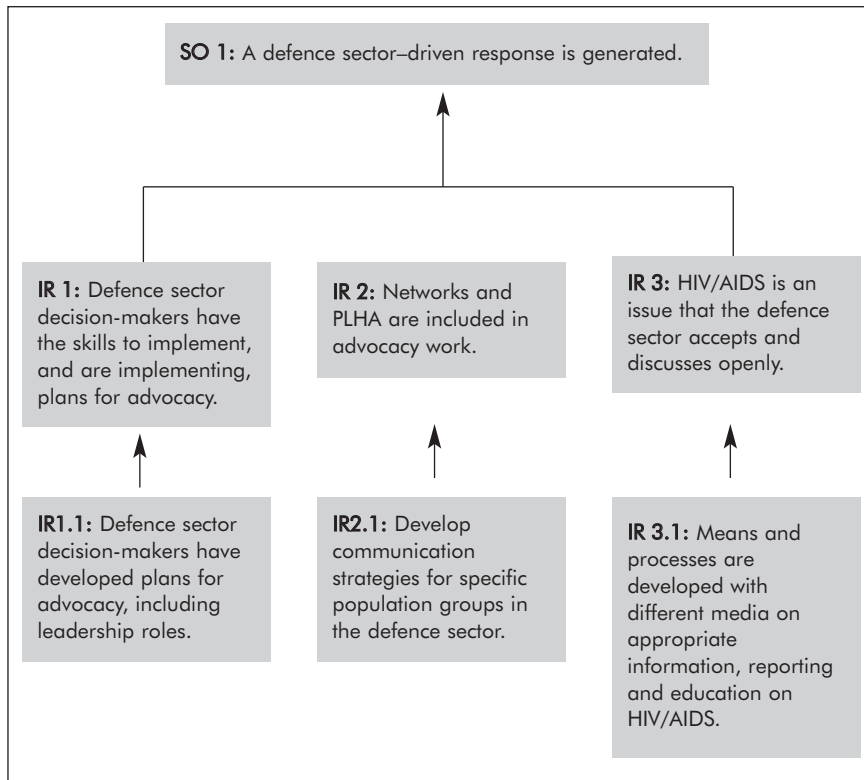


Figure 2: Strategic (results) framework on stigma and discrimination

GENDER-SPECIFIC AND OTHER PREVENTION STRATEGIES

Including:

- sexually transmitted infection (STI) control and management;
- condom use promotion and free distribution;
- compulsory testing on recruitment, and voluntary or compulsory testing for in-service military personnel, coupled with strict confidentiality and counselling for those found to be HIV-positive;
- the provision of balanced and health-sustaining rations to defence personnel and families, particularly those living with HIV/AIDS;

- health promotion for vulnerable groups such as women and girls in barracks, prisoners in prisons and retired service men and women; and
- safety of blood, blood products and universal precautions in health care and non-health care settings, including waste management.

HIV/AIDS CARE, SUPPORT AND TREATMENT

Including:

- treatment of common opportunistic infections, including HIV/AIDS, in order to increase the proportion of PLHA having access to the best available treatment and medical care, including ARVs.

THE HIV/AIDS NMSSF: IMPLEMENTATION IN THE DEFENCE SECTOR

The NMSSF presents a monitoring and evaluation system designed to measure progress towards goals and to provide institutional, coordination and financial frameworks for the HIV/AIDS response. The programme, which covers all sectors including the military, identifies goals, objectives and strategies for the 2003–07 period. Goals for this five-year period include:

- reducing the spread of HIV by 30% by 2007;
- reducing mother-to-child HIV transmission by 20% by 2007;
- formulating programmes, projects and interventions to address stigma and discrimination and to promote respect for the human rights of PLHA. (Stigmatisation creates a hostile and fearful environment concerning everything related to HIV and AIDS. It also results in the condemnation of PLHA. For fear of prejudice, stigmatisation may cause people to react to HIV/AIDS by blaming those infected for their infection, and seeing them as shameful);²⁸
- reducing the prevalence of STIs in the security sector population by 70%, and in health facilities by 80%, by 2007;
- increasing the knowledge of HIV transmission in the defence sector

population to at least 95% by 2007 through access to information and education, including peer education and peer-specific HIV education;

- encouraging political and government leaders in the defence sector to give high visibility to HIV/AIDS in their public appearances and similar activities;
- increasing the number of PLHA who have access to a continuum of care and support from home or community to hospitals at sector and communal levels, including those who have retired from the military service and are living within communities; and
- reducing the adverse effects of HIV/AIDS on orphans within the defence sector.

The goals are in line with international commitments made by the government of Tanzania as incorporated in the Millennium Development Goals (2000), and the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS of June 2001.

Section 3(14) of Tanzania's 1977 Constitution supports the development and implementation of the National HIV/AIDS Policy and the NMSSF for HIV/AIDS in all sectors, including the military. This policy and framework addresses the overall impact of the response, as well as achievements in prevention, care, support and treatment, and the mitigation of socio-economic impacts.

IMPLEMENTING THE NATIONAL HIV/AIDS POLICY AND THE 2003–07 NMSSF IN THE DEFENCE SECTOR

The national HIV/AIDS implementation strategy requires a large number of stakeholders to develop a new response. The military, other security sectors, ministries, community-based organisations, CSOs, churches and local government authorities have all been charged with developing sector-specific plans for integrating HIV/AIDS into their work programmes. Far-reaching defence sector plans will cover workplace interventions to protect their own staff and to incorporate HIV/AIDS activities into the delivery of their core security services.²⁹

The main objective is to coordinate a multi-sector approach intended to curb the effects of the pandemic and to mobilise adequate financial

resources for HIV/AIDS-related activities. It should be noted that there is no separate sector policy on HIV/AIDS for the military, prisons, police and national security operations outside the mandate of the National HIV/AIDS Policy. However, as earlier indicated, the defence sector roles on HIV/AIDS include:

- designing and implementing HIV/AIDS activities in their sector;
- drawing up, in collaboration with TACAIDS, an NMSSF strategic implementation plan for the control and prevention of HIV/AIDS;
- budgeting, raising funds and mobilising material and human resources for the NMSSF's activities for HIV/AIDS prevention and control; and
- identifying, prioritising and implementing the NMSSF's HIV/AIDS prevention and control activities in line with its mandate.

LINKAGE OF THE NMEF FOR HIV/AIDS AND DEFENCE SECTOR PLANS

TACAIDS has developed a National Monitoring and Evaluation Framework for HIV/AIDS (NMEF) that maps out information needs at local, national, sector and international levels, as well as the flows of information and roles and responsibilities at different levels.

The NMEF caters for all sectors, including the military. A core indicator set for tracking progress of the response is defined, and the need for a baseline data exercise to collect information on all indicators included in the monitoring and evaluation framework is identified.

Conceptually, and through pragmatic practices, confusion between monitoring and evaluation is common in all sectors, particularly the military.

There is a simple distinction between monitoring and evaluation that may be helpful. Monitoring is the routine, daily assessment of ongoing activities and progress. In contrast, evaluation is the periodic assessment of overall achievements. Monitoring looks at what is being done, whereas evaluation examines what has been achieved or what impact has been made.³⁰

In the defence sector, monitoring and evaluation are used to complement response efforts in key areas, including:

- determining the progress in implementing the response;

- identifying what works and what does not work, and providing evidence on the effectiveness of the response;
- detecting and, if necessary, addressing any problems arising in the course of the implementation and redesign of the response;
- allowing trends of the HIV/AIDS pandemic to be tracked; and
- monitoring outcomes and the impact of the response.

Many of the major current initiatives in the defence sector include references to the HIV/AIDS pandemic. So, for example, President Mkapa, as commander-in-chief of the defence forces, has said: “Together we can and must win the war against HIV/AIDS. Our survival as a nation and as a people critically depends on this victory.”³¹

This assertion demands a strong monitoring and evaluation process within the NMSSF that includes effective coordination and consistency between information collection and analysis in order to avoid duplication and extra work.

TACAIDS is working closely with the security sector to ensure that its monitoring and evaluation includes the generation of the best possible data, and the sharing of this information by government and other sectors.

Other linkages include the NMSSF’s contribution to the realisation of the national aspirations as enshrined in the Tanzania Development Vision 2025.³²

It is axiomatic that HIV/AIDS poses a serious threat to what has been achieved in reducing poverty and that it is an obstacle to the realisation of national goals. Poverty significantly influences the spread and impact of HIV/AIDS. The fight against HIV/AIDS is therefore considered an integral part in efforts aimed at poverty eradication, as outlined in the Tanzania Poverty Reduction Strategy Paper.³³

The major issue in the defence sector is how to retain the impetus of the fight against HIV/AIDS and to ascertain its effectiveness in the military.

The ongoing defence sector reform—and in particular the parts related to combating HIV/AIDS—is a critical vehicle for creating an enabling environment for reducing the spread of the virus within the military and the surrounding communities in which military personnel are living or are deployed.

DEFENCE SECTOR EMPLOYMENT POLICY ON RECRUITMENT OF MILITARY STAFF IN RELATION TO HIV PREVENTION

The Tanzania People's Defence Force (TPDF) has a total manpower complement of some 27,000 and includes the Army, the Naval Wing, the Air Defence Command and National Service.³⁴ Contingents are distributed throughout Tanzania in various regions, with varying HIV prevalence, as shown in Table 5.

Results from the Tanzania Household Indicator Survey for 2003/04 indicate that some 7% of Tanzanians in the 15–49-year age group are infected with HIV. As shown in Table 5, regions with a high HIV prevalence include Mbeya (nearly 14%) followed by Iringa and Dar es Salaam. Regions with a low HIV prevalence include Manyara and Kigoma (2%).³⁵ These are therefore the regions from where the military recruits much of its manpower.

Table 5: Prevalence of HIV by regions in which TPDF camps are based

S/N	Region	Percentage of prevalence
1	Mbeya	13.6
2	Iringa	13.4
3	Dar es Salaam	10.6
4	Mtwara	7.4
5	Coast	7.3
6	Kilimanjaro	7.3
7	Mwanza	7.2
8	Tabora	7.2
9	Ruvuma	6.8
10	Shinyanga	6.5
11	Rukwa	6.0
12	Tanga	5.7
13	Morogoro	5.4
14	Arusha	5.3
15	Dodoma	4.9
16	Kagera	3.7
17	Lindi	3.6
18	Mara	3.5
19	Singida	3.2
20	Manyara	2.0
21	Kigoma	2.0

Source: Tanzania Household HIV Indicator Survey 2003/2004, p 12.

Although TPDF regulations prohibit under-18s from recruitment into the armed forces, Tanzania has a military manpower recruitment requirement for 15–18-year olds who have graduated from secondary school and who can be conscripted for two years of national service.³⁶ With a population of 36.3 million, of which 19 million are under 18 years, Tanzania has a total male manpower availability of 7.4 million in the military age group of 18–49 years.³⁷

The military employment policy on staff recruitment in relation to HIV/AIDS prevention stresses compulsory HIV/AIDS testing. In practice, as indicated by one senior military officer at the Lugalo Military Hospital:

The recruitment is done through the District Commissioner's offices through a process of screening. Each nominee is required to undergo a medical check-up to ascertain physical fitness for the military training. HIV/AIDS, tuberculosis and other long-term ailments are among those being tested. On registration at a designated centre a screening medical test that includes HIV/AIDS testing is undertaken for the purpose of determining the candidate's fitness. This test is compulsory and a precondition for entry into the military. This is contrary to the voluntary testing stipulated in the national AIDS policy. Candidates found to be HIV-positive are not directly informed of the results but are treated under the guiding principles of counselling and care. However, these are not engaged, on medical grounds, but are turned away.³⁸

The approach by the military contradicts the National Policy on HIV/AIDS, which prohibits any employment discrimination against those suffering from HIV/AIDS. While the policy calls for voluntary testing and adherence of confidentiality of the tested status, the requirements of the military have persuaded its commanders to adopt the ad hoc but rational approach to recruit selection described in the quotation above. The argument for this contradiction is that the military needs a medically fit workforce, and in particular one free from HIV/AIDS and other related diseases such as diabetes, asthma, hypertension and peptic ulcers.

