CHAPTER SIX

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

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INTRODUCTION

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

The chapter then attempts to examine the epidemiology of HIV/AIDS within the military and the military's response to the pandemic, using data that is available to the public. The military's recruitment, in-service and post-employment policies in relation to HIV/AIDS are outlined. These policies are juxtaposed against local, regional (Southern African Development Community—SADC) and international (International Labour Organisation—ILO, United Nations—UN) policies on occupational health and HIV/AIDS in the workplace. Various recommendations are offered on how Zimbabwe's military could use its leading role in the region to impact on various international levels via, *inter alia*, UN Resolution 1308 on HIV/AIDS and the Military,[1] the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases,[2] the African Union (AU) Commission's HIV/AIDS Strategic Plan 2005–07, the AIDS Watch Africa (AWA) Action Plan[3] and the SADC Inter-State Defence and Security Committee's sub-regional

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

BACKGROUND

GEOGRAPHIC AND DEMOGRAPHIC PROFILE

Zimbabwe is a landlocked country in Southern Africa with an area of 390,784 km^2. It has long borders with Mozambique in the east, Zambia in the north, Botswana in the west, South Africa in the south and a small thin border with Namibia at the Caprivi Strip.

A national census is done every ten years. According to the last (2002) census, Zimbabwe had 11.6 million people, 1.2 million more than in 1992 and 4.2 million more than in 1982.[5] The country's growth rate was estimated to be 3.1% in the first two decades after independence (in 1980). It has therefore been suggested that the 2002 population excludes about three million Zimbabweans in the diaspora. Nevertheless, it is now accepted that the HIV/AIDS pandemic has probably lowered the growth rate. About 3,000 people die every week in Zimbabwe of AIDS-related illnesses.[6]

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

POLITICAL ECONOMY

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

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

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

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

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

Zimbabwe is the only country in the SADC region that has had a negative growth rate over the past six years. The IMF and World Bank estimates that the economy shrunk by between 4.7% and 5.6% of gross domestic product in 2005, and that the economy will shrink by another 4.1% in 2006.[7] The official inflation rate from the Reserve Bank of Zimbabwe was 913.6% for March 2006 and more than 1,000% in April 2006. Formal unemployment is estimated to be greater than 75%. However, the informal sector has been growing, although its extent is not yet fully known. Sadly, the government's so-called 'clean up' exercise

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

NUTRITION AND FOOD

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

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

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

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

MILITARISATION OF CIVILIAN INSTITUTIONS

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

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

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

HIV/AIDS IN ZIMBABWE

EPIDEMIOLOGY OF HIV/AIDS IN ZIMBABWE

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

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

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

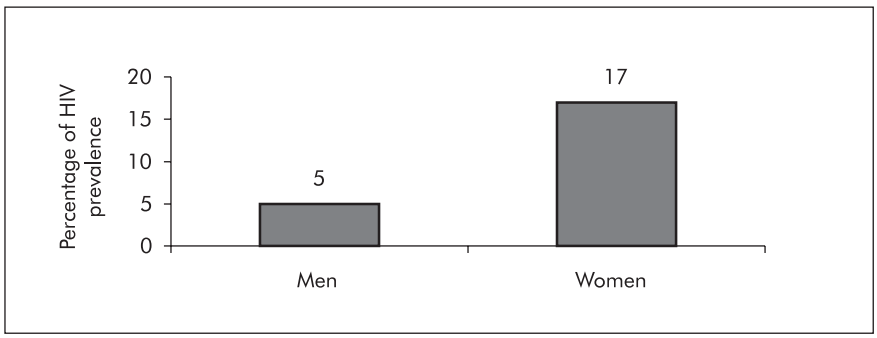
Child Welfare, Dr Timothy Stamps, championed debate on HIV/AIDS issues to be in the public domain.

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

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

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

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



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

pandemic are numerous, but key among them are poverty and exclusion, governance and accountability".[16] The 2005 adult HIV prevalence figure is 20.1%.[17] Though lower than the 2003 figure, this prevalence is still very high.

In Zimbabwe, as in the rest of Africa, women and young girls in particular are at greater risk of contracting HIV/AIDS.[18] In 2001–02, about 17% of girls and young women aged 15–24-years old were HIV-positive, as opposed to only 5% for boys and young men of the same age (*see Figure 1*).[19] The AU attributes this to:

> gender differences and inequality, as women have a greater biological vulnerability to infection, earlier onset of sexual activity, lower socio-economic status and economic dependence. This is aggravated by potentially harmful cultural practices, the inability to negotiate safe sex, the effects of armed and social conflicts, sexual violence and discrimination and the non-recognition of the importance of reproductive health and sexual rights.[20]

The ILO also adds that:

> women's access to prevention messages is hampered by illiteracy . . . women make up a substantial proportion of migrants . . . and refugees. . . . In conflict situations there is an increasing incidence of the systematic rape of women by warring factions. The burden of caring for HIV-infected family and community members falls more often on women and girls.[21]

HIV/AIDS is affecting many adults, including health workers and workers in security agencies. A 2003 study by various institutions that included the United Nations Development Programme (UNDP) revealed that about 3,000 people die of AIDS-related illnesses every week in Zimbabwe.[22] The study estimated that there were about 1.8 million HIV-positive people in Zimbabwe.[23] The report also revealed that as far back as 1996, 72% of prison deaths were AIDS-related.[24] The pandemic has seen an increase in the number of orphans to some 761,000[25]—others estimate over one million—with a resultant increase in child-headed families and child labour.[26]

Hospital-based studies in grey literature suggest that as many as three-quarters of occupied hospital beds in medical wards at tertiary hospitals are occupied by people with HIV/AIDS-related illnesses. In addition, a

study in Zimbabwe showed that "hospital care for HIV/AIDS patients is twice as expensive as it is for non-HIV/AIDS patients".[27]

The April 2006 World Health Organisation (WHO) report states that life expectancy has declined for women from 36 years in 2004 to 34 years, while remaining at 37 years for men.[28] The report attributes this to a number of possible factors, including AIDS and deteriorating economic conditions. The Zimbabwe Ministry of Health and Child Welfare has disputed the results but has offered no figures of its own.

Studies conducted in Zimbabwe and elsewhere have shown that HIV transmission is five to 20 times more likely in the presence of sexually transmitted infections (STIs) such as gonorrhea, *Chlamydia trichomoniasis* and genital ulcer disease, in particular syphilis and genital herpes (herpes simplex virus type 2).[29] There is therefore some suggestion that male circumcision may be of value.[30] A study in South Africa in 2005 showed that bacterial vaginosis doubