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# The potential impact of HIV/AIDS on the South African armed forces: Some evidence from outside and within<sup>1</sup>

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## Introduction

At the 2007 International Department of Defence HIV and AIDS Conference in Pretoria, the then Deputy President, Phumzile Mlambo-Ngcuka, expressed the concern that ‘HIV/AIDS in the armed forces could pose a significant security threat’.<sup>2</sup> What she was implying is that every soldier infected by HIV/AIDS erodes the capacity of the military to execute their mandate in much the same way as this disease incapacitates its human host. The following analogy sums this up:

The immune system is like the body’s army. It is full of little soldiers that are always looking out for bad guys and then killing them as soon as they are spotted. When someone gets HIV what happens inside his or her body

is that the virus is slowly sneaking up on all the little soldiers in the immune system army and killing them one by one. In this way the immune system army is getting weaker and weaker all the time. Inside the body the immune system army gets weaker because it has fewer and fewer soldiers to fight the sickness. More and more sicknesses are getting into the body and causing bigger and bigger problems. What HIV does is make the immune system army so weak that just about any other sickness can kill them.<sup>3</sup>

According to the South African National Defence Force's (SANDF) own estimates a quarter of its body of soldiers are HIV positive, and many have already died.<sup>4</sup> Shell claims that if the pandemic were a war, South African generals would be seated in the tents of ignominy signing articles of capitulation in every single theatre of the conflict.<sup>5</sup> But, as he says, if only 'it was a war', then one could at least attempt to destroy the enemy, or come to some peace agreement. Unfortunately, this enemy is invisible and secretly continues to wear away the abilities of the institutions it affects. Thus knowledge of how this disease is impacting on armed forces is as critical as intelligence is to warfare.

As the SANDF grapples with ways to prevent this disease from infecting and killing its soldiers, so it tallies the costs in terms of recruitment, training, preparing operationally ready forces and meeting the demands of expensive AIDS treatments, while at the same time ensuring that its policies are not in violation of the human rights of its members.

In this article I reflect on these issues and examine the potential impact HIV/AIDS has on the SANDF at various levels. My analysis is based on evidence contained in recent publications, empirical findings from other sectors within South African society, information obtained from personnel statistics, and conversations with SANDF military personnel. The purpose of this article is to provide some factual base from which to uncover the long-term impact this disease may have on the organisational and operational capacity of the South African armed forces, which at present is still the leading military power in the region.

## **Why is HIV/AIDS of strategic concern?**

As a chronic disease, HIV/AIDS has wide ramifications for the armed forces, especially in those regions where the epidemic is most prevalent. National estimates for 2007 for countries in Southern Africa indicate that the adult prevalence rate exceeds 15 per cent in eight countries in the region with at least five countries – Botswana, Lesotho, Swaziland, Zimbabwe and South Africa – close to or beyond the 20 per cent infection rate.<sup>6</sup> Although accurate figures of the exact extent of infection in militaries are hard to come by, most claim that infection rates are between 3 and 10 per cent higher than national averages. For example, in Kenya in 2005 the national average was 6,4 per cent,

while the military averaged 9,4 per cent; and in Botswana a 30 per cent national average is contrasted with 40 per cent in the military.<sup>7</sup> It is of great concern that the leading regional military power, South Africa, reports infection rates of between 22 and 25 per cent, about 3 per cent above the national average.<sup>8</sup>

Most of the armed forces in the region now openly state that AIDS accounts for over half of in-service mortality.<sup>9</sup> The impact is so severe that in some cases, certain African armed forces have been unable to deploy a full contingent or even half of their troops at short notice.<sup>10</sup> In March 2003 the Malawi Defence Force reported that troop strength was down by more than 40 per cent as a result of HIV deaths and in Mozambique it was reported that 'the country is no longer able to recruit and train police officers fast enough to replace those dying of AIDS'.<sup>11</sup> The SANDF faces similar challenges, with death rates peaking in the age category 30–39 years, which indicates that members have become infected in their early twenties.

This has severe implications for national armed forces. At the organisational level, the disease 'undermines military effectiveness through its medium-and long-term consequences which result in capacity deficits and personnel attrition, increased costs for training and replacing deceased staff, absenteeism, emotional strain, exhaustion, compromised productivity, loss of morale, internal dislocations and spiralling military health costs'.<sup>12</sup> This affects the operational capability of armed forces and their ability to not only defend their nations and maintain civil order, but to provide fit, healthy and qualified personnel for peacekeeping and other humanitarian aid missions. As many become infected in their early twenties, it becomes more difficult to staff peacekeeping missions with soldiers who are HIV negative.