The military commanders argue that recruitment into any uniformed service includes various provisions: one being that recruits must be medically fit; and another being that those who volunteer to join the uniformed services are aware of the mandatory testing requirement. In

so doing, the commanders argue, candidates for recruitment have in fact volunteered for HIV/AIDS testing along with other demands for medical fitness. Those who are fit are recruited and those who are not fit are rejected. Their HIV status is not disclosed to them. The reason given by one medical officer at the Lugalo Military Hospital for the exclusion of those found unfit during recruitment was that:

Prolonged periods of recruit training are no doubt strenuous. This endurance training goes on day and night, in deliberately harsh terrain during cold, wet, humid, dusty environments coupled with enforced lack of adequate rest and sleep. The effect of this strenuous training on asymptomatic HIV patients accelerates the HIV illness conditions and predisposes the affected recruits to continual respiratory infections, diarrhoea, and dehydration. Eventually the affected recruits die.³⁹

Based on this conviction, the authorities have agreed to the exclusion policy for HIV-positive recruits.

CARE, SUPPORT AND TREATMENT FOR MILITARY PLHA

Irish Prime Minister Bertie Ahern advocated the need for care, support and treatment of PLHA in poor communities. In an address that resonates with the situation in Tanzania, he said in 2001 that:

People living with HIV/AIDS must have access to effective support and treatment. The infected need our help to prolong their lives and allow them to live in dignity and with the respect they deserve. The debate on access to medicine must be placed in the wider context of access to care. Governments, development agencies, the private sector and civil society organisations need to work together to overcome the obstacles to the provision of care for the infected.⁴⁰

In view of the above, the UN General Assembly Special Session on HIV/AIDS held in New York on 25-27 June 2001 recognised that:

Effective prevention, care and treatment strategies require behavioural change; increased access to vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs, including antiretroviral therapy, diagnostics, and increased research and development.⁴¹

The military in Tanzania has taken various measures for the care, support and treatment of uniformed service personnel living with and without HIV/AIDS. The measures include:

- preventing HIV/AIDS transmission by raising awareness through the promotion of peer education and condom provision and distribution;
- promoting preventive and behavioural change activities: these include sensitisation campaigns and workshops. Mobile drama groups and traditional dancing groups and choirs are used as advocates in the fight against HIV/AIDS by ensuring that people are provided with the relevant tools to contribute to the national response to HIV/AIDS;
- promoting early diagnosis of HIV/AIDS and proper treatment. The availability of ARVs is optimal and distribution is controlled by medical practitioners within the military. Patients on ARV treatment are strongly encouraged to be assisted by military HIV/AIDS counsellors and social workers in their respective camps or communities; and
- introducing voluntary counselling and testing (VCT) for personnel and their families at all military levels: VCT has been shown to be effective in influencing change in sexual behaviour and practices.⁴² VCT also minimises the fear of suffering from stigmatisation and discrimination, which discourages PLHA from finding out if they are HIV-positive or not, and results in PLHA not getting encouragement and support at the time they need it most.⁴³ PLHA, if rejected, feel alone and isolated and can end up living in poverty; their lives may be shortened if they are not able to look after themselves or benefit from access to health services.

SUMMARY OF KEY ISSUES AND RECOMMENDATIONS ARISING FROM STUDY FINDINGS

This desk-top study on the Tanzanian National Policy on HIV/AIDS as related to the defence sector has shown that various key issues need be taken seriously by all Tanzanians, and in particular the military, if they are to wage a war on the pandemic.

The following issues and recommendations are worth taking on board for further action and study:

GENERAL KEY ISSUES AND RECOMMENDATIONS

- It is axiomatic that HIV and AIDS prevalence has, over the past decade, further aggravated the country's health status by eroding the Human Development Index and the future prospects of Tanzania. It has indeed undermined the foundations for development and attainment of the Millennium Development Goals and national targets. To counteract this situation, it is important to build a deeper understanding of the pandemic through awareness campaigns at grassroots level, both in the military and other sectors, including civil society, so as to contain the spread of the pandemic and minimise its impact. Indeed, preventive campaigns have succeeded in raising people's awareness, but this has not yet translated into required behavioural changes, either among civilians or military personnel who interact freely with the civilian population. Minimising the risk of transmission requires that the poor levels of awareness among sexually active young men and women be squarely addressed and elevated through making it easier for them to access useful life skills on how best to protect themselves against HIV/AIDS.
- Prevention of mother-to-child transmission of HIV is a paramount strategy for reducing 0–5-year infant and child mortality.
- Efforts to eradicate HIV/AIDS should feature strong and committed leadership from both government and defence organs, juxtaposed with increased support members of civil society who interact freely with uniformed service personnel.
- Tanzania, as one of the poorest countries in the world, is faced with much poverty. Food shortages and inadequate nutrition for poor families are great dangers for the spread of HIV/AIDS. Proper nutrition is a factor that slows the progression of HIV to AIDS. People fighting the infection, including those who are HIV-positive, have greater nutritional needs. It is particularly important that the protein and other nutritional needs of PLHA be met if they are to maintain their vital body functions, including resistance to opportunistic infections. The provision of macronutrient-fortified blended foods should therefore be a priority in food aid strategies to mitigate the impact of HIV/AIDS in both the military and civil society.
- Given the indication that HIV/AIDS has no cure and has yet to peak,

there is an urgent need to refocus efforts to deal with the underlying causes of the spread of the pandemic. These efforts should be immediate, strongly led and broadly implemented, with an active engagement and substantially increased support to the defence sector and CSOs. It may be noted that there have already been some remarkable grassroots initiatives.

- There is a need to better understand and appropriately measure current HIV/AIDS complex crises. Most of our respondents from TACAIDS, the NACP and those spontaneously interviewed during this study expressed concern that the targeted approaches were made difficult partly by lack of in-depth understanding or the measuring of new phenomena. These included the impact of HIV/AIDS on the functioning of households and in the military in order to indicate any imminent collapse, for which assistance could be mobilised in a timely fashion. As such, humanitarian emergencies must be viewed through the lens of HIV/AIDS on the capacity of the population, CSOs, the defence sector and the Tanzanian government to engage effectively, with HIV/AIDS being viewed as a potential catalyst of broader humanitarian crises.
- The NMEF for HIV/AIDS, which is under way in all sectors including the military, should encompass a multi-sector vulnerability assessment. This is essential for establishing the level of required assistance and transparency in demonstrating to donors and other stakeholders the logic for intervention. The on-going sectoral vulnerability assessment process needs to extend its current focus to include aspects of vulnerability (such as health indices and food security) by qualitative and quantitative data collection and analysis of the defence, security and social sectors, including households. The ‘secrecy shrouding’ impediment—which is now common in some sectors including the military—needs to be solved in order to make transparent and tangible data available to concerned individuals and organisations in the field, without compromising national security.
- HIV/AIDS has had a tremendous impact on households and on the armed forces. It is altering the demographic structures by having a differential impact on women and men of all ages. Women tend to carry a heavier burden of the negative impact of HIV/AIDS due to existing gender inequalities that put them at a disadvantage. At household level,

women are also carrying a heavier burden of stress as a result of the pandemic. While a greater proportion of younger women are being infected, older women are saddled with caring for the orphans of HIV/AIDS parents from the military or in local communities. This disproportionate burden is worsened by the existing inequalities in accessing resources generally, and particularly those directed at combating the virus at grassroots level. Addressing these gender imbalances in the military is a necessary prerequisite to addressing the broader question of HIV/AIDS protection and transmission.

- VCT is another issue in Tanzania. Many people shy away from VCT despite government appeals. People who care for their lives need to know and accept their HIV status. VCT services therefore need to be justified, widely available and acceptable. Ideally, everyone should have access to such services since there are clear advantages in knowing one's serological status. People who know they are HIV-infected are likely to be motivated to look after their health, perhaps with behaviour and lifestyle changes, and to seek appropriate counselling and early medical attention for problems at early stages of the disease. They can make informed decisions about their sexual practices, childbearing, and infant feeding, and can take appropriate steps to protect themselves, their partners and children from infection. Furthermore, VCT has an important role to play in challenging denial of the epidemic. It helps societies that are currently only aware of people who are ill with AIDS to recognise that there are many more people living with HIV and who show no outward signs. Extended advocacy campaigns are needed to awaken this new approach, and resources should be made available to the poor.

SPECIFIC KEY ISSUES AND RECOMMENDATIONS

- The fact that the majority of the military's labour force are in the sexually active 20–45-year age group and are better paid than their civilian counterparts makes them feel financially superior. This situation gives them power and influence over their potential partners to engage in risky sexual behaviour. The interaction that exists between military personnel and civilians living in close proximity to one another, combined with sexually active behaviour, predisposes both communities to contract the infection if they are involved in risky sexual conduct.

- There is a need to support the families of military personnel deployed away from them. Separation of service military personnel from their regular partners increases the chances of these personnel engaging in sexual relations with casual partners. Some specific policy changes that could be taken to support stable family and other partnerships include:
 - clarifying housing policies and increasing the level of resources available for housing for military personnel, especially in camps outside Dar es Salaam;
 - shortening the length of tours of duty away from bases where the families of military personnel reside; and
 - shortening the periods between home leave for military personnel stationed at remote border areas.
- Military personnel make up closed communities living in designated camps where male values dominate, thereby disposing them towards risky sexual behaviour. They tend to exchange sex partners, especially on operations. In this situation, a high HIV prevalence is found within the camps and among civilians living near the camps, or associated with their operational movements, when military personnel have a limited choice of partners.
- It is essential for future planning and the improvement of the national response to the pandemic that free, transparent and accurate information be available to the military in a way that does not undermine the secrecy code of conduct within the military. The dynamism and complexity of HIV/AIDS demands that the security sector remains vigilant in documenting changes in the behaviour of the pandemic and adopts appropriate interventions. This is in line with the National Policy on HIV/AIDS.⁴⁴
- Section 7(5) of the National Multi-Sectoral Strategic Framework on HIV/AIDS: 2003–2007 emphasises best practice documentation.⁴⁵ This necessitates increased efforts in research, and the documentation and dissemination of substantial achievements in major areas of HIV/AIDS prevention, control and mitigation in different parts of the military.
- Full confidentiality for VCT is important. Military personnel will come for testing more readily if they are confident that the service is confidential.

CONCLUSION

This study has been carried out by civilian researchers, one of whom, however, has had experience with the Tanzanian paramilitary as well as service experience on the Ugandan border during the Kagera war. The researchers found convincing evidence that HIV/AIDS is still having a negative impact on the lives of the Tanzanian people, particularly in the defence sector.

The negative picture is overwhelming and points to the need for a concerted effort by all sectors to fight the pandemic. The country's National HIV/AIDS Policy and other interventions provide a recipe for the prevention, care and support needed by Tanzanians. However, the country's leaders, including those in the military, need to live up to their commitment to implement both the HIV/AIDS policy and the specific plans described in the NMSSF. The ongoing monitoring and evaluation processes will succeed only if all Tanzanians join hands in the struggle for survival against the pandemic.

The TPDF interacts freely with local communities, and this relationship—which includes social, cultural and economic interdependence—has a bearing on the spread of HIV/AIDS to military personnel and civilians alike. The good military–civilian relationships that exist provide an opportunity for setting up workable mechanisms for combating the pandemic.

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HIV/AIDS in the Zimbabwe Defence Force: A civil society perspective

Reginald Matchaba-Hove

INTRODUCTION

This chapter constitutes a civil society perspective of HIV/AIDS and the military in Zimbabwe. A brief background is provided outlining the country's geographic and demographic profile, political economy, aspects of food supply and civil society's concern about the militarisation of civilian institutions. A detailed outline of the epidemiology of HIV/AIDS in Zimbabwe is provided, including Zimbabwe's response to the pandemic, followed by some discussion of recent results that reflect a decline in national HIV prevalence.

The chapter then attempts to examine the epidemiology of HIV/AIDS within the military and the military's response to the pandemic, using data that is available to the public. The military's recruitment, in-service and post-employment policies in relation to HIV/AIDS are outlined. These policies are juxtaposed against local, regional (Southern African Development Community—SADC) and international (International Labour Organisation—ILO, United Nations—UN) policies on occupational health and HIV/AIDS in the workplace. Various recommendations are offered on how Zimbabwe's military could use its leading role in the region to impact on various international levels via, *inter alia*, UN Resolution 1308 on HIV/AIDS and the Military,¹ the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases,² the African Union (AU) Commission's HIV/AIDS Strategic Plan 2005–07, the AIDS Watch Africa (AWA) Action Plan³ and the SADC Inter-State Defence and Security Committee's sub-regional

harmonisation of AIDS programmes.⁴ Specific policy recommendations are also offered to the Zimbabwe Defence Force (ZDF) on how to further improve its HIV/AIDS policies and intervention programmes.

BACKGROUND

GEOGRAPHIC AND DEMOGRAPHIC PROFILE

Zimbabwe is a landlocked country in Southern Africa with an area of 390,784 km². It has long borders with Mozambique in the east, Zambia in the north, Botswana in the west, South Africa in the south and a small thin border with Namibia at the Caprivi Strip.

A national census is done every ten years. According to the last (2002) census, Zimbabwe had 11.6 million people, 1.2 million more than in 1992 and 4.2 million more than in 1982.⁵ The country's growth rate was estimated to be 3.1% in the first two decades after independence (in 1980). It has therefore been suggested that the 2002 population excludes about three million Zimbabweans in the diaspora. Nevertheless, it is now accepted that the HIV/AIDS pandemic has probably lowered the growth rate. About 3,000 people die every week in Zimbabwe of AIDS-related illnesses.⁶

A Demographic and Health Survey is conducted every five years. The 2005 survey report is currently in preparation. It will provide additional data on HIV prevalence and sexual behaviour.

POLITICAL ECONOMY

Zimbabwe is a republic. The Zimbabwe constitution guarantees separation of powers between the executive, the legislature and the judiciary. Chapter III of the constitution is a bill of rights. However, civil society is of the view that the constitution affords the president enormous powers, even to the extent of suspending parliament. There has, as a result, been a call for an urgent all-inclusive constitutional conference. This call is symptomatic of the crisis characterising the country's political situation and has implications for the responses to, and capacity of the leaders to respond to, the HIV/AIDS pandemic. The constitution has been amended 17 times since independence and some of the amendments have effectively weakened the bill of rights.

The country has an executive presidency, which is contested through national elections every six years by registered voters, who are required

to be 18 years or older. The last presidential election was in 2002. The legislature consists of a lower chamber, the House of Assembly, and an upper chamber, the Senate. Parliament is elected every five years using the Westminster-type constituency first-past-the-post system. However, the president also nominates representatives to both houses of parliament. The last parliamentary election was in March 2005. This context is significant as it partly explains the approach and priority accorded to HIV/AIDS issues in the country.

Zimbabwe attained its independence on 18 April 1980 after a protracted armed struggle. After independence, the British Military Advisory and Training Team played a positive role in helping to integrate the two main guerrilla forces, the Zimbabwe African National Liberation Army (ZANLA) and the Zimbabwe Peoples' Revolutionary Army (ZIPRA) with the conventional former Rhodesian Army. The country now has a fully integrated army, with many new recruits who have no links with any of the former forces, although the top commanders are largely former combatants from either ZANLA or ZIPRA. The ex-combatants from ZANLA and ZIPRA formed the Zimbabwe Liberation War Veterans' Association (ZLWVA). The Zimbabwe Liberators' Platform was established by more progressive ex-combatants who were not happy with some of the policies (or lack thereof) and activities of the ZLWVA. The war veterans sometimes play a prominent role in national politics, for better or for worse.

The country has been experiencing a severe political and economic crisis since the flawed parliamentary elections of June 2000 and the presidential elections of March 2002. Zimbabwe also witnessed violent land reforms that commenced on the eve of the 2000 elections. Owing to these and other factors, there has been a significant decrease in international aid from the European Union, the United States, the International Monetary Fund (IMF), the World Bank and several individual Western donor countries.

Zimbabwe is the only country in the SADC region that has had a negative growth rate over the past six years. The IMF and World Bank estimates that the economy shrunk by between 4.7% and 5.6% of gross domestic product in 2005, and that the economy will shrink by another 4.1% in 2006.⁷ The official inflation rate from the Reserve Bank of Zimbabwe was 913.6% for March 2006 and more than 1,000% in April 2006. Formal unemployment is estimated to be greater than 75%. However, the informal sector has been growing, although its extent is not yet fully known. Sadly, the government's so-called 'clean up' exercise

in May–June 2005, code-named Operation *Murambatsvina*, largely targeted the informal sector in all major urban areas and growth points in rural areas.⁸ The country is also experiencing acute shortages of foreign currency, liquid fuels and electricity.

NUTRITION AND FOOD

Malnutrition has a direct impact on the human body's response to HIV/AIDS. Also, some antibiotics, anti-tuberculosis (TB) drugs and antiretrovirals (ARVs) should be taken only in conjunction with adequate nutrition. However, Zimbabwe is currently experiencing a severe shortage of food and livestock. This is due to a number of factors. The first of these is that the country has experienced severe droughts in recent years. Second, the violent and chaotic 'land reform' programme since 2000 has seen the departure of experienced farmers and capital. Third, the president told the international donor community in 2004 that Zimbabwe had enough grain to feed the nation and therefore did not need food aid. During an interview aired by Sky TV on 24 May 2004, President Mugabe remarked: "We are not hungry. It [food aid] should go to hungrier people, hungrier countries than ourselves. Why foist this food upon us? We don't want to be choked, we have enough."⁹ Fourth, the government also wanted food aid to be channelled through government structures. Civil society and other players were concerned that food could be used as a weapon during national and local government elections. Finally, although there were adequate rains during the 2005/06 rainy season, there remain critical shortages of seed, fertiliser, pesticides, tractors and other agricultural implements and fuel. Intermittent and erratic electricity power supplies will also negatively impact on the winter wheat crop that relies heavily on irrigation, in addition to the fact that the area under irrigation is much smaller.

In 2005, it was estimated that while the country would be requiring about 2.4 million tons of grain, only 600,000 tons would be harvested. In effect, about two million people were at risk of starvation.¹⁰ This prompted the UN secretary-general to ask the director of the World Food Programme (WFP) to visit Zimbabwe and other countries in the region. The WFP director's visit was focused on assessing the region's needs in terms of food production and HIV/AIDS.

More recently, in April 2006, the government stopped the UN Food and Agriculture Organisation (FAO) and the WFP from carrying out a crop and food supply assessment mission for the 2006/07 season.¹¹

It is worth noting that Zimbabwe's economy, like others in the region, is agro-based. The FAO estimated that because of the HIV/AIDS pandemic, Zimbabwe would lose about 23% of its agricultural workforce and that the agricultural sector would experience a negative growth rate of -7.7%.¹² This would also have an obvious deleterious impact on food production.

MILITARISATION OF CIVILIAN INSTITUTIONS

Civil society has been very concerned by the increasing militarisation of state institutions. Institutions that are headed by serving or retired military personnel include the outgoing Electoral Supervisory Commission, the new Zimbabwe Electoral Commission, the Grain Marketing Board, the National Railways, the Ministry of Energy, National Parks and Wildlife, the Prisons Service, the Central Intelligence Organisation and even the Sport and Recreation Commission.

In mid-2005, in the aftermath of the destructive Operation *Murambatsvina*,¹³ the military launched 'Operation *Garikayi/Hlalani Kuhle*', an ambitious civic works programme to build houses in the urban areas. In early 2006, the military ventured into agriculture by launching yet another programme codenamed 'Operation *Maguta*', in a desperate attempt to boost agricultural output for the 2006 harvest. More recently, in April 2006, the government launched an economic recovery programme, the National Economic Development Priority Programme (NEDPP). The NEDPP is administered by the National Security Council, which is chaired by the president and comprises military and other security personnel.

In effect, Zimbabwe is increasingly becoming a closed society. Civil society is particularly worried that the increasing role of the military in civilian affairs is sadly and inexorably edging the country towards a Burma (Myanmar) scenario. This may have negative implications for the nation's efforts to control HIV/AIDS. Civil society is of the view that HIV/AIDS prevention, management and control can succeed only in a democratic and open environment.

HIV/AIDS IN ZIMBABWE

EPIDEMIOLOGY OF HIV/AIDS IN ZIMBABWE

HIV/AIDS was first noticed in Zimbabwe in 1985. There was, however, much denial until 1990, when the then new Minister of Health and

Table 1: Estimated HIV prevalence in adult population (%), 1986–2003

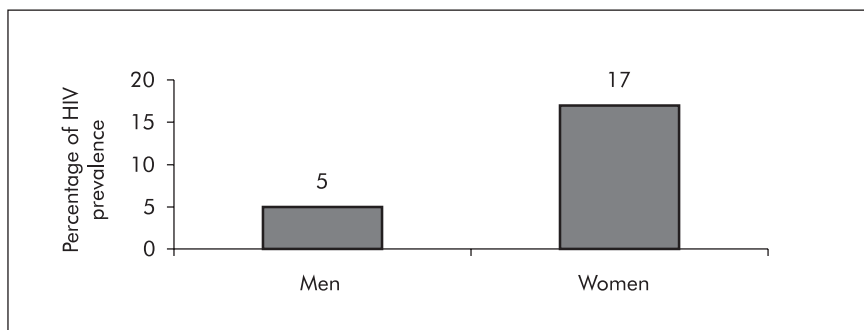
Year	1986	1995	1997	1999	2001	2003
Prevalence	3.2	17.1	25.8	25.1	24.9	24.6

Child Welfare, Dr Timothy Stamps, championed debate on HIV/AIDS issues to be in the public domain.

In 1986, the prevalence was estimated to be 3.2%. Routine sentinel surveillance of healthy pregnant women attending antenatal care clinics commenced in 1990 and has provided the estimated HIV prevalence rates for the adult population. Peak prevalence levels of 25.8% were seen in 1997, declining slightly to 24.6% in 2003 (*see Table 1*).¹⁴

The first thorough national prevalence study was in 2003. It revealed that prevalence was much higher, 35%, on commercial farms and mines, compared with 28% in the major cities and 21% in the communal farming areas.¹⁵ This has to do with the legacy of the colonial migrant labour system whereby men went to work on commercial farms and mines and in urban areas, living in single-sex accommodation, leaving their wives in the communal rural areas.

Transmission is predominantly heterosexual but there is also an element of parent-to-child transmission. The AU states that “the underlying root causes of the disproportionate affliction of Africa by the

Figure 1: HIV prevalence among 15–24-year-old men and women in Zimbabwe, 2001–2002

Source: Adapted from UNAIDS/WHO *Aids pandemic update* Dec 2005 UNAIDS and WHO. *AIDS pandemic update*, Geneva, December 2005 (UNAIDS/05.19E), p 9.

pandemic are numerous, but key among them are poverty and exclusion, governance and accountability".¹⁶ The 2005 adult HIV prevalence figure is 20.1%.¹⁷ Though lower than the 2003 figure, this prevalence is still very high.

In Zimbabwe, as in the rest of Africa, women and young girls in particular are at greater risk of contracting HIV/AIDS.¹⁸ In 2001–02, about 17% of girls and young women aged 15–24-years old were HIV-positive, as opposed to only 5% for boys and young men of the same age (see *Figure 1*).¹⁹ The AU attributes this to:

gender differences and inequality, as women have a greater biological vulnerability to infection, earlier onset of sexual activity, lower socio-economic status and economic dependence. This is aggravated by potentially harmful cultural practices, the inability to negotiate safe sex, the effects of armed and social conflicts, sexual violence and discrimination and the non-recognition of the importance of reproductive health and sexual rights.²⁰

The ILO also adds that:

women's access to prevention messages is hampered by illiteracy . . . women make up a substantial proportion of migrants . . . and refugees. . . . In conflict situations there is an increasing incidence of the systematic rape of women by warring factions. The burden of caring for HIV-infected family and community members falls more often on women and girls.²¹

HIV/AIDS is affecting many adults, including health workers and workers in security agencies. A 2003 study by various institutions that included the United Nations Development Programme (UNDP) revealed that about 3,000 people die of AIDS-related illnesses every week in Zimbabwe.²² The study estimated that there were about 1.8 million HIV-positive people in Zimbabwe.²³ The report also revealed that as far back as 1996, 72% of prison deaths were AIDS-related.²⁴ The pandemic has seen an increase in the number of orphans to some 761,000²⁵—others estimate over one million—with a resultant increase in child-headed families and child labour.²⁶

Hospital-based studies in grey literature suggest that as many as three-quarters of occupied hospital beds in medical wards at tertiary hospitals are occupied by people with HIV/AIDS-related illnesses. In addition, a

study in Zimbabwe showed that “hospital care for HIV/AIDS patients is twice as expensive as it is for non-HIV/AIDS patients”.²⁷

The April 2006 World Health Organisation (WHO) report states that life expectancy has declined for women from 36 years in 2004 to 34 years, while remaining at 37 years for men.²⁸ The report attributes this to a number of possible factors, including AIDS and deteriorating economic conditions. The Zimbabwe Ministry of Health and Child Welfare has disputed the results but has offered no figures of its own.

