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. The Botswana Defence Force (BDF) had by 2004 grown to just over 12,000 personnel (with a planned ultimate level of about 15,000). 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).

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, 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. 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, 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%. In 1991, half the population was below the age of 20. According to latest estimates, the population of Botswana currently stands at 1.7 million.

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. 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. 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 1985\(^1\) 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.\(^1\)

The prevalence of HIV among sexually active adults was estimated to be 9% in April 1992.\(^1\)\(^5\) 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%.\(^1\)\(^8\)

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”.\(^1\)\(^9\) 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.\(^2\)\(^0\) Furthermore, UNAIDS estimates that Botswana has one of the highest proportions of adults between the ages of 15 and 49 living with HIV/AIDS.\(^2\)\(^1\) 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. 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%. 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%. 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. 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.

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.

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, 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**

<table>
<thead>
<tr>
<th></th>
<th>All districts</th>
<th>Selubi</th>
<th>Phikwe</th>
<th>Chobe</th>
<th>Francistown</th>
<th>Gaborone</th>
<th>Mahalapye</th>
<th>Southern</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>37.4</td>
<td>52.2</td>
<td>47.0</td>
<td>45.8</td>
<td>44.8</td>
<td>37.4</td>
<td>25.7</td>
<td></td>
</tr>
</tbody>
</table>

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. 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
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.\textsuperscript{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.\textsuperscript{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 networking 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. 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. 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.

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.

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. Economic hardships in neighbouring Zimbabwe, and the resultant mass mobility of the citizens, are also likely to account for cross-border infections.
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 MTP II 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. 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.

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

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. 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.

Some observers have noted that Botswana’s response to HIV/AIDS relates well to the national reality of the disease on the ground. 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.\textsuperscript{50}

\textbf{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.\textsuperscript{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.

\textbf{OTHER RESPONSES}

\textbf{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.\textsuperscript{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. 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.

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.

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. 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. 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. 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. 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. 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. 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
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.  

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.

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 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.

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. 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, Tebeloepole 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.  

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. 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.
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. 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. 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. 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
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.\textsuperscript{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. 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.

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. 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. 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.\textsuperscript{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 \textit{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.

\textbf{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. 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. 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.”

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 a 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.

NOTES

4 M G Molomo, Civil-military relations in Botswana’s developmental state,

It is to be noted that the BDF does not have women in its ranks. However, plans are under way to recruit them. This comes after several years of consultation on the issue at various forums, including the government and in civil society circles. For insights on this development see, *inter alia*, L Tutwane, New hope for women in the BDF, *Mmegi* 20(73), 2 December 2003, < (21 August 2005); R Gabathuse, BDF to recruit women, *Mmegi* 22(17), <www.mmegi.bw/> (3 August 2005); M Kebotsamang, Council to receive report on women soldiers, *Daily News* 162, 26 August 2005, p 1; and M Kebotsamang, BDF to enlist women, *Daily News* 186, 29 September 2005, p 1.


*R. Gabathuse, Botswana to have 200,000 orphans in 2010?, Mmegi* online, 27
31 Ibid.
32 Ibid. The authors here underline the meaning of sex networking as a term used to denote the cultivation of multiple sexual relationships in a variety of environments.
33 Ibid, p 17.
36 H Jackson, op cit, pp 30-31.
38 G Anabwani & W Jimbo (eds), Botswana guidelines on anti-retroviral treatment, Ministry of Health, Gaborone, 2005.
40 Ibid.
47 P Lewis, op cit, p 59.
48 Ibid.
49 Ibid.
51 R Pharaoh, op cit, p 38.
52 J Mwala, head of the Serowe Infectious Disease Control Centre (IDCC), quoted in *Masa Antiretroviral Therapy* 7, February 2004.
56 Ibid.
57 T Hultman, Merc official says partnership in Botswana is learning from experience and passing it on, <http://allAfrica.com/> (14 August 2005).
59 Ibid.
60 Ibid, p 8.
61 This is according to latest figures obtained from the Programmes Management Office, National Aids Coordinating Agency.
63 SJ Kingma, *HIV and the military—Prevention education is the key to protection*, address to the First International Conference of Military and Police Medicine, Yaoundé, Cameroon, 23-24 February 1995, Geneva, WHO.
64 As in the rest of society, HIV was not easily or immediately noticeable in the BDF. However, indications from interviews with some BDF medical personnel attest to the early 1990s’ estimation. A few cases of AIDS-related deaths and illnesses/infections were noted at around this time. This is also the time when structures and policies aimed at combating the pandemic were put in place, indicating a response to an identified problem.
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.
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.
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.
- Col MN Alidi, Director, Legal Services, BDF Headquarters, 31 August 2005.
- Maria Kegaisamang, ARV Programme Coordinator, SSKB Clinic, 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.
– P Molete, member of the SSKB HIV/AIDS Executive Committee, 2 September 2005.
– Maj A Mandiwana, Medical Officer, Thebephatswha Airbase Hospital, 8 September 2005.
– M Tselayakgosi, Programme Manager, NACA, 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.