While fit healthy HIV-positive soldiers are able to perform peacekeeping duties, there are other concerns that stretch beyond the health and operational implications this disease poses. This relates more directly to the sexual conduct of peacekeepers whilst on deployment. Concern that peacekeepers may serve as vectors for the spread of the disease have been reinforced by ongoing accusations of sexual abuse perpetrated by peacekeepers.<sup>13</sup> Knowingly sending HIV-positive troops to conflict zones can have serious trust and diplomatic implications. Not only are host countries becoming less willing to accept HIV-positive peacekeepers, but other nations may be less willing to contribute personnel to multinational peacekeeping operations where other contingents have high infection rates.<sup>14</sup>

In this regard the SANDF faces a challenge. A recent ruling on the exclusion of HIV-positive members from recruitment and deployment has obliged the SANDF to review its policies of not enlisting or deploying HIV-positive soldiers.<sup>15</sup> The effect of the court order is that a blanket exclusion of HIV-positive individuals is unlawful. This does not mean that the SANDF must now hire or deploy all HIV-positive individuals, but that

a nuanced policy that allows for HIV-positive persons who are still fit enough to be considered for employment, deployment and promotion, is implemented.<sup>16</sup>

## **Impact of HIV/AIDS on the SANDF**

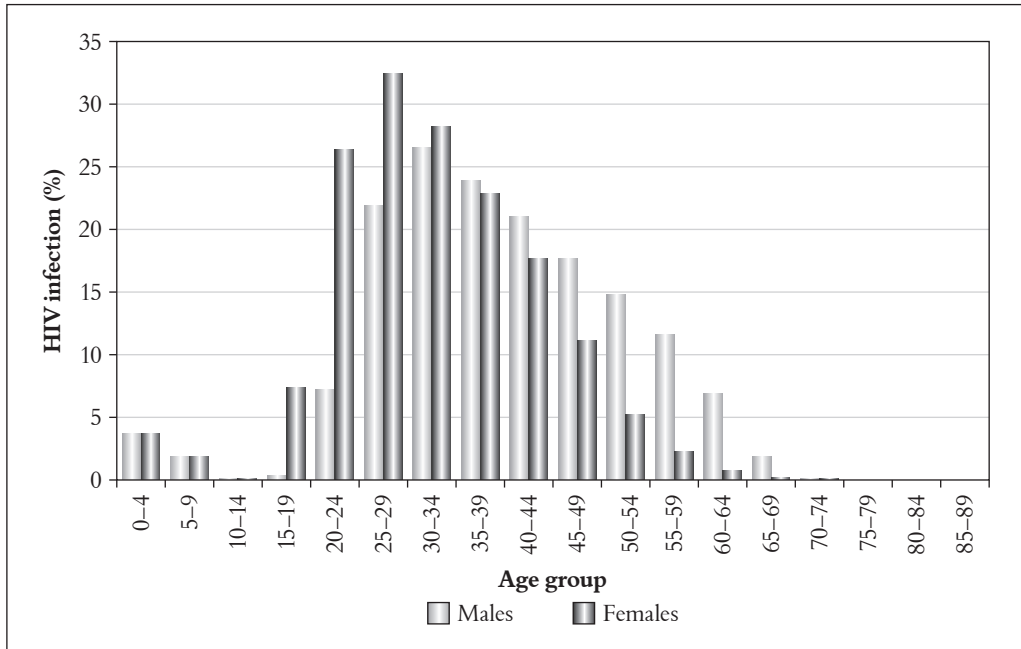
Understanding how this disease is affecting the SANDF is not only of national but of regional and international concern given that South Africa is at present the largest troop-contributing country to peacekeeping operations in the region. In this article I attempt to uncover how this disease may affect the ability of the SANDF to create, train, deploy and maintain an effective military force.

### **HIV/AIDS and force procurement**

Force procurement refers to the ability to acquire suitable recruits for the armed forces. As with most armed forces, the SANDF selects candidates based on a wide range of criteria including character traits, educational qualifications, and physical, mental and overall health profile. In terms of their medical profile, recruits found medically unfit on psychological and medical grounds are at present not recruited. In terms of current policy, HIV/AIDS is managed in the same way as any other chronic, progressive and potentially fatal disease. Thus, recruitment restrictions that apply to other comparative diseases, apply equally to HIV/AIDS. While intending to reduce the incidence of HIV within the ranks upon entry, this policy is not only highly controversial, but may limit the ability to recruit suitable personnel in a shrinking skills market.

At present recruitment does not pose a major challenge. In fact, the SANDF has an oversupply of applications of which only a small portion (fewer than 3 500 members) were recruited into the voluntary Military Skills Development System (MSDS) in 2007. Of interest is that only 1 882 members completed their two-year initial contract period. In 2008, only 2 506 reported for duty, of whom 96 per cent were black and 31 per cent were female.<sup>17</sup> Owing to budgetary constraints, this is way short of the 10 000 the SANDF envisaged recruiting every year and will impact on the SANDF's ability to rejuvenate its ageing forces and supply sufficient personnel for peacekeeping operations. The question is: What does the long-term future hold given our society's youth health profile? Armed forces aim to recruit precisely the age group at greatest risk for HIV infection – those between the ages of 18 and 26.

The 2006 STATS SA estimates of HIV infection in the age group 15–19 were 3,2 per cent for males and 9,4 per cent for females. This increases dramatically in the age groups 20–24 with figures estimated at 6 per cent for males and an alarming 23,9 per cent for females. Among females, HIV prevalence is highest in the 25–29 age cohort, with figures peaking for males in the age group 30–34, where for the first time they

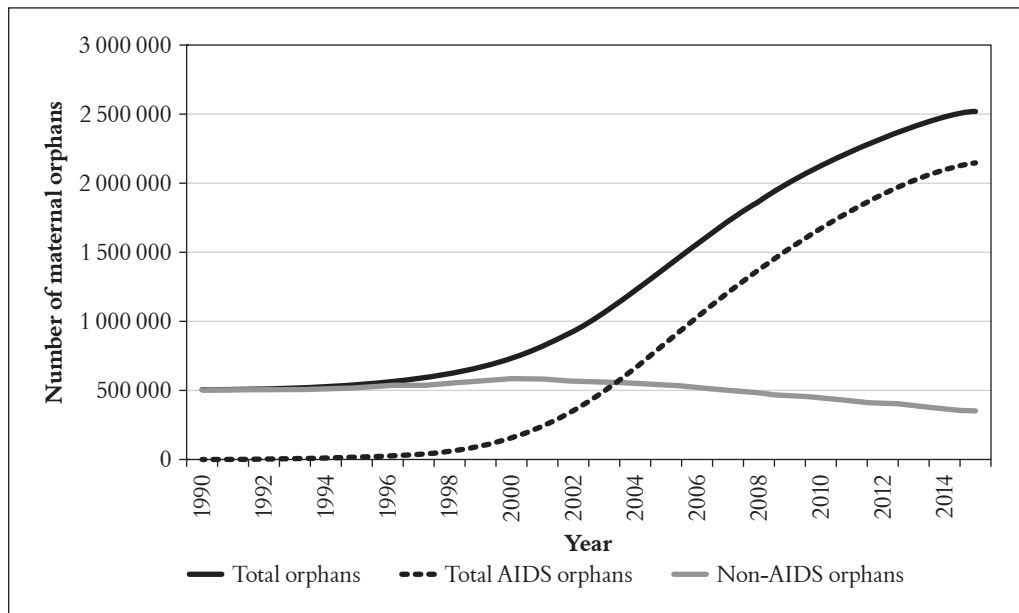
**Figure 1 Estimated HIV prevalence, 2006**

Source R Dorrington, L Johnson, D Bradshaw et al, 2006, *The demographic impact of HIV/AIDS in South Africa*, <http://www.assa.org.za> (accessed 10 November 2007)

overtake female infection rates.<sup>18</sup> Similar statistics are cited by ASSA, with projections for the 20–24 age category for males being slightly higher at 7,2 per cent and females 26,5 per cent, and for the age cohort 25–29 males 21,8 per cent and females 32,5 per cent (figure 1).<sup>19</sup> These estimates concur with the HSRC household prevalence survey conducted in 2006.

Should HIV status continue to be a criterion for enlistment, it may affect the SANDF in a number of ways. First, the cohort of suitable young recruits that meet the specified health assessment standards is likely to decline unless there is a notable change in infection rates among the youth in years to come. Second, as women are more affected in the younger age cohort, there may be difficulties in meeting gender targets, which at present are around 30 per cent. Third, the results of a recent survey among educators indicate that black Africans have a significantly higher HIV prevalence rate than other population groups (ELRC 2005:56). As reflected in recent SANDF intakes, whites are no longer volunteering for military service. For example, in 2006, at the lower levels whites comprised only 6,7 per cent of the forces – 2007 figures are down to 2,3 per cent for privates (troops)<sup>20</sup> This implies that a larger number of applicants may be health non-compliant. Fourth, the level of education among the youth is likely to decline given the growing cohort of AIDS orphans who may either not have had the opportunity to complete their formal schooling, or had a disrupted education (figure 2).

**Figure 2 Projected number of maternal orphans under the age of 18 years due to AIDS and other causes of death for 1990–2015 (Actuarial Society of South Africa 2003)**



Source R Dorrington, L Johnson, D Bradshaw et al, 2006, *The demographic impact of HIV/AIDS in South Africa*, <http://www.assa.org.za> (accessed 10 November 2007)

While it differs from society to society, many armed forces and police tend to draw recruits from the poor and disadvantaged youth.<sup>21</sup> The same applies to the SANDF and former SADF, which tended to attract recruits from the middle to so-called lower classes. Although the SANDF has no shortage at present in terms of applicants, it does struggle to recruit members with the necessary mathematical skills for certain specialised posts, and this situation is likely to worsen. A UNAIDS/UNICEF report on orphan estimates for 2003 indicated that 13 per cent of all children in South Africa under the age of 17 were orphans, of whom 48 per cent were AIDS orphans. It is estimated that by 2010, orphans will make up 19 per cent of all children. In terms of actual numbers this amounts to 3,1 million orphans under the age of 18.<sup>22</sup> Invariably orphans suffer from higher levels of malnutrition, lower school enrolment and stigma. They are also exposed to an environment where they are socially, culturally and economically more prone to HIV infection.<sup>23</sup>

Traditionally, armed forces seek to recruit young adults with a specific character profile – fit young individuals who display leadership skills, are well-adapted emotionally, have at least completed secondary school, and have no criminal record. Thus, the need to monitor how this disease is affecting the youth of South Africa and those volunteering for military service is essential for defence personnel planning. To cite an example, in 2003 in Mozambique with an infection rate of only 13,6 per cent, more than half of recruits tested HIV positive.<sup>24</sup> Where HIV status is used as a criterion for recruitment

irrespective of CD4 count or viral load, it may eliminate a potential pool of otherwise suitable candidates. Here the SANDF may need to review their current force design and assess which posts should be filled by military personnel with a specific medical classification, which posts can be filled by civilians where HIV status is not a criteria, which functions can be outsourced, and how many reserves need to be trained and maintained to ensure an adequate operational capacity.