Studies conducted in Zimbabwe and elsewhere have shown that HIV transmission is five to 20 times more likely in the presence of sexually transmitted infections (STIs) such as gonorrhea, *Chlamydia trichomoniasis* and genital ulcer disease, in particular syphilis and genital herpes (herpes simplex virus type 2).²⁹ There is therefore some suggestion that male circumcision may be of value.³⁰ A study in South Africa in 2005 showed that bacterial vaginosis doubled a woman’s risk of contracting HIV infection.³¹

On the positive side, the prevention of mother-to-child transmission (PMTCT) programme is expanding. Indeed, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO report that “in Zimbabwe almost all women testing positive were reported to have received antiretroviral prophylaxis”.³²

However, not all pregnant women are opting for voluntary counselling and testing (VCT). There is still scope for a greater programme uptake. Zimbabwe has also seen a huge upsurge in TB cases as a result of HIV/AIDS, poverty, overcrowding in some urban areas and poor nutrition.

NATIONAL RESPONSES TO HIV/AIDS

The period 1994–98 witnessed the Multi-Sectoral Second Medium Term Plan (MTP2). The plan was intended, *inter alia*, to:

- reduce the transmission of HIV and other STIs;
- reduce the personal and social impact of HIV/AIDS and STIs;
- reduce the socio-economic impact of the HIV/AIDS pandemic; and
- develop a national HIV/AIDS policy.

The Criminal Procedure and Evidence Amendment Act of 1997 saw the creation of Victim Friendly Courts. The government also formulated a policy on home-based care and care of orphans. The 2002 amendment

to the Labour Relations Act of 1998 also contains a code of conduct on HIV/AIDS and the workplace.

The National AIDS Policy was finalised in 1999. The National AIDS Council of Zimbabwe Act was gazetted in 1999, thereby allowing for the establishment of the National AIDS Council (NAC). As a result, the National AIDS Strategic Framework became operational from 2000. Section 4(c) of the Act mandates the Council to enhance and coordinate the capacity and responses of various sectors of the community to the HIV/AIDS pandemic.

Section 32 of the Act provides for the establishment of AIDS action committees from national to village levels. These structures include provincial AIDS action committees, district AIDS action committees, ward AIDS action committees and village AIDS action committees. A variety of government departments and non-governmental organisations (NGOs) participate in these committees as implementation agents at various levels. The NAC is independent of Ministry of Health and Child Welfare and liaises with other government ministries and agencies, including the military, UNAIDS, various donor agencies and civil society, including trade unions, employer organisations and faith-based organisations.

The policy summarised the key public health and human rights principles in relation to the HIV/AIDS pandemic. These included issues of confidentiality and avoiding discrimination and stigmatisation, care for people living with AIDS, reduction in sexual partners and casual sex, condom availability and use, reduction of STIs and blood safety. In a move designed to strengthen the 1999 HIV/AIDS policy, the Sexual Offences Act was gazetted in 2001.

The Act provides for a penalty of 20 years for rapists convicted of infecting their victims with HIV. The Act also criminalises the wilful transmission of HIV between husband and wife. However, there is no compulsory testing and therefore the majority of Zimbabweans do not know their status.

As part of the nation's attempts to raise funds for the control and management of HIV/AIDS, employees pay a tax of 3% called the National AIDS Levy. In this connection, Zimbabwe has been regarded as a leading and best-practice country for creating specific funding to tackle the HIV/AIDS pandemic. The AIDS levy, along with funding from various donor agencies, contributes to the National AIDS Trust Fund, which is administered by the NAC, and recipients include the military.

Against a background of increasing prevalence rates and the impact of the pandemic, the government used the Presidential Powers (Temporary)

Regulations to declare HIV/AIDS a national disaster. This legally empowered Zimbabwe to manufacture generic drugs locally, so as to reduce the cost of various antibiotics, antifungals and ARVs. This was done by collaborating with some Indian pharmaceutical companies. The move was in keeping with the November 2001 Declaration of the World Trade Organisation's (WTO) Fourth Ministerial Conference in Doha, Qatar, regarding the Agreement on Trade-Related Aspects of Intellectual Property Rights.

This provision dramatically increased the effectiveness of the fight against the pandemic in Zimbabwe. For instance, the measure cut the cost of ARVs by nine-tenths, making Zimbabwe the lowest-cost producer of ARVs in Southern Africa, closely followed by South Africa. However, out of the estimated 1.8 million HIV-positive people in Zimbabwe, about 300,000 require ARVs. Unfortunately, only some 20,000 have access to ARVs, or about 5% of those in need. Fewer than half these access ARVs through the public sector, with the remainder accessing ARVs through the private sector and NGOs. Civil society was therefore very concerned when many urban poor people accessing ARVs via NGOs such as the Centre in Harare were displaced during Operation *Murambatsvina* in May–June 2005.³³ It meant that many defaulted on treatment for several days until they could be located, thereby raising the danger of drug resistance. Concerned civil society groups and members also lost contact with many of these patients.

The NAC has promoted the VCT and prevention of mother-to-child transmission (PMTCT) programmes. However, Retired Brig Gen David Chiweza claimed in March 2003 that VCT programmes had tested only 110,000 people between the inception of VCT in 1999 and December 2002. This, he said, was out of the then estimated three million HIV carriers.³⁴

Chiweza founded the Citizens AIDS Survival Trust in 2001 and has been advocating compulsory HIV testing of all citizens, starting with ten-year olds, if Zimbabwe is to create AIDS-free generations. He has suggested that everyone tested should be given a certificate that they have been tested but that the result would not be displayed on the certificate, and that those who are HIV-negative should be tested annually.

Chiweza controversially recommends that only those with certificates to show that they were tested for HIV/AIDS would be considered for education, marriage and employment. He therefore argues that the Sexual Offences and Health Act is inadequate to deal with the threat posed by HIV/AIDS.³⁵

FOREIGN FUNDING FOR HIV/AIDS

The initial decline in foreign aid, which was largely due to the political crisis, has had a negative effect on the control and management of HIV/AIDS. For example, neighbouring Zambia received US\$187 in foreign aid for every HIV-positive person in 2004, whereas Zimbabwe received only US\$4 per HIV-positive person for the same year. The UN Children's Fund estimated that Southern Africa received US\$47 for every HIV-positive person, as compared to Zimbabwe's US\$4 per HIV positive person.³⁶

There has, however, been a recent policy shift by some international donors to provide funding to help the poor and vulnerable. In particular, significant funding has been released for health in general and for HIV/AIDS in particular. In 2005, the government was granted US\$107 million over the next three years by the Global Fund for AIDS, Tuberculosis and Malaria. In February 2006, the assistant director of the US President's Emergency Plan for AIDS Relief (PEPFAR), Dr Mark Dybul, visited Zimbabwe and pledged US\$20 million. The funding will be coordinated via the local Centre for Disease Control office and the USAID mission in Harare. (PEPFAR had by then given US\$15 billion to control HIV/AIDS to 14 developing countries but to the exclusion of Zimbabwe, which is one of the countries in the epicentre of the HIV/AIDS pandemic.)³⁷

In March 2006, the European Union provided the Zimbabwe government with significant funding for health and HIV/AIDS. Also in March 2006, the World Bank announced that Zimbabwe had been chosen, along with Zambia and Malawi, to receive US\$87,000 for NGOs, community groups and other civil society organisations (CSOs) working towards solutions in HIV/AIDS. The funding would come from the Bank's Country Development Marketplace, a funding facility launched in 2004 for civic organisations engaged in HIV/AIDS work.³⁸ The United Kingdom's Department for International Development provided substantial funding in April 2006 for poverty alleviation, health and HIV/AIDS programmes. Sweden's SIDA has also provided some funding for poverty alleviation, health and HIV/AIDS.

The government has of late been insisting on controlling and coordinating HIV/AIDS resources via the UNAIDS 'Three Ones Initiative'; that is, one strategy, one coordinating body and one monitoring system. This is also in keeping with the AU Commission's HIV/AIDS Strategic Plan 2005–07 and the AWA Action Plan (Objective 3 Harmonisation and Coordination, Strategy 30b).³⁹ However, civil society

is concerned that the government could stifle the independence of private welfare organisations with the resultant loss of further external support for HIV/AIDS.

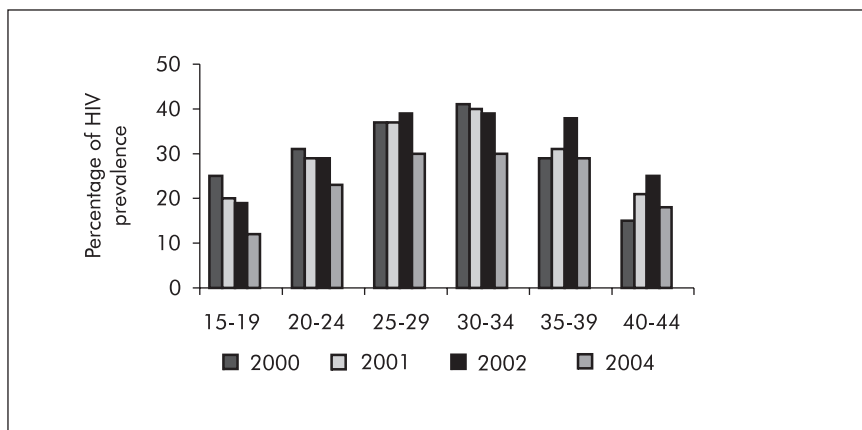
RECENT DECLINE IN HIV PREVALENCE

On a positive note, the latest (2005) figures show some decline in HIV prevalence in the adult population. This is now estimated at 20.1%, compared with 24.6% in 2002 and 31% in 2000.⁴⁰

Figure 2 shows that there has been a significant decline, particularly in the 15–19-year age group. These results have stimulated a lot of enthusiasm and debate. After all, Uganda had until then been the only country in sub-Saharan Africa that had recorded a decline in HIV/AIDS prevalence. The government, along with UNAIDS and other partners, argue that this is a genuine decline attributable to behaviour change as a result of health education and district and community management of HIV/AIDS. More specifically, it is argued that there is an increase in condom use and an increase in the number of young people delaying the onset of their first sexual experience, while both males and females are now having fewer partners.

A recent study of HIV prevalence in eastern Zimbabwe during the period 1998–2003, and published in the reputable journal *Science* in

Figure 2: HIV prevalence among pregnant women attending antenatal clinics by age group, 2000–2004



Source: Adapted from UNAIDS/WHO AIDS, AIDS pandemic update, (UNAIDS/05.19E), Geneva, December 2005, p 21.

February 2006, supports the view that the decline is genuine and that it is due to behaviour change.⁴¹ The study reveals the following startling results: HIV prevalence has declined by 49% in women aged 15–24 years and 23% in men aged 17–29 years. The reduction was more prevalent in more educated people. Sexually experienced men and women reported a decline in casual sex of 49% and 22% respectively. Delayed sexual debuts were also recently reported.

The authors argue that these spectacular results were most probably due to, *inter alia*,⁴²

- a well-educated population;
- a change of behaviour due to fear of dying from AIDS;
- a relatively good communications and health services infrastructure;
- radio and TV dramas;
- early control of STIs;
- social marketing of condoms;
- the VCT programme; and
- the positive impact of the Zimbabwe AIDS Trust Fund.

