

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

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## **INTRODUCTION**

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

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

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

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

The impact of HIV/AIDS in Tanzania has been felt across all major sectors including the defence sector. HIV/AIDS has caused a significant increase in the sickness rate of adults and children. An increased mortality rate was estimated to have reduced the life expectancy of Tanzanians from the previous 56 years to 47 years by the year 2004.<sup>4</sup> The increased adult mortality rate has resulted in a rapid increase in the proportion of children under 15 years of age who are orphans. By 2005, it was estimated that some 2.1 million children in the country had no parents compared to a figure of 1.5 million in 1996.<sup>5</sup>

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

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

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

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

#### **BRIEF ON TANZANIA DEMOGRAPHY**

Tanzania is a united republic comprising Tanzania Mainland and Zanzibar. It has a total area of 945,087 km<sup>2</sup>. According to the 2002 census,<sup>8</sup> Tanzania then had a population of some 34.4 million, with all but slightly less than one million of this population living in Zanzibar. With an annual population growth rate of approximately 1.83%, Tanzania had an estimated population of 36.8 million in 2005.<sup>9</sup>

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

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

## **OUTLINE**

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

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

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

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

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

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

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

#### **RELEVANCE OF THE STUDY**

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

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

#### **AIMS AND OBJECTIVES OF THE STUDY**

The study aims to provide an understanding of how the defence force has responded to the HIV/AIDS pandemic through documenting different national responses. The process relied on documenting shared experiences and policies crafted to combat the HIV/AIDS pandemic since its advent in Tanzania in 1984.<sup>13</sup> The study focused on:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

\*Case rate = cases/100,000 population

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

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

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

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

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

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

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

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

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

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

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

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

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

### **TRENDS IN THE NATIONAL RESPONSE TO HIV/AIDS**

#### **ESTABLISHMENT OF THE NATIONAL AIDS CONTROL PROGRAMME (NACP)**

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

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

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

#### **ESTABLISHMENT OF THE TANZANIA COMMISSION FOR AIDS (TACAIDS)**

A February 2001 Act of Parliament<sup>23</sup> established TACAIDS under the Prime Minister's Office to facilitate and strengthen the expanded response to the pandemic. At this time, it was felt that the special department located in the Ministry of Health had insufficient capacity. As a result, this departmental activity was upgraded to a national programme, TACAIDS.

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

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

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

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

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

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

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

#### PREVENTION OF TRANSMISSION OF HIV/AIDS

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

#### HIV TESTING AND COUNSELLING

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

#### CARE FOR PLHA

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

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

#### DEFENCE SECTOR ROLES AND FINANCING

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

#### RESEARCH

- Participating in HIV/AIDS research.

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

#### LEGISLATION AND LEGAL ISSUES

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

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

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

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

Factors<sup>27</sup> that predispose members of the uniformed services to contracting or transmitting HIV include the following:

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

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

#### ADVOCACY

##### Including:

- strengthening political support and public awareness;