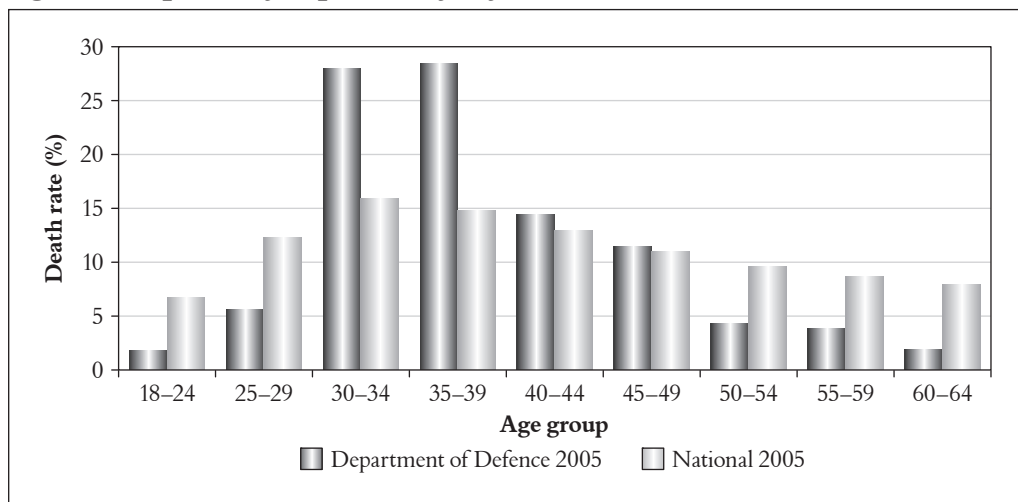
## **HIV/AIDS and force preparation**

The impact of HIV on recruitment is negligible compared to the effect it has on human resource management within the Department of Defence (DOD). The military is a highly vulnerable organisation as HIV prevalence tends to peak in the age group 25–44 for both sexes, which is the age at which they are most productive and deployable. Furthermore, the military provides exactly the right circumstances for infection to take place. Personnel are generally placed in single-sex barracks (hostels), away from their families for considerable periods and on a regular basis. They generally serve in remote locations where recreational activities are limited, where alcohol and drug use are common and sex workers are abundant. Added to this, they are often deployed to high-risk environments where exposure to this disease is heightened. This makes the military a highly vulnerable institution and more likely to have employees with high infection rates.

The DOD reported that during 2006, 34 810 members underwent a comprehensive health assessment – over half of the uniformed component. Of these 70 per cent received a ‘green status’, which implies, among other things, that they were HIV negative.<sup>25</sup> From this one can deduce that HIV prevalence is below 30 per cent among the uniformed component of the SANDF and that the infection rate may well be around the claimed national average, between 23 and 25 per cent for the economically active sector of the population. However, whether the spread of HIV across the different age groups resembles the national average is disputable, as the demographic profile in terms of age, gender and race differs.

On closer scrutiny by age, for example, deaths in the DOD (including civilians) peak in the 25–39 cohorts, declining steadily until retirement. When compared to the national death profile for 2005, an interesting pattern emerges (figure 3). For DOD personnel, death rates are higher in the age bracket 30–39 years, but notably lower in the younger (18–24 years) and older (50–64 years) cohorts. In the younger cohort, this is because the SANDF does not currently recruit anyone who is HIV positive into the uniformed services. That death rates are notably higher in the 30–39 age group indicates that a substantial number become infected while in service. However, what appears encouraging is that when one examines DOD death statistics over the past six years, one observes a decline in death rates in the 25–29 cohort and the same, although to a slightly