A comprehensive review of epidemiological and behavioural data released by UNAIDS in November 2005 concludes that both HIV prevalence and incidence rates have fallen in Zimbabwe over the past five years.⁴³

Others doubt whether there has been a real decline. Even Gregson and colleagues note that “owing to the long average incubation period of HIV infection, HIV prevalence reflects the accumulation of infection over a period of more than ten years and is therefore insensitive to behaviour change”.⁴⁴

There are some thoughts that this could be because of a change in the method of collecting data on sero-prevalence. Others, including Gregson et al, concede that the decrease in prevalence could also be due to a higher number of deaths among AIDS sufferers.⁴⁵ Furthermore, prevalence rates alone tell us little about the potential reasons behind the figures.

The Demographic and Health surveys in Zimbabwe include both HIV prevalence and behavioural indicators. The latest Demographic and Health Survey results are due in mid-2006. Thus, it will be possible to further elucidate the impact of behavioural indicators on the latest national HIV prevalence rates. However, even if the recent results are a genuine reflection of a decline in HIV/AIDS infection, a prevalence rate of 20.1% is still too high.

ZIMBABWE DEFENCE FORCES (ZDF)

BRIEF OVERVIEW OF ORGANISATIONAL AND COMMAND STRUCTURE

The security agencies in Zimbabwe consist of the Zimbabwe National Army (ZNA), the Air Force of Zimbabwe (AFZ), the Zimbabwe Republic Police (ZRP), the Zimbabwe Prisons Service (ZPS) and the Central Intelligence Organisation (CIO).

From the civil society perspective, and taking into consideration HIV/AIDS, the role of the military in training and possibly arming the ZNWVA and some graduates of the national youth training programme (popularly referred to as the 'youth militia') needs to be questioned. These two organisations played a significantly negative security role during the parliamentary and presidential elections of 2000 and 2002, with some of their members accused of rape. Our emphasis here, however, will be on the ZNA and the AFZ, which constitute the Zimbabwe Defence Forces (ZDF).

The Defence Forces Act governs the ZDF, which does not fall under the Public Service Act. Zimbabwe's president is commander-in-chief of the ZDF. He appoints the commander of the ZDF, who is the equivalent of the chairman of the Joint Chiefs of Staff. Below the ZDF commander are the commander of the ZNA and the commander of the AFZ. The president appoints all the officers of these two forces, on the recommendation of the ZDF commander. Civilian control of the military is structured via the Ministry of Defence, with the Minister of Defence answerable to parliament.

ZDF'S INTERNAL AND EXTERNAL SECURITY ROLE

The principal role of the ZDF is to safeguard the borders of the country against external threats. The very long borders therefore pose a challenge for deployment. The ZDF also complements the ZRP in ensuring internal security when called upon. The ZDF may be called upon to implement some of the country's foreign policy objectives. It was in this connection that the ZDF was deployed in Mozambique's civil war soon after independence, from 1982 to 1992, in particular in the provinces of Manica and Sofala. The intervention was codenamed 'Operation Butterfly' and was initially aimed at protecting Zimbabwe's rail, road and fuel pipeline to the Indian Ocean. Thereafter, the ZDF became more involved in the civil war and supported the Frelimo government against the Renamo rebels.

More controversially, the ZDF was deployed from August 1998 until October 2002 in the Democratic Republic of the Congo (DRC) civil war in support of the regime of the late Laurent Kabila. This intervention was codenamed 'Operation Sovereign-Legitimacy'. The Zimbabwean troops were joined by troops from Angola and Namibia. The rebels were supported by Rwanda and Uganda. Thus began Africa's so-called First World War.

ZDF'S INTERNATIONAL PEACEKEEPING ROLE

ZDF personnel have been deployed to several trouble spots around Africa under the umbrella of the UN in Angola, Rwanda and Somalia, and with the Organisation of African Unity Observer Group in Burundi. ZRP personnel have also been deployed in international peacekeeping exercises.

Zimbabwe has become the leading country for peacekeeping training in the SADC region via the SADC Organ for Politics, Defence and Security and the Inter-State Defence and Security Committee. The training has been coordinated by the Zimbabwe Staff College in Harare. The first joint command and staff course was held in 1996.

These external missions, whether offensive in nature (as in Mozambique and the DRC) or peacekeeping (as in Angola and elsewhere), have a bearing on the transmission of STIs, HIV/AIDS and other infections within the armed forces and to and from civilian populations, both at home and abroad. There is a particular concern about the possibility of introducing new strains of HIV and other dangerous diseases such as Ebola.

ZDF AND HIV/AIDS

HIGH HIV AND STI PREVALENCE

It is understandable that militaries are often reluctant to divulge figures on HIV/AIDS prevalence for fear that this would tip off potential enemies as to their perceived strategic weaknesses due to illness. For instance, the high attrition rates associated with the recent maturing of HIV/AIDS has resulted in the "loss of continuity at command levels and within the ranks, increased recruitment and training costs for replacements, and a general reduction in preparedness, internal stability, and external security".⁴⁶

There is some evidence that “ST[I] infection rates among military populations are between two and five times the infection rates of the civil societies in which they reside”.⁴⁷ As noted previously, STIs significantly increase the risk of contracting HIV/AIDS.

Like the civilian population, militaries in the Southern African region are the most affected by, and vulnerable to, HIV/AIDS.⁴⁸ UNAIDS and other sources estimate that military personnel have a two to five times higher risk of contracting HIV than the general population during peacetime, and an even greater risk during conflict.⁴⁹ Postulated reasons for this, including in Zimbabwe, include that:

- those in the military are predominantly in the most sexually active age groups;
- young recruits may be socially inexperienced;
- military culture tends to favour risk-taking behaviour;
- there is stress during wartime and boredom during peacetime;
- there is abuse of alcohol and drugs;
- the militaries are highly mobile populations and are often away from their families for long periods;
- the militaries are often surrounded by opportunities for casual sex;
- those in the military have steady incomes, privileges and power, thereby creating potentially unbalanced sexual relations with local civilian populations;
- there is the possibility of occupational infection through caring for the wounded and the possibility of receiving contaminated blood during emergency transfusions; and
- there is a lack of HIV/AIDS intervention programmes, including a general lack of adequate HIV testing and monitoring equipment, especially under field conditions.⁵⁰

Retired Brig Gen Chiweza revealed that when he was Zimbabwe’s

military attaché in China in the 1990s he was shocked by the high number of Zimbabwean military officers who were HIV-positive and who had STIs and had been sent for training. (China has a policy of mandatory testing for all foreigners coming for training.) In 1990, 13 out of every 60 ZDF officers sent to China for training were HIV-positive (that is, 21.7%) and 30 out of 60 had STIs (50%).⁵¹

In South Africa, it was noted in 2002 that:

the greatest prevalence of HIV/AIDS was found among the 25–33-year age bracket. . . . When considering that this comprises the mean middle-management, from lieutenant to lieutenant-colonel for officers and from sergeant to warrant officer for other ranks, the implications with respect to force preparation and application (deployment) as well as budgetary considerations, become obvious.⁵²

There is no reason to believe that the situation would be any different in the ZDF.

The Southern Africa HIV/AIDS Information Dissemination Service, an NGO, reported in 2002 that about half of Zimbabwe's soldiers were HIV-positive and that "this obviously has serious repercussions on military preparedness and functions, individual soldiers, their families and the civilian populace with whom they interact".⁵³ The report further says, "widespread illness in the ranks threatens the ability of the military to respond to external threats or to fulfil its other functions".⁵⁴

The US Defence Intelligence Agency is cited by Mock as estimating that the ZDF has a sero-prevalence of 70–75%.⁵⁵ Others estimated that 80–90% of Zimbabwean troops engaged in the DRC war were HIV-positive.⁵⁶

More recently, a study by the Poverty Reduction Forum, the Zimbabwe Institute of Development Studies and the UNDP—the 2003 *Zimbabwe Human Development Report*—estimated that the ZDF had an HIV/AIDS sero-prevalence of 55%.⁵⁷ The study also reported that about 75% of ZDF personnel die within one year after discharge and that 72% of all prison deaths are due to HIV/AIDS.⁵⁸

IMPACT OF EXTERNAL DEPLOYMENT

As previously noted, ZDF personnel have been deployed to several countries on the African continent. "Deploying large numbers of soldiers and peacekeepers around the planet adds new complications to the

spread of HIV/AIDS.”⁵⁹ Sarin and UNAIDS also warn that peace often exacerbates the problem as demobilised forces return home and mingle with the local civilian population.⁶⁰

Of particular concern to civil society in Zimbabwe is the potential impact of deployment to the DRC, where Zimbabwean troops spent four years. The Los Alamos Laboratory in New Mexico, US, keeps genetic details of every HIV strain. A *Newsday* article of 9 July 2000 quotes Dr Bette Korber from the laboratory noting with concern that “... something strange is going on in Congo. It’s as if all the African HIV clades (subtypes) are mixing there, forming strange recombinants. We are seeing variants never seen before”.⁶¹

The Lake Victoria region adjacent to the DRC, where the HIV/AIDS pandemic is thought to have originated, predominantly has the D and A clades. Southern Africa, where the pandemic is newer, has predominantly the C clade. Korber concluded that “recombination is happening so fast that we see the clade distinctions beginning to blur”.⁶² Having exposed Zimbabwean troops to the DRC means that the troops could have introduced new strains to that region, and also that they could have brought back new HIV strains, along with other communicable infectious diseases such as Ebola.

MILITARY, GENDER AND HIV/AIDS

We have already noted that in the civilian population, women and young girls in particular are at greater risk of contracting HIV/AIDS.⁶³ In relation to the military, risks are present from three fronts:⁶⁴

- Women and young girls are at increased risk of sexual abuse by armed personnel during both peacetime and times of conflict. In the milder form, this can take the form of poor and vulnerable women and girls being drawn to military barracks and resorting to survival sex in search of money and food. Military personnel often have higher incomes than the people in the surrounding communities. This is further exacerbated by the fact that many military barracks are single-sex accommodation facilities. Also, when away from home for long periods, military personnel may visit local brothels. In the more extreme form, this may include rape in exchange for allowing women, especially cross-border traders with no documents, to cross checkpoints and borders. During conflict, even more violent forms of rape occur (rape as a tool of war).

- The partners of military personnel are at increased risk of contracting STIs and HIV/AIDS when the troops return home from both internal and external deployment.
- Young female recruits in the military are also at great risk of sexual abuse from their male superiors. As in other militaries, the UNDP report notes that the same risks are also present in the Zimbabwean scenario.⁶⁵

IRREGULAR PARAMILITARY FORCES AND HIV/AIDS

Civil society was very concerned that sections of the war veterans' movement and young recruits from the national youth training centres, popularly known as the 'youth militia', were engaged in election-related violence, including allegations of rape, during the 2000 and 2002 general and parliamentary elections.

There has also been anecdotal evidence of young female recruits in the national youth training centres being subjected to sexual abuse by their male peers. Several authors and organisations have warned that young boys and girls, including young combatants, are highly vulnerable to sexual violence and exploitation.⁶⁶

Although the situation in Zimbabwe was not as bad as the very sad case of child soldiers witnessed in the DRC, Southern Sudan, Sierra Leone, Liberia and other parts of Africa and elsewhere,⁶⁷ it is nevertheless a worrying development that needs to be nipped in the bud. Such practices put these young people at higher risk of contracting STIs and HIV/AIDS.

ZDF RESPONSE TO HIV/AIDS

HIV/AIDS POLICY AND COORDINATING STRUCTURES

The ZDF's HIV/AIDS policy is informed by the national policy as promulgated by the NAC. However, the ZDF has its own structures to respond to the HIV/AIDS challenge. On a positive note, the ZDF has not relegated HIV/AIDS as a purely public health challenge to be handled by the health division. Instead, the ZNA launched its AIDS Coordinating Committee in 2002. This is headed by a high-ranking officer, Brig Gen Douglas Nyikayaramba. The committee has introduced the HIV/AIDS programme to all the army's units. The programme includes distribution

of educational material, home-based care, and more recently VCT, for both army personnel and their dependants.