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

Figure 1: Strategic (results) framework on advocacy

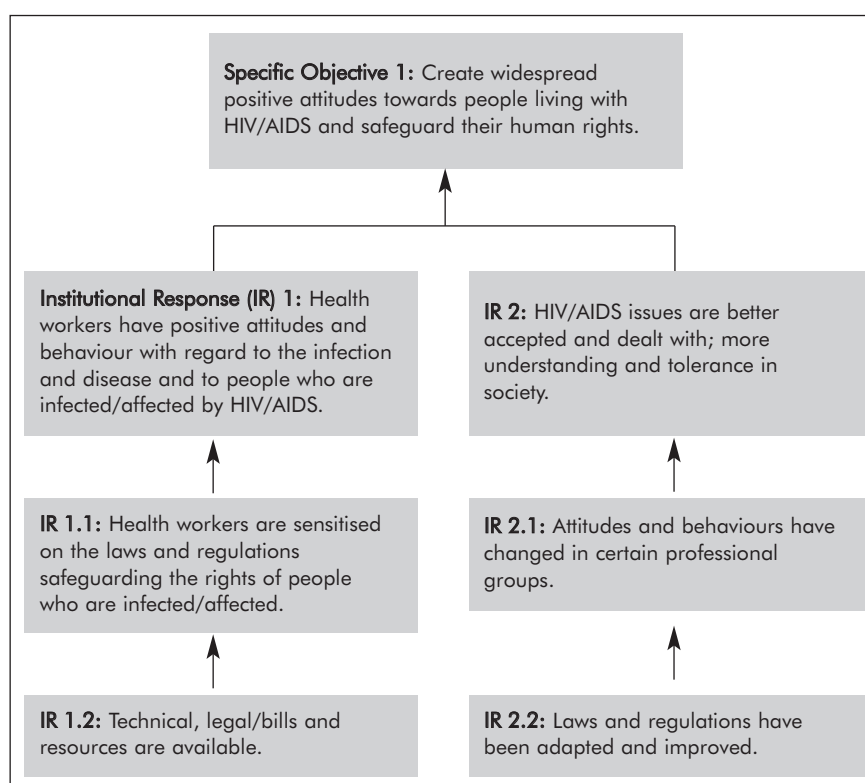
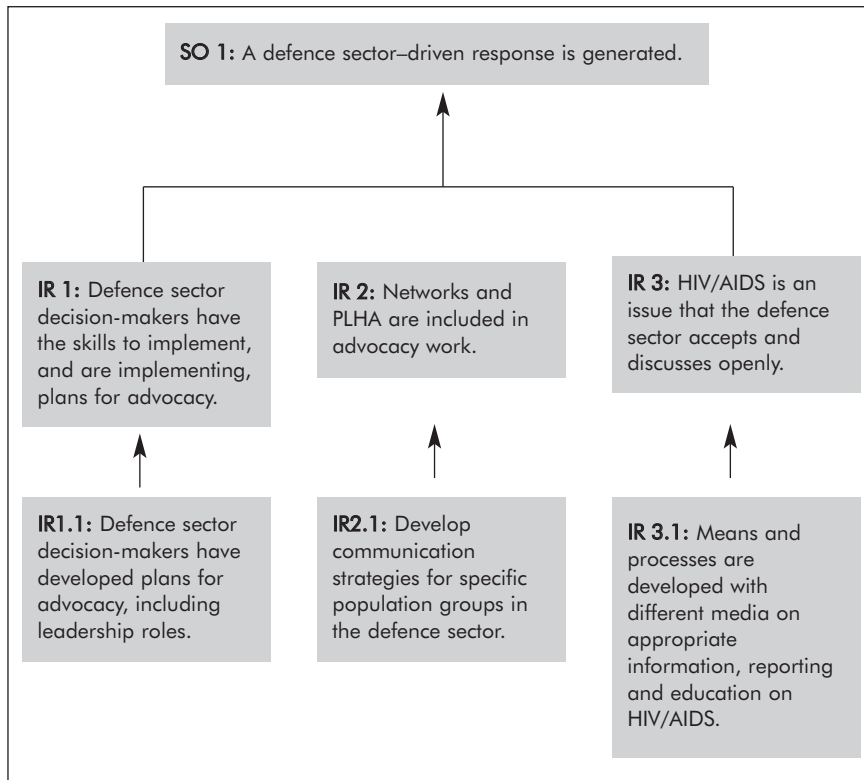


**Figure 2: Strategic (results) framework on stigma and discrimination**

#### GENDER-SPECIFIC AND OTHER PREVENTION STRATEGIES

Including:

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

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

#### HIV/AIDS CARE, SUPPORT AND TREATMENT

Including:

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

#### **THE HIV/AIDS NMSSF: IMPLEMENTATION IN THE DEFENCE SECTOR**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- determining the progress in implementing the response;

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

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

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

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

Other linkages include the NMSSF’s contribution to the realisation of the national aspirations as enshrined in the Tanzania Development Vision 2025.<sup>32</sup>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### CARE, SUPPORT AND TREATMENT FOR MILITARY PLHA

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

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

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

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

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

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

#### **SUMMARY OF KEY ISSUES AND RECOMMENDATIONS ARISING FROM STUDY FINDINGS**

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

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

## GENERAL KEY ISSUES AND RECOMMENDATIONS

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

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

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

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

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

#### SPECIFIC KEY ISSUES AND RECOMMENDATIONS

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

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

## CONCLUSION

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

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

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

## NOTES

- 1 UNAIDS, *AIDS epidemic update 2004*, <<http://www.unaids.org/wad2004/report.html>>.
- 2 URT/PMO, *National Multi-Sectoral Strategic Framework on HIV/AIDS: 2003-2007*, p 10.
- 3 UNAIDS, *Monitoring and Evaluation Operational Manual*, 02.47E, August 2002, p 2.
- 4 Ibid, p 13.
- 5 URT/MOH/National AIDS Control Programme, *HIV/AIDS/STI Surveillance Report—January to December 2003*, No 18, October 2004, p 18.
- 6 New Year Message to the nation, President H.E. Benjamin William Mkapa, Dar es Salaam, 31 December 1999.
- 7 URT/PMO, op cit, pp 22-51.
- 8 *Tanzania 2002 Census*, Government of Tanzania, p 4.
- 9 *World Fact Book*, Tanzania, <<http://www.cia.gov/cia/publications/factbook/print/tz.html>> (12 December 2005).
- 10 Ibid.