**Figure 3 Comparison of Department of Defence and national deaths, 2005**



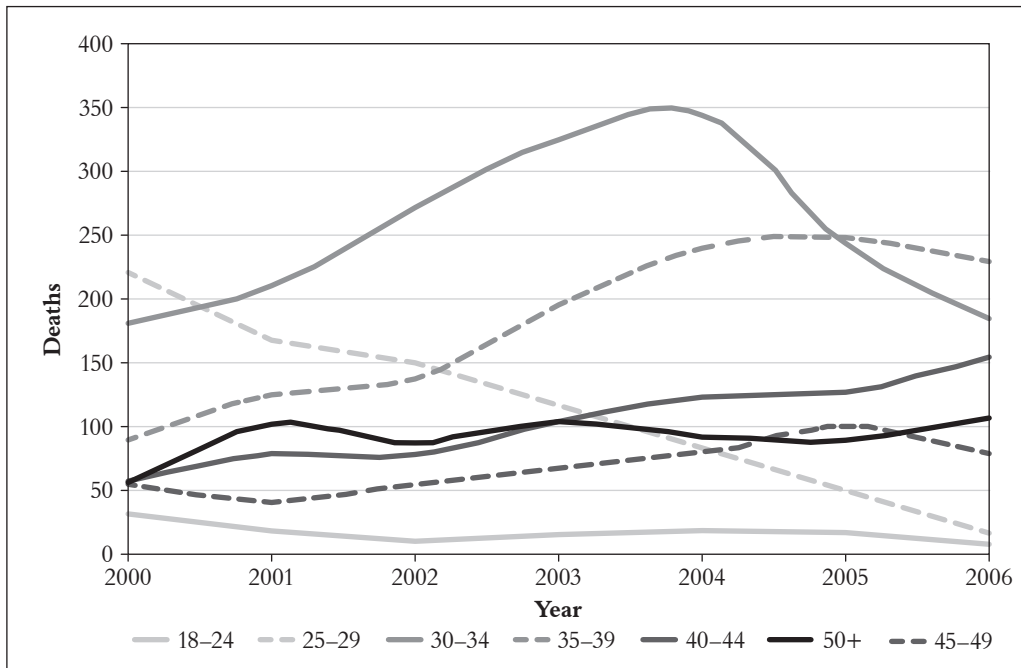
Source Compiled from South Africa (Republic), Department of Defence, Personnel Statistics, Statistics South Africa, 2007, 9

lesser extent, in the 30–34 year bracket, with those in the ages 35–39 showing a slight tapering off before picking up in the 40–44 age group (figure 4).

If one is to relate age to various rank categories the greatest loss in terms of personnel is in the middle ranks from major to lieutenant-colonel. In terms of non-commissioned officers, this would equate to the rank groups sergeant to warrant officer grade 2. However, these statistics imply that these members are becoming infected at a very early stage in their military careers, which will affect their suitability for deployment. At present the greatest number of people infected with HIV are in the lower ranks: the troops on the ground and those in junior leadership positions because of the skewed age profile of those serving in the lower ranks. These make up the greatest percentage of the peacekeeping forces.

As with most statistics, the trends reflected in figure 4 must take into consideration certain mitigating factors. The recent decline in death rates may be due to the non-renewal of service contracts of those who are HIV positive (although this is difficult to verify at this point). A further explanation is the impact of antiretrovirals (ARVs), which may be slowing down the death rates. In 2004 Project Phidisa was launched to make ARVs available to soldiers, and also to provide improved clinical management, psychosocial support and family-oriented care for HIV-affected military families.<sup>26</sup>

Clearly not all these deaths are related to HIV/AIDS. National statistics for 2005 indicate that more than 90 per cent of all deaths are due to natural causes, although in the age groups 20–24 and 25–29 a higher proportion of deaths can be ascribed to non-natural causes.<sup>27</sup> After this the percentage of non-natural deaths declines significantly. HIV/AIDS as a cause of death is under-reported because the majority of deaths due to HIV

**Figure 4** Department of Defence, death profile by year and age

Source Department of Defence, Personnel statistics, 2000–2006

are misclassified under either tuberculosis or respiratory infection.<sup>28</sup> However, most analysts agree that AIDS constitutes around 47 per cent of *all* deaths and a staggering 71 per cent of all deaths in the age category 15–49 years.<sup>29</sup> Thus, we can assume that DOD deaths due to HIV/AIDS are at least similar, if not higher than national estimates.

Here due consideration must be given to other variables such as the racial/gender mix of the SANDF. We know that nationally women have a higher rate of infection in the age groups 20–24 years and 25–29 years; it is only after the age of 35 years that male infection rates overtake those of women. As with men, women enter the SANDF with a HIV-negative status. If one is to extrapolate this to the SANDF, one can assume that because of the lower percentage of women in the SANDF and their negative status upon employment there will be a difference in HIV infection statistics between the national and DOD profile.

Towards the end of 2007 approximately 19 per cent of uniformed personnel were women. While only 11 per cent served in the senior ranks of brigadier general and above, they were well represented in the junior officer ranks of second lieutenant and lieutenant (35 per cent) and captain (36 per cent). This is typically the age category 25–29 years. If one compares these rank groups to teachers in the same age group, it is alarming to find that young black female educators (18–24 years old) had a much higher HIV prevalence of 17,4 per cent, compared with 12 per cent among their male counterparts. The sex differences

widened substantially for black educators at age 25–29, where women had a prevalence of 30,4 per cent as contrasted with 24,5 per cent among men in the same age group.<sup>30</sup>

The race and age profile of the SANDF also differs from the national profile. There are proportionately fewer black Africans (69,7 per cent) and more whites (17,7 per cent) in the SANDF than in the general population. Coloureds make up 11,5 per cent of the total staff composition of the SANDF and Asians 1,2 per cent. This too may influence the prevalence rates, as indicated above. Few whites are joining the SANDF and those who serve at present tend to be clustered in the upper non-commissioned officer ranks (staff sergeant or warrant officer) and officer ranks (major to colonel) (mostly late thirties to 50 years old). In terms of race and age this segment generally has a lower overall HIV prevalence rate.<sup>31</sup> Most SANDF members serve in the ranks of private (20 586 members) of whom only 2,3 per cent are white. However, due to the legacy of the flexible service system introduced in 1994, a vast number of poorly paid and educated troops over the age of 30 years serve in these ranks.<sup>32</sup>

In terms of their level of education, the overwhelming majority of those serving in the SANDF have only completed 12 years of formal schooling to Grade 12. The officer ranks are more highly educated than the non-commissioned ranks. As reflected in the educators' survey, both education and income influence HIV prevalence. In terms of the latter, almost half of all uniformed members earn below R60 000 per annum, and again it is the lower non-commissioned ranks that make up the bulk of these members.