One of the challenges facing HIV/AIDS in militaries has been the incorrect perception that militaries in Africa are well funded. This often leads to their exclusion from civil society resources. In July 2003 the ZDF did, however, receive ZW\$30 million from the National AIDS Trust Fund. Receiving the money on behalf of the army, a very senior military commander, Maj Gen Amoth Chimombe, was quoted as saying “the ZNA will by the end of the year include HIV/AIDS education as part of military training”.⁶⁸ This development—the mainstreaming of HIV/AIDS-related issues in the military curriculum—is crucial for countries seeking to communicate the effects of HIV/AIDS at an early age.

HIV/AIDS AND RECRUITMENT POLICY

In principle, the ZDF provides ‘voluntary’ testing with counselling. Confidentiality of one’s HIV/AIDS status is also assured.

The recruit undergoes a variety of tests. These include gruelling fitness tests, interviews and medical tests. It is probable that all new recruits are screened for HIV/AIDS. In the past, around 1996, recruits who passed the fitness test but were found to be positive but generally physically healthy would be recruited.⁶⁹ Currently, it is probable that HIV-positive potential recruits are not admitted into the military. However, it appears that potential recruits are not told why they were not successful. The failed recruit is thus left to ponder the reason for exclusion. This could be failure of the fitness test, the medical examination or the interview. This has obvious ethical implications, as it does not fall within the realm of ethical VCT. This apparent new policy of admitting only HIV-negative recruits is likely to be intended to reduce both the financial burden and the security threat posed by high HIV/AIDS prevalence rates.

The AFZ was the first to declare openly that recruits for some specified jobs, such as pilots, must be HIV-negative. This was the case even before 1996—as indicated in the paper by Yeager, who noted that “persons applying for pilot training must first be tested because of the high cost of this education”.⁷⁰ This was most probably as a result of recommendations from the then Zimbabwe military attaché to China, who was alarmed by the high numbers of pilots who were HIV-positive and had been sent back from China where they had gone for further training.⁷¹

IN-SERVICE POLICY ON HIV/AIDS

Since the mid-1990s, the ZDF has been providing voluntary counselling and testing.⁷² It is not known how many soldiers have gone for VCT. However, judging from the scepticism expressed by Brig Gen Chiweza (who retired from the ZDF in 1995) concerning the very low uptake of VCT in the general population in March 2003, it would be safe to assume that the VCT uptake is also low in the military.⁷³

Confidentiality is said to be assured, “with commanders only having to know about their units’ aggregate strength. . . . HIV-positive but otherwise fit cases continue in service and are provided with education and counselling”.⁷⁴

This is in keeping with ILO Code of Practice 8.3, Epidemiological Surveillance, which states that “anonymous, unlinked surveillance or epidemiological HIV testing in the workplace may occur provided it is undertaken in accordance with ethical principles of scientific research, professional ethics and the protection of individual rights and confidentiality”.⁷⁵ Soldiers who are HIV-negative are counselled and encouraged to remain negative. “Some HIV-positive officers, for example pilots of high-performance aircraft, may be reassigned.”⁷⁶

Exceptions to VCT include those going for further training abroad and pilots. “Personnel slated for overseas training are tested to comply with requirements set by host countries.”⁷⁷ However, it is probable that colleagues may become aware that those not sent abroad for further training were HIV-positive, thereby compromising confidentiality. Nevertheless, there is no obvious evidence of stigmatisation of such personnel. Pilots undergo regular HIV testing. “HIV-positive pilots are counselled. If there are no apparent symptoms, a pilot may continue flying, but if the pilot becomes HIV-symptomatic, he is grounded and, if AIDS-symptomatic, he is discharged.”⁷⁸

Soldiers who are both HIV-positive and ill are treated with the available medication, including ARVs. However, they are encouraged to go on early retirement on medical grounds if their illness persists. “AIDS patients must appear before medical boards and be discharged if found no longer able to perform their duties.”⁷⁹ This includes health personnel within the ZDF. This is done in order to allow the ZDF to recruit new staff. Recruitment cannot be done when the personnel members concerned are still at their posts.

Soldiers who die of HIV/AIDS (or any other illness) while on the job are provided with full funeral support, including transport of the body to the burial site chosen by the family, no matter how far.

POST-EMPLOYMENT HIV/AIDS POLICY

As noted above, if the medical board determines that the disability due to the illness is permanent, the soldier is recommended to go on early retirement on medical grounds with full benefits, and in fact to “receive a better pension than is normally offered”.⁸⁰ Processing of the necessary papers is speeded up so that soldiers may obtain their benefits while they are still alive, and also to allow prompt replacement of personnel.

To its credit, the ZDF does not neglect its retired and ill soldiers. “Personnel thus discharged are entitled to free medical care until they die.”⁸¹ Furthermore, “dependants of deceased male personnel are provided for until their children mature or their wives remarry”.⁸²

GENDER

We have already discussed the aspect of the military, gender and HIV/AIDS. In addition, HIV/AIDS among the spouses of male soldiers presents an important challenge. The ZNA Wives and Women’s Association has led the battle to break the silence and deal with the issue of stigmatisation.

RESEARCH

The Ministry of Health and Child Welfare has conducted several epidemiological studies on HIV/AIDS⁸³ and has also encouraged other researchers to do the same.⁸⁴ The ZDF has a corps of clinical and public health scientists headed by a medical practitioner with a master’s degree in public health and the rank of brigadier general. The army has been conducting its own studies on aspects of HIV/AIDS in the military. Unfortunately, these are not in the public domain. However, it is hoped that efforts will be made to get cooperation from the military for future publications, as such studies are in the public interest and are not necessarily a threat to national security.

FUTURE CHALLENGES

Zimbabwe needs to embark on constructive, broad political and socio-economic reforms that will enhance some of the positive public health measures that are being pursued. It is only then that Zimbabwe will be able to achieve some of the targets of the Millennium Development Goals, in particular those that relate to HIV/AIDS.

Since the military is now recruiting largely HIV-negative young people, it is assumed that, in theory, there may come a time when the HIV prevalence in the military is lower than it is in the general adult population. However, the greater challenge is to ensure that HIV-negative personnel remain negative. So long as the factors that put military personnel at higher risk of contracting HIV/AIDS remain, the battle will not be won.

It is important to note that employment policies at national, regional and international levels do not favour discrimination on the basis of HIV-positive results, even at the pre-employment stage. The reforms in the Royal Thai Military in relation to HIV/AIDS demonstrate that it is possible to reduce HIV/AIDS in the military without discrimination and stigma.⁸⁵

The challenge of harmonising HIV/AIDS policies in the military in the region, both within SADC through the SADC Organ on Politics, Defence and Security Cooperation⁸⁶ and the Southern Region of the AU Standby Force,⁸⁷ still remains. The Zimbabwe military therefore needs to continue to be fully engaged in that regional endeavour.

Finally, the challenge of further developing multidisciplinary HIV/AIDS research in the military remains. One way of achieving this is by developing stronger civil–military cooperation. Such cooperation would not only help to resolve some of the suspicions and misunderstandings, but it would also help in reducing HIV/AIDS in both the military and civilian populations.

SUMMARY AND CONCLUSION

In spite of the enormous socio-economic and political challenges faced by Zimbabwe, the country should be applauded for having taken HIV/AIDS seriously. Credit should particularly be given for the following initiatives:

- An independent national AIDS policy coordinating body, the NAC, a National AIDS Levy and the National AIDS Trust Fund have all been established.
- Overall, with few exceptions, the ZDF's HIV/AIDS policies are consistent with national policy on HIV/AIDS, as promulgated by the NAC.
- The NAC, through the National AIDS Trust Fund, has allocated money to the ZDF's HIV/AIDS campaign.

- The top leadership of the ZDF has tackled HIV/AIDS as a priority challenge, as opposed to just leaving it to the medical department.

If Zimbabwe and other Southern African countries are to achieve the Millennium Development Goals of taking “necessary action to halt and begin to reverse the global AIDS pandemic by 2015”, then the active participation of the military will be vital. This calls for active civil–military cooperation.⁸⁸

Nancy Mock noted in 2002 that “the role of the military [in HIV/AIDS] is only a recent concern of the international community” and that “the military is seen as part of the problem, not part of the solution”.⁸⁹ It is hoped that this publication will help to change this perception both in Zimbabwe and in the SADC region generally.

RECOMMENDATIONS

UNITED NATIONS

The UN Security Council adopted Resolution 1308 in July 2000 in response to the challenge posed by HIV/AIDS in the military.⁹⁰ Hence, UNAIDS and the UN Department of Peacekeeping Operations have been working closely to develop further AIDS prevention and education for all peacekeepers.⁹¹

The UN is still grappling with the controversial question of compulsory pre-deployment HIV testing for peacekeepers. The rights-based approach remains the cornerstone, so as to ensure testing with informed consent and confidentiality, as well as dealing with the implications of HIV-positive results, which include reducing discrimination and stigma. Nevertheless, several countries, Eritrea being one, have demanded that peacekeepers be tested and that only HIV-negative personnel be deployed so as to protect the local civilian population.⁹² Zimbabwe has contributed to the UN peacekeeping pool. It is imperative that the UN draws up sound guidelines on this controversial topic.

Major peacekeeping operations have full-time AIDS advisers and smaller missions have AIDS focal points.⁹³ The ZDF should follow this example and designate AIDS focal points in all its barracks.

AFRICAN UNION

The UN has suggested the creation of regional standby forces. The AU

has already devised plans to create five regional standby brigades that would be part of the Africa Standby Force.⁹⁴ Zimbabwe falls within the proposed Southern Africa Standby Brigade. Zimbabwe could use its leading training role in SADC to propagate common policies and standard operating procedures on HIV/AIDS in the Southern African region in keeping with the AU's HIV/AIDS strategic plan.⁹⁵

The AU Commission's HIV/AIDS Strategic Plan 2005–07 and the AWA Action Plan (Objective 5: Programme Priorities, Strategy 34g) recommends that the continent should “accelerate effective implementation of comprehensive HIV/AIDS programmes in AU peacekeeping operations, African militaries and other conflict, emergency and humanitarian responses”.⁹⁶

The Zimbabwe military should be an active player in addressing this continental challenge. The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases asks African nations to set a target of at least 15% of their annual budgets to the improvement of the health sector.⁹⁷ It is now five years since the Abuja Declaration⁹⁸ and five years since the UN General Assembly Special Session on HIV/AIDS.⁹⁹

This is a challenge that the Zimbabwe government should be seen to be addressing. To repeat the situation where more was being spent on defence than health during the DRC campaign would be unacceptable.

SADC/ISDSC

The SADC Protocol on Politics, Defence and Security binds SADC member states to “cooperate fully in regional security and defence . . . [and] develop a regional peacekeeping capacity with national armies”.¹⁰⁰ There is therefore a strong need to develop a collective and harmonised HIV/AIDS policy for SADC defence forces, as recommended by the SADC Inter-State Defence and Security Committee. In this regard, Zimbabwe could use its leading role in peacekeeping training to propagate common policies and standard operating procedures in the region for HIV/AIDS in the armed forces.

The SADC Treaty of 17 August 1992 converted the region from a treaty of the executive arms of the states to a treaty of peoples.¹⁰¹ As such, there is need for greater cross-border collaboration of SADC citizens to combat HIV/AIDS, including regional civil–military initiatives. The initiative by the Institute for Security Studies is therefore appropriate.

ZIMBABWE

The ZDF should continue to improve its “capacity to collect and analyse the data required to generate these (HIV/AIDS) estimates”.¹⁰² Since HIV/AIDS knows no boundaries, closer civil–military relations could contribute to this improvement.

During Zimbabwe’s participation in the war in the DRC, it was estimated that the country was spending about twice as much on defence as on health.¹⁰³ If Zimbabwe is to continue to make a significant impact on the HIV/AIDS pandemic, these figures need to be substantially reversed. The ZDF should expand its information and education programme, in particular the training for peer educators.¹⁰⁴ There should be more targeted information and education on the provision of condoms and their use in the military.

The ILO recommends that “HIV testing should not be required at the time of recruitment or as a condition of continued employment”.¹⁰⁵ The ZDF needs to take note of this and also to further promote VCT in the military.