- 11 Ibid. The age structures: 0–14 yrs: 44% (male 8,100,216/female 8,074,171); 14–64 yrs: 53.4% (male 9,665,957/female 9,963,772); 65 yrs and above: 2.6% (male 418,080/female 544,160) (2005 estimates.)
- 12 TGNP, 1999, p 15.
- 13 Thanks are due to officials of the National AIDS Control Programme and Tanzania Commission for AIDS for their close working relations and in providing secondary data up to 2004. We express our gratitude to the military personnel and AIDS patients, particularly from the military referral hospital in Lugalo, for their willingness to talk with us at short notice and for the working relationship that fostered an amicable exchange of views. Thanks also go to Dr Anath Rwebembera, head of the National Antiretroviral Drug Programme, Mwanayamala Hospital, Kinondoni Dar es Salaam, for her insightful assistance during the study period on the use of ARVs in Tanzania.
- 14 *Reader: SARPCO Training: HIV/AIDS*, Module 1: Understanding HIV/AIDS and its transmission: Set. 3.1 Where does HIV come from?, ISS, p 4.
- 15 *HIV/AIDS/STI Surveillance Report*, op cit, p 1.
- 16 URT (Tanzania Mainland), *HIV/AIDS Indicator Survey 2003-2004*, p 1.
- 17 URT-PMO, *National Monitoring and Evaluation Framework for HIV/AIDS*, 2004, p 1.
- 18 Ibid.
- 19 *HIV/AIDS/STI Surveillance Report*, op cit, p 29.
- 20 *Tanzania Mainland HIV Indicator Survey 2003-2004*, op cit, p 2.
- 21 Ibid.
- 22 *National Monitoring and Evaluation Framework for HIV/AIDS*, op cit, p 1.
- 23 *The Tanzania Commission for HIV/AIDS Act of 2001*.
- 24 *National Monitoring and Evaluation Framework for HIV/AIDS*, op cit, p 2.
- 25 Ibid.
- 26 UNAIDS, *Engaging uniformed services in the fight against HIV/AIDS on the frontline: A review of policies and programmes to address HIV/AIDS among peacekeepers and uniformed service*, 2002, p 4.
- 27 Ibid.
- 28 Ibid, p 33.
- 29 *National Policy on HIV/AIDS*, Dodoma, November 2001, p 35; *National Multi-Sectoral Strategic Framework on HIV/AIDS: 2003-2007*, op cit, pp 66-70.
- 30 URT/PMO, *Monitoring and evaluating HIV/AIDS programmes and activities: A guide for facilitators and practitioners*, November 2004, p 23.
- 31 BW Mkapa, President of the United Republic of Tanzania, Foreword, *National Policy on HIV/AIDS*, 26 October, 2001, p vii.
- 32 URT Planning Commission, *The Tanzania Development Vision 2001*, 1999.
- 33 URT, *Poverty Reduction Strategy Paper*, August 2001; URT, *Poverty and Human Development Report*, 2002, p 79 emphasises the need to double the absolute per capita amounts of allocations for health services in Tanzania in order to make a desired impact on health indicators.
- 34 *World Fact Book*, op cit.
- 35 URT (Tanzania Mainland), *HIV/AIDS Indicator Survey 2003-2004: Key Findings*, p 11.

- 36 *World Fact Book*, op cit.
- 37 Ibid.
- 38 Open ended interview with a senior military officer at Lugalo Military Hospital, 23 August 2005.
- 39 Discussion with a medical officer at Lugalo Military Hospital, 23 August 2005.
- 40 Cited in *Keeping the promise: Summary of the Declaration of Commitment on HIV/AIDS*, UN General Assembly Special Session on HIV/AIDS, 25-27 June 2001, New York, p 10.
- 41 Ibid, *Summary of the Preamble*, para 23.
- 42 URT/ MOH, *National Guidelines for Clinical Management of HIV and AIDS*, second edition, NACP, April 2005, p 15.
- 43 URT/PMO, *A guide to HIV/AIDS/STI programming options for uniformed services*, 2003, p 33.
- 44 *National Policy on HIV/AIDS*, op cit, 2001, pp 30-31.
- 45 *National Multi-Sectoral Strategic Framework on HIV/AIDS: 2003–2007*, op cit, p 65.