As the epidemic is still in the infection stage, with few physically ill or dying from AIDS, the overall impact is uncertain, except that we can assume with relative certainty that the SANDF is more adversely affected than broader society. Although the highly acclaimed and supported ARV programme may mitigate the impact, the long-term effect remains disturbing. To date there have been no institutional assessments to determine exactly what sectors are most vulnerable, what the critical posts are, and what should be done to avoid future gaps. Currently gaps are filled either by assigning these duties to another member in the unit (over and above his/her normal duties) or letting the task stand over until the 'sick' member returns, or the vacant post is filled. Besides the obvious implications for military leadership and continuity of command, a major consideration is how to provide the required quality and quantity of personnel to meet current deployment commitments.

One can assume from attrition and vacancy rates that there are certain terms of shortages, but this cannot be ascribed solely to HIV. Based on conversations with military personnel, it is clear that the army (as compared to the navy and air force) is the most affected given that it is both the largest arm of service and the most frequently deployed. Judging from current shortages (whether due to HIV or not), the branches in the army most

affected are the infantry, logistics, combat support (including health practitioners in the medical service) and intelligence sectors. These branches are all critical components of peacekeeping operations.

Besides HIV, the SANDF faces many challenges in ensuring that there are sufficient adequately trained soldiers. Rising operational commitments, which at the same time have been associated with declining operating budgets, have impacted severely on force preparation. As money cannot be taken from salaries or equipment contracts, it invariably comes from training and maintenance budgets. As Romer-Heitman pointed out: 'For the better part of a decade the SANDF has not been able to train properly, to maintain its equipment properly, or to maintain its infrastructure. Proper unit training is almost impossible, causing operational capability to decline.'<sup>33</sup> This situation is exacerbated by personnel shortages in certain age and skill categories. Clearly this has a spillover effect on future operations, as many of the current members in the junior ranks are either over-age, unfit or ill, and therefore not deployable.<sup>34</sup>

## Force employment and deployment

South Africa supports the current UN recommendation to deploy only medically fit soldiers, and this includes an HIV-negative status.<sup>35</sup> The argument against deploying HIV-positive soldiers on peacekeeping missions stems from the following:

- Medical treatment available during peacekeeping missions may not be adequate to meet the special requirements of peacekeepers with HIV
- Peacekeepers have to undergo deployment vaccinations and may be exposed to diseases during deployment, both of which pose additional risks to their health
- The presence of HIV-positive peacekeepers poses the risk of transmission to medical personnel, fellow peacekeepers and the civilian population<sup>36</sup>

With the high HIV prevalence rate within the ranks, the SANDF grapples with the challenge of ensuring sufficient personnel for deployment. The current expectation is that every African Standby Force in the region maintains a brigade of about 3 000 infantry soldiers as well as 1 258 logistical specialists, signallers, engineers, military police and civilian support staff for rapid deployment in Africa at appropriate notice. A battalion commander preparing for deployment confirmed in an interview<sup>37</sup> that out of the approximately 18 000-strong SA infantry corps, the army struggles to meet the requirements to supply current rotations. To have three battalions in the field (which equal one brigade) there needs to be at least 3 000 personnel in force preparation, an equal number in combat readiness training and similar numbers entering the system (ideally between 9 000 and 12 000 personnel at various stages).

Another factor affecting the SANDF's ability to sustain an operationally effective force is attrition due to members not qualifying for contract renewal (because of their health status or other reasons) or resigning. The most critical is attrition in the middle ranks of skilled personnel in key posts such as airspace control, aircrew, anti-aircraft, artillery, combat navy, engineers and technical posts and health practitioners – especially where skills have market value.<sup>38</sup> A recent report, for example, slates the private sector for poaching its 'trained' naval personnel.<sup>39</sup>

Unlike business, the military cannot readily recruit personnel from the civilian labour market to fill gaps left by 'unplanned' attrition as a result of deaths, sickness, medical discharge or resignation. Particularly for the army, which carries the main brunt of peace support operations, this means that personnel have to be supplied from a variety of units prior to deployment, and often there is not sufficient time to create 'cohesive units'. Consequently 'units are made up by fragments of other units due to health and welfare reasons, resulting in troops working under commanders they do not know and with equipment that is neither theirs nor their responsibility'.<sup>40</sup> Clearly this compromises force readiness and performance in the field.