In view of the close relationship between STIs and HIV/AIDS, it is imperative that the ZDF should continue to prioritise STI prevention and treatment. The ZDF should draw some lessons from the Royal Thai Army on early surveillance of HIV within conscripts, treatment and care of military personnel, medical research and development, multi-sector cooperation and the need for a long-term commitment.¹⁰⁶

On gender and HIV/AIDS in the military, Yeager recommends the need to “overcome sexual harassment in the ranks by empowering women through promotions and other measures”.¹⁰⁷ This is consistent with ILO Code of Practice 6.3 on the need for gender-specific programmes. The code recommends that:

information for women needs to alert them to, and explain, their higher risk of infection. . . . Education should help both women and men to understand and act upon the unequal power relations between them. . . . Harassment and violence should be addressed. . . . Women should understand their rights, both within the workplace and outside, and they should be empowered to protect themselves.¹⁰⁸

The ZDF should also improve the availability of user-friendly female condoms, the early recognition and treatment of bacterial vaginosis and the promotion and use of microbicides, as recommended at the recent 2006 international conference in Cape Town, South Africa.

The ZDF should continue to address the need to provide family housing for its personnel, as opposed to single-sex barracks that are akin to the old and discredited single-sex hostels in the mining, urban and commercial farming sectors in the Southern African region. Yeager underscores the need to “provide better living conditions for married military couples”.¹⁰⁹

Since a lack of recreational facilities in military barracks has been implicated in increasing the risk of contracting HIV/AIDS, the ZDF should increase the provision of adequate sport and recreation facilities in the armed forces. Already, the ZDF has active sporting programmes in soccer, volleyball, athletics, shooting and other disciplines.

Currently, personnel may be away from home for up to six months. Yeager recommends a maximum period of three months’ deployment away from home and family.¹¹⁰ It is strongly recommended that HIV/AIDS programmes also target war veterans and ‘youth militia’.

The ZDF should study seriously the public health impact of male circumcision. Several studies in sub-Saharan Africa have shown that uncircumcised males are highly susceptible to HIV infection, whereas male circumcision is equivalent to a vaccine with a 60+% efficacy.¹¹¹ It would therefore appear logical to recommend circumcision and provide free circumcision to military recruits who request it.

Finally, there should be less secrecy pertaining to HIV/AIDS in the military in Zimbabwe and in the region. This is a topic that is in the public domain and is of national interest.

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PART III

CONCLUSIONS AND RECOMMENDATIONS

Lessons learned

Martin Rupiya

This study is expected to make an important contribution to the complex problem of HIV/AIDS and its impact on the militaries in Africa, as well as on their responses to the pandemic. The study is based on empirical evidence and participation in the project of the armed forces of Botswana, Swaziland and Zambia, with the authority of their governments, as well as contributions from civil society colleagues who have intimate knowledge and experience gained from working on this issue with the militaries of Tanzania and Zimbabwe.

This summary of lessons learned emanates from several dimensions:

- The first is a range of common trends identified in each of the militaries that can provide information and insights to other defence and security institutions.
- The second is what is unique in each of the case studies that the other organisations can learn from.
- The third is that we need to identify what we know from the debate that has not necessarily been previously highlighted, and to seek to bring this to bear as comprehensive lessons learned for Southern African militaries in particular, and Africa in general.

The basis of the knowledge gained revolved around research questions, dialogue with members of the research group through correspondence,

email and other forms of communication during the period of the research, and, finally, other interactions, including participating as the core group in a scenario workshop that took place the day after the completion of the October 2005 conference on the final review of the manuscript. What follows, therefore, are key points and lessons learned from the research, dialogue and interactions over the past year or so.

However, a word of caution. This is not a summary of the very rich and unique country chapter presentations. It is, instead, merely a selection of the more common trends and similarities, without detracting from our initial intention, which is that readers should refer to each of the chapters in this book.

The first lesson to almost jump out of the research was a confirmation of the existence of the HIV/AIDS pandemic in all the countries represented. This is an important lesson, in which the incidence, threats and challenges of HIV/AIDS continue to be universal in the countries selected for the study. As a result, there is a morbid reality in which, either individually or in cooperation, the said countries need as a matter of urgency to find similar policy options on how to respond to the debilitating nature of the pandemic.

The ‘discovery’ of the presence of HIV/AIDS in Southern Africa appears to have emerged within a single decade, around the late 1970s and early 1980s. In alphabetical order, Botswana, Swaziland, Tanzania, Zambia and Zimbabwe are some of the countries grappling with the presence and accelerated impact of the incidence of HIV/AIDS. There is, however, a difference in the prevalence rates. Tanzania exhibits the lowest prevalence rate at national level while Swaziland and Botswana reflect the highest. The other two, Zambia and Zimbabwe, have prevalence rates that lie somewhere in between.

Related to the question of prevalence is the recognition of a similar trend in the methods of transmission of the disease. As John Iliffe asserts in *A History of the African AIDS Pandemic*, more than 90% of African victims have had their infection transmitted from heterosexual activities, while 10% of the transmissions were from blood transfusions or mother-to-child transmissions.¹

This assertion, however, misses out on what we think is a known phenomenon but one that has not been addressed. This is homosexual activities within African communities, including the armed forces. Given the criminalisation and taboos surrounding homosexual practices in African societies, this is not surprising. However, conference participants acknowledged that while homosexual activities existed as a means of

transmission, their extent was difficult to document. This was because whenever homosexual activities occurred and became known, those engaging in them were immediately prosecuted, jailed or even dismissed from the various defence forces in terms of existing regulations.

A consequence of the heavy-handed policing of homosexuals has resulted in the low to very low admitted incidence of transmission compared to the much talked about San Francisco American example. Although in the debates and dialogue with the researchers this question was raised, its practice was noted to be highly secretive and therefore difficult to document.

However, this development provided us with a second important lesson, which was the inability by African states to come up with appropriate counter-measures two decades after the ‘discovery’ of HIV/AIDS within their societies and among the ranks of their defence forces.

In the case studies, most of the policies referred to had been developed but were still awaiting final adoption by the various legislatures. What is the explanation for this common policy freeze? There are two main reasons and perhaps a third secondary reason for this inertia in policy formulation among African states.

REASONS FOR POLICY FORMULATION INERTIA

LACK OF RESEARCH APPROPRIATE TO AFRICA

The first main reason is that HIV/AIDS types and strains have developed along different lines. Europe and the United States (US) are characterised by HIV/AIDS Type 1, while the African continent is characterised by HIV/AIDS Type 2. While Type 2 is more virulent, Type 1 is relatively benign from the perspective of its effects and the survival of those infected with it. Based on this differential—which is also revealed in the global prevalence rates, as published by the Joint United Nations Programme on HIV/AIDS (UNAIDS) annually—the impact of HIV/AIDS has remained within manageable levels in the northern hemisphere (or ‘the West’), while it has escalated to a pandemic on the African continent, where it has caused horrendous fatalities and has threatened national security.

With HIV/AIDS remaining a public health issue in the West and falling in the realm of the various health ministries, there has been a lack of appropriate policy formulation by skilled and experienced institutions in the West from which Africa could copy and paste.

This absence of policy focus in the West has also not been helped by the differences in viral types. Research has generally not concentrated on the African Type 2 virus, which has been regarded as exotic. Instead, resources and attention have been concentrated on the Type 1 that is more prevalent in the developed world.

WEAK STRUCTURES WITHIN AFFECTED GOVERNMENTS

Second, African states are going through a period of considerable political reform, nation building and reconstruction, after the removal of the strictures of the Cold War and its replacement by the 'winds of globalisation'. In this context, HIV/AIDS has left most African countries in a state of near-collapse, weak and barely able to manage a rudimentary development agenda.

COMPLEX NATURE OF THE DISEASE

A third, secondary, reason for the lack of an emergence of appropriate policies has been the nature of the disease. HIV/AIDS has been described as "silent [and] hypocritical and visible only when the damage is irreparable".²

Stated differently, the incidence, evolution and impact of HIV/AIDS is complex and demands the dedication of huge amounts of resources, as well as multiple and sector approaches that are beyond the capacity of most African countries. The challenges include how to:

- benefit from a mature pharmaceutical industry;
- raise the significant amount of resources required;
- provide basic food security for diverse nutritional needs;
- train skilled medical and social science human resources supporting research, and administering new regimes of drugs as well as care and treatment; and
- develop a health system that includes private and public entities as well as host research and development capacity.

To this end, there are points and periods in the evolution of HIV/AIDS

in which the absence of counter-measures may appear superfluous but be proved not to be so only when it is too late.

For the above three reasons therefore—an absence of similar impact in the North and therefore no policy effort that could be appropriated by Africa; the weak structures within affected governments on the African continent; and the complexity and multi-dimensional challenge of HIV/AIDS—African people have been left floundering.

SOUTHERN AFRICA'S RESPONSE

Against this debilitating background, attempts by Southern African states studied to come up with effective and timely policy options have been characterised by fits and starts, and eventually inertia. Each of the countries has traversed three steps in its attempts to come up with HIV- and AIDS-related policies:

- Faced with the 'discovery' of HIV/AIDS during the 1980s, a common trend was to establish a unit within the Ministry of Health charged with investigating the disease and providing the country's Cabinet with options.
- When this failed, the unit was expanded to a National Commission with the same mandate and expectation.
- Finally, the National Commission managers have since gone back to each sector—such as agriculture, mining, tourism, education and labour—and encouraged the sectors to come up with specific sector-oriented policies that together will form the national framework.

This last is the stage reached by most of the countries examined in this study. The national commissions in Botswana, Swaziland, Zambia, Tanzania and Zimbabwe may therefore benefit from the summary contained in this study. It must be pointed out, however, that the failings at national level described in the case studies are not unique. Similar evidence is also available at the international level. In this regard, the experience of the World Health Organisation (WHO) before 1995–6 and the successor United Nations (UN) cluster approach through UNAIDS is striking. Each of the countries has followed similar criteria and processes in their attempts to come up with policies that respond to the threat of HIV/AIDS, both at national and at institutional levels.

LESSONS SPECIFIC TO THE ARMED FORCES

In 2001, the International Labour Organisation published a code guiding the recruitment and employment of individuals suffering from HIV/AIDS.³ This provided for non-discrimination on the basis of HIV/AIDS for anyone being recruited, including in the military, as well as support for those who become affected during their working lives. Then there is the question of human rights regimes, which provide individuals with protection against any violations of their personal liberties.

These are issues that confront defence and security institutions when they recruit personnel or reassign personnel away from physically demanding posts in, for example, the air force or the commandoes.⁴ One of the by-products of this protection of HIV/AIDS sufferers is an unforeseen economic cost. While armed forces' budgets are usually calculated on manpower requirements, the HIV/AIDS pandemic has led to an increased turnover of personnel. Unit commanders now have to carry a number of people on their books who are operationally incapable but who are given home sick leave on humanitarian grounds, and who in the process reduce the effectiveness of sections, platoons and companies.

The Zimbabwe case study reveals that its country's air force was the first to announce that "persons applying for pilot's training must first be tested because of the high cost of this education".⁵

The Tanzanian approach is also pragmatic when it argues that:

prolonged periods of recruit training are strenuous. This endurance training goes on by day and night, in deliberately harsh terrain during cold, wet, humid, dusty environments coupled with enforced lack of adequate rest, [food and drink] and sleep. The effect of this strenuous training on asymptomatic HIV patients accelerates the HIV illness conditions and predisposes the affected recruits to continual respiratory infections, diarrhoea, and dehydration. Eventually, the affected recruits die.⁶

Medical evidence supporting this statement is referred to in the Swaziland case study, which claims that militaries in all five of the countries surveyed are testing recruits for HIV/AIDS and rejecting those suffering from the disease on medical grounds. All the countries appear to have adopted the same approach, citing victims of HIV/AIDS as having been rejected on medical grounds in the same way as potential

recruits would be if they had flat feet, an asthmatic condition, diabetes, or squint eyes.

There is, however, a second aspect related to recruitment that appears to require further serious consideration. This is that HIV prevalence rates may generally be lower among 17–18-year old recruits, and that there is therefore a need to mount aggressive programmes in order to maintain the HIV-negative status of these recruits once they are taken into the armed forces. When the debate on this issue was focusing on the dimensions of personal and institutional responsibility, evidence relating to the testing of recruits in Swaziland came to light, revealing an astonishing low rate among the 17–18-year olds. Based on this finding, are institutions now facing up to the challenge of how to maintain the negative status of these young recruits who are in the prime, productive and sexual age group?