As the SANDF currently only deploys HIV-negative soldiers, the concern is how many become infected on deployment. Loneliness, frustration and peer pressure combined with access to drugs, alcohol and sex workers induce soldiers to engage in risky behaviour. Their relative anonymity as foreigners also frees them from social norms that guide their behaviour when they are with their families or in their own communities and cultures.<sup>41</sup> During 2006, the SANDF had almost 3 500 members deployed in various operations across the African continent, with the largest contingents serving in the Democratic Republic of Congo (DRC), Burundi, Sudan and the Comoros.<sup>42</sup> While national HIV rates in these countries are comparatively low,<sup>43</sup> national prevalence rates of Southern African states supplying troops to these peacekeeping missions exceed 15 per cent.

In the survey conducted among South African teachers, for example, frequent nights away from home per week were significantly associated with a HIV-positive status. Those who always slept at home had the lowest HIV prevalence (8,6 per cent), whilst those who were away one or two nights per week had a significantly higher HIV prevalence (16,5 per cent). An even higher prevalence was indicated for those who were away from home six nights or more (27,6 per cent).<sup>44</sup> In comparison, a study by the Civil Military Alliance found that peacekeepers returning from Liberia and Sierra Leone had infection rates more than double those of non-peacekeepers. The risk of HIV infection doubled with each deployment in conflict zones, suggesting a direct link to duty in war zones. Among Nigerian troops deployed to Sierra Leone, HIV prevalence increased from 7 per cent after one year to 10 per cent after two years and to more than 15 per cent after three years in the operational area.<sup>45</sup>

Often neglected is the gender dimension of military deployment and the impact this may have on HIV transmission. Whereas male soldiers tend to find alternative sexual partners either through consensual relationships or commercial sex workers, women soldiers are more likely to form relationships with soldiers on base.<sup>46</sup> This does not make them less vulnerable to sexual exploitation or HIV infection. Where they face sexual abuse or harassment by their own comrades, few report this due to the impact it may have on their own careers, or acceptance among male compatriots.<sup>47</sup> On base there are reports that 'personnel were allowed to visit brothels and run brothel-like activities in the camp'.<sup>48</sup>

The unacceptable sexual behaviour of SANDF soldiers engaged in peacekeeping operations has signalled the need to bring greater discipline to troops, coupled with a stronger sense of the moral code of military treatment of civilian populations.<sup>49</sup> From this one can deduce that the more professional and disciplined a force, the lower the level of HIV infection. This boils down to good leadership and a sense of responsibility, with the knowledge that there are certain sanctions imposed for sexual misconduct, as well as some serious personal consequences. In this regard, knowing that one will not be deployed if one becomes HIV positive is a powerful financial deterrent.

One should not ascribe infection rates solely to deployment. We often ignore what is happening back home. The high divorce rate among military personnel indicates that not only soldiers but also their spouses form relationships with other partners during long periods of absence. Given the high prevalence of HIV/AIDS within our borders, it may well be that soldiers become infected not on deployment, but when they return. In South Africa there is a lack of research on military families and the impact HIV is having on family relations within the armed forces.

### **Force sustainment and human rights implications**

The extent to which the SANDF is able to sustain their operational effectiveness is not only a matter of human resources, but also of finance. The challenge in these times when armed forces have been downscaled to minimum force strength is the need to keep training sufficient numbers. This is a huge challenge as current budget constraints have restricted the number of recruits the SANDF has been able to enlist and train at the point of entry. This means that the SANDF does not have a sufficient reserve capacity to call upon, nor does it make use of civilian contractors or private military companies to fill personnel gaps or to expand capacity in times of operational need. Thus, the under-utilisation of personnel because of their HIV status has far-reaching implications for force design and how the SANDF in future will balance the mix between uniformed posts, civilians, contractors and reserve forces.

The effect of constantly having to recruit, train, and retrain personnel is expected to have a significant impact on the future personnel budget and various options need to

be considered to provide a large enough personnel pool as the pandemic unfolds. An immediate strategy to sustain force readiness is to train members more broadly to enable soldiers to perform an array of tasks. Multi-skilling allows a degree of flexibility and an ability to fill critical posts more readily from within the ranks. Even so, the greatest challenge lies with having to accommodate large numbers of HIV-compromised members who are unable to perform the tasks for which they have been trained. The inability to dismiss and the need to utilise unfit, untrained personnel in support functions could erode operational effectiveness even further. Complicating the placement of HIV-compromised people is the reduction in the number of posts available, as many support posts have been civilianised, rationalised, or outsourced in recent restructuring and in many cases are already overstuffed.

Even though the provision of ARVs may mitigate the effect of skills loss and preserve military command in the short term, the long-term implications are daunting. HIV-positive members may be deployed internally in borderline duties and in support of the South African Police Service. Recent reports proclaim that many HIV-positive soldiers on ARVs 'are now running around in the mountains and are now serving in border control units'.<sup>50</sup> The dilemma is that HIV infection rates are generally higher along border posts and where members become tempted to partake in risky sexual behaviour, this could complicate the administration of ARV treatment. HIV is a rapidly mutating and adaptable virus and deploying soldiers who have been exposed to various strains raises concerns vis-à-vis the spread of the virus within the country's borders.

Then there is the cost of maintaining long-term ARV treatment. In the 2008 DOD annual report it is indicated that the DOD received an additional R32 million to assist with its ARV rollout.<sup>51</sup> At present ARVs are provided to all members and their dependants through the US-funded Phidisa programme. This five-year programme, which commenced in 2004, provides ARVs at six military hospitals and it is hoped that it will eventually provide ARV treatment at all the 65 military health clinics throughout the country.<sup>52</sup> Although the DOD already has 16 accredited ARV treatment sites, human resource shortages have impacted negatively on the process of ARV roll-out.<sup>53</sup>

The question is whether this initiative can be sustained in the long run and if not, what are the implications? Will government be pressurised to provide more funding to the SANDF to manage the impact of HIV/AIDS on the forces? In Zambia, for example, military members argued that they should have priority access to more government funding for ARVs because they are in a high-risk job and because they contribute to world peace. In Rwanda, high-ranking officers increasingly have access to ARVs that the general population does not have. According to Elbe,<sup>54</sup> 'this is part of the wider development in Africa, whereby the soldiers of many countries now have greater or better access to health care and AIDS medicines than the civilian population'.

Many militaries in the region are committed to providing treatment for their soldiers. These costs increase where armed forces are compelled by human rights activists to recruit and deploy HIV-positive soldiers (as will possibly be the case in South Africa). Aids activists claim that there is substantial evidence to show that ‘HIV-positive people, who are asymptomatic, are able to undertake difficult physical activity with no adverse effects on their health – in fact, regular exercise is beneficial to their health’.<sup>55</sup> Although the SANDF does not dismiss members on the basis of their HIV status, it has now been forced to review its policies in terms of the recruitment, promotion and utilisation of HIV-positive members for peacekeeping operations.

Besides the obvious healthcare costs, should HIV status be considered an unfair discriminatory practice in recruitment, the SANDF may have to cope with a higher attrition rate due to deaths at a younger age. This will increase training costs and lead to additional losses in the middle ranks, even with ARV treatment. The deployment of HIV-positive members on peacekeeping operations has other implications in terms of sub-optimal healthcare provision, nutrition and compliance whilst on deployment, which may pose serious risks not only to the individual concerned, but also to those reliant on the member in military operations. While nobody can condone discrimination against HIV-positive members, the implications for morale, discipline, and military effectiveness needs serious consideration as it extends beyond the human rights of individual soldiers.

Last, but by no means least, are the diplomatic implications of deploying HIV-positive soldiers to war-torn areas in Africa. With the litany of sex charges against SANDF peacekeepers, sanctioning the deployment of HIV-positive soldiers could result in the SANDF being a vector of the disease in conflict zones.<sup>56</sup> Already countries such as Eritrea have requested the UN Security Council not to allow peacekeepers who are HIV positive into their country. Hence the seriousness of this pandemic and how it is being managed by African armed forces has far-reaching implications for national and international security as it may affect many more lives than those already infected by the deadly virus.

## **Concluding remarks**

If we reflect on what we know about the pandemic in South Africa’s and other armed forces in the region, it is clear that this disease has severe implications for the overall effectiveness of national armed forces. As with the human body, HIV/AIDS slowly erodes the institutional capacity of the military at various levels. At the level of recruitment, there will be fewer suitable recruits to serve in the military in South Africa in future. There will be fewer young recruits who are physically fit, well educated and have the character traits desired by most professional armed forces. The SANDF is well advised

to monitor how this disease is impacting on its recruitment pool from not only a health but also a sociological perspective.

At the level of force preparation, close monitoring of which segments of the military are most affected and vulnerable requires similar scrutiny. We already know that the combat branches are more vulnerable, but what are the estimated shortages and how does one deal with this? Here, some thought needs to go into the future force design to give the SANDF the necessary functional and numerical flexibility to meet mission requirements. HIV/AIDS and affirmative action have been responsible for high attrition rates at the heart of the institution – at tactical and operational level. At present the SA Army is the hardest hit but is coping, and there are promising signs that infection rates may be on the decline. Nonetheless, this is a long-wave epidemic and astute planning is needed to cope with this evasive disease.

On force employment the question of health standards is possibly the most critical issue. Already there is talk of lowering standards in terms of certain health criteria, and this may include HIV status. The implication of deploying HIV-positive soldiers has far-reaching ramifications for the SANDF at the institutional, social, economic and political level that stretch way beyond the human rights of individuals, but may in effect undermine the human rights of precisely those who the armed forces are constitutionally obliged to defend. Whose human rights should weigh more heavily – those of soldiers who want to serve on external deployment for ‘money’, or the state’s obligation to maintain a disciplined, cost-effective and efficient defence force?

HIV/AIDS does not only undermine the operational, but also the entire organisational effectiveness of armed forces as they become obliged to divert resources away from line functions, training and deployment, while exacerbating existing capacity and skills shortages. ARVs may slow down skills loss, but this is not a long-term solution, especially where the armed forces are reliant on external funding. Projects like Phidsa are essential in helping us understand the course of the epidemic, but not the long-term future impact on the military. More open discussion and analysis of recorded data is required to inform decision-making, planning and policy formulation for without this knowledge, armed forces will lack the ‘intelligence’ they need to combat the enemy within.

## Notes

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