The focus on the testing of recruits in all the case studies also revealed an interesting aspect that demonstrates the power relations and social class struggles which underlie the seeming pragmatic approach. According to a survey undertaken in 1996 by the UN Civil Military Alliance (CVA) to combat HIV and AIDS, “only 46% of serving senior officers actually submit themselves for testing”.⁷ The reasons why most middle and senior officers do not ‘volunteer’ included the:

- fact that there was no real reason to subject them to testing as they were in largely administrative posts;
- fear of stigmatisation and reclassification once the results were known; and
- basic cost and availability of medical personnel required to undertake such an extensive exercise.

This phenomenon of low rates of voluntary testing among the hierarchy extended to include personnel on deployment—for which the CVA survey quoted only a 55% success rate—and lower rates for those on scheduled periodic testing (31%) and for those going on new assignments within their own countries (26%).

In the same CVA survey, a much higher rate (88%) was noted for officers going on overseas courses and duties, where the recipient countries had stringent requirements. These countries would insist on testing for all members being sent for courses or, in the case of the

quoted example of Zimbabwean officers going to China for training, once the officers arrived in that country, they were tested and the results were sent back to the despatching country. A similar incident occurred when senior Ugandan officers went for advanced training in Cuba. They were, on arrival, subjected to HIV/AIDS tests and the results were sent back to Uganda's commander-in-chief, who was President Museveni.

In most armies, there are at least four points at which mandatory testing appear to happen. These are:

- the entry point when recruits join;
- the annual fitness tests;
- on deployment for peacekeeping operations—and, on paper, on their return from such peacekeeping operations, either when these are completed or when personnel members are rotated; and
- when a member retires, as provided for in the normal retirement packages.

Accordingly, there is no testing when troops are deployed on urgent national interest operations, such as during the just-finished African war in the Great Lakes in the Democratic Republic of the Congo, or even during the fading Ethiopian-Eritrea war.

Yet another common factor that appears to have been almost drowned out of the debate is the place of traditional medicine and the role of cultural precepts in African armies. It is a fact that most military personnel come from backgrounds that have long-running and successful experiences with the use and application of traditional medicine.

In the HIV/AIDS debate, what is apparent is the fact that, in relation to the core challenge of the virus that causes AIDS, neither modern science nor traditional medicine have been able to come up with a cure. However, in relation to the treatment of some of the symptoms—such as diabetes, tuberculosis, fever and asthma—both modern and traditional medicine have had some success in controlling or slowing down the massive replication of viruses that represents the evolution of the disease within humans.

John Iliffe provides a basic social science understanding of the medical transformation that takes place in victims:

Like all viruses, HIV has no life of its own but is a parasite of cells, the most important being the CD4 helper T cells that activate the body's immune system. [When] the virus enters a cell and integrates its generic information into its host's, using the cell's life to reproduce an immense number of new viruses . . . up to 10 billion new viral particles destroy up to two billion of the host cell each day—and hence ultimately the immune system—while producing an immense number of new viruses to attack further cells . . . and the reproduction is prone to error⁸

To try to counter the above, both modern science and traditional medicine disciplines have struggled to come up with effective drugs and medicines along the lines of what has been termed a 'silver bullet'. Some attempts have achieved some relief on aspects of the impact of the virus, without serious side-effects but also without success in eliminating the basic cause. Faced with this inability to reverse the effects of HIV, proponents of scientific and traditional medicines have resorted to debilitating in-fighting, accusations and counter-accusations, and by so doing have undermined the concerted effort that needs to be made to fight this still-growing pandemic in sub-Saharan Africa.

External support received by the countries whose case studies appear in our document has been similar. There has been direct support from the US to the militaries in the form of training medical staff and supplying laboratory facilities, condoms and medicines. Other support has been through the various countries' own ministries of health, to which the militaries have been able to refer the diverse maladies arising from the HIV/AIDS condition. There has also been external support from the Global AIDS Fund. Botswana has had the unique support of philanthropic bodies such as Microsoft's Bill and Linda Gates Foundation. However, in this respect, authorities have not lost sight of the need to develop local resource support capabilities for the long term.

Because the countries in Southern Africa have been recipients, they have not been able to coordinate the nature, focus and extent of the donations, whose effect may or may not alter intended regional cooperation programmes.

A final observation concerns the policy documents produced by the five countries. There has been no concerted attempt to come up with regional policies that would address the regional security aspects of the African Union (AU) or the Southern African Development Community (SADC) region. For example, the aspect of acquiring cheap supplies of

drugs has not benefited from an integrated regional approach to the dominant foreign pharmaceutical companies. Based on the World Trade Organisation (WTO) provisions and the declaration of HIV/AIDS as an emergency by the UN, only Zimbabwe and South Africa have embarked upon the production of affordable generic drugs.

The following summary includes salient recommendations from the five country studies.

RECOMMENDATIONS

- Southern Africa needs to move beyond the rhetoric and to coordinate country programmes at the regional level, given the fact that the spread and transmission of the pandemic is located around sexual networks that traverse the whole region and beyond.
- There needs to be a harmonising of the institutional policies of the militaries as they relate to HIV/AIDS, given the desirability of an integrated regional brigade under the auspices of the AU's Standby Force. To this end, aspects of testing before deployment and 'take-aways' of antiretroviral (ARV) prescriptions for victims for 90 days, such as is the case in Botswana, need to become standard operating procedures for all the region's forces. Stated differently, those national armies lacking, for any reason, the required drugs while deployed on external operations need to be provided with these drugs in line with Botswana Defence Force best practice.
- The prevalence statistics produced by the militaries are incomplete and therefore undermine comprehensive policy response initiatives. Policy makers must be aware of the power relations around the testing that has now been established within the armed forces. Recruits are subjected to the highest standards possible, even with the limited resources available, in order to deflect attention away from demands for a more comprehensive and thorough programme that periodically examines and evaluates the full complement of military personnel. Without political intervention at the highest level, the current status quo is likely to remain, resulting in a cover-up on the real impact of HIV/AIDS on the human resources of the various defence forces.
- There is need for a close civil-military approach to tackling the complex HIV/AIDS challenges. The impact of HIV/AIDS on the

armed forces has demonstrated the old adage that no sector survives in a vacuum. Owing to the intimate linkages of prevention, transmission, care and treatment, counselling, nutritional support, home-based care, spouses and other partners, no approach will succeed unless it embraces contributions from, and collaboration between, civil society and the military. One case study refers to this as expanding and intensifying an outreach programme that includes support for and input from dependants, civilians and other stakeholders.

- There is a need to coordinate regional responses to the supply of generic drugs and to create a constructive environment in which to engage the pharmaceutical industry. After the UN declared the pandemic a global emergency, normal WTO rules could be renegotiated. In Southern Africa, Zimbabwe and South Africa have sought to suspend normal trade relations in the pharmaceutical industry with a view to producing generic drugs in collaboration with like-minded Brazil and India. For some reason, however, their initiative has not enjoyed further regional support. This needs to change as new negotiations with international drug companies can only benefit from a coordinated regional response. Southern Africa represents a market of some 230 million people, of whom perhaps 20% are infected with HIV and require medication. Viewed from this perspective, it makes sense for the region's health and medical industry to consider providing locally produced drugs to combat the threat to the region's working population. This is in line with the SADC HIV/AIDS regional strategy, which has pointed out that:

the HIV pandemic is concentrated in the working age population, affecting both men and women, skilled and unskilled labour. . . . The protection of human capital from HIV and its impact forms an integral component of all SADC policies and programmes.⁹

- Homosexual relationships exist in Southern Africa and the implications of this fact need to be considered as part of any HIV/AIDS strategy. Homosexual relationships are taboo or frowned upon or even criminalised in all the countries in Southern Africa, except South Africa. The existence of homosexual relationships is a fact that most African armies have so far refused to acknowledge. The continuing denial is based on the region's cultural sensibilities.

However, this dimension cannot be wished away or legislated against, but has to be addressed head on. While vector and transmission models for the region have so far not included gays, the experience of San Francisco should make it clear that if the prevention of HIV/AIDS from this sector in Southern Africa is the priority it should be, this reality must be addressed.

- The region's militaries need to come up with a structure that includes people living with HIV/AIDS (PLHA) from among the ranks. As part of its mandate, PLHA should inform policy makers and medical practitioners about aspects of HIV/AIDS, as well as how to maintain operational integrity without compromising the human factor. In the absence of contributions from those affected, all recommendations will lack realism.
- The case studies suggested that militaries in Southern Africa were 'islands of plenty' that were able to enjoy the benefits of formal paid employment while in their sexually active 20–45-year-old prime. This is all the more reason why military personnel need concerted and extensive education and training on HIV/AIDS. Given an impoverished environment, commercial sex is a readily available commodity that offers easy access to several sexual partners and increases the incidence of risky behaviour. Related to this, the research also drew attention to long deployments and postings that separate soldiers' families, while placing both partners in situations where there is no recognised social and peer restraint. Against this background, important strategies were believed to include:
 - investing in more housing within camps to allow married couples to benefit from stable family relationships; and
 - shortening periods of deployment and duty away from home stations.
- Unit commanders should consider seriously how best to use troops' 'free time' when they are not deployed, patrolling and/or in administrative bases. Organised sports and other activities—such as chess, television, concerts and libraries—are antidotes to boredom and risky behaviour outside the camps.
- Given their inherent structure and discipline and their ability to follow set regimes, military organisations can become change agents

in their societies in the fight against HIV/AIDS. The Tanzanian Commission on AIDS has borrowed heavily from the trail-blazing of that country's defence force, including the secondment of retired Maj Gen Lupogo as its chairman. This lesson can be replicated elsewhere, as, among other things, an antidote to the attempts to stigmatise the military as the 'worst affected', and therefore the alleged culprit for spreading HIV/AIDS.

- There is a need to invest urgently and heavily in home-based care and terminally ill administrative discharges. Most commanders now adopt a humanitarian approach that ignores the cost factors but leaves front-line units short of able manpower as a consequence of HIV/AIDS, absenteeism and long periods of illness before personnel members die or are given early retirement. Policy guidelines are required as resources are currently being drawn from other budgets without authorisation or debate. There will eventually, and inevitably, be a negative impact on the ultimate goal of preparedness and integrity of the armed forces in upholding national security.
- It is important that deliberate policies be introduced to increase the representation of women in higher ranks of the armed forces. Such policies will counter the dominant military 'macho' male culture and lead to a better and more sensitive social environment in the military.
- Our researchers recommend that consideration should be given to the short- and medium-term enrolment of young people within the military. The deployment of, say, 16-year-olds would meet rejuvenation goals and be balanced by the need to retain the advantages of seniority and experience that comprise the historical memory of the military institutions.
- There is, finally, an urgent need to undertake a sustained investigation of military institutions in order to determine the nature and complexity of HIV/AIDS since the 1980s. In addition to the contribution that might be made by the present research—which has focused on the history and experience of the military over a quarter-of-a-century—further multidisciplinary and collaborative research initiatives need to be embarked upon if we are determined to come up with long-term solutions to the HIV/AIDS pandemic in the defence forces of Southern Africa.

NOTES

- 1 J Iliffe, *The African AIDS pandemic: A history*, James Curry, Cape Town, 2006, p 139.
- 2 Ibid, p 8.
- 3 International Labour Organization (ILO), *Code of practice on HIV/AIDS and the world of work*, Geneva, 2001.
- 4 See for example the decision on pilots, aircraft engineers and air traffic controllers in Swaziland after undergoing the mandatory annual medical examination that includes HIV/AIDS screening.
- 5 *Code of practice on HIV/AIDS and the world of work*, op cit (case study on Zimbabwean, Chapter Six of this volume).
- 6 The Tanzanian case study researchers, with a medical officer at Lugalo Military Hospital, 23 August 2005.
- 7 R Yeager & S Kingma, The HIV/AIDS pandemic: Programme imperatives and policy issues, in *Civil Military Relations*, Civil Military Alliance to Combat HIV/AIDS, 2005, pp 2-3.
- 8 Iliffe, op cit, pp 7-8.
- 9 SADC, *SADC HIV & AIDS Strategic Framework and Programme of Action: Managing the HIV & AIDS Pandemic, 2003-2007*, July 2003, p 17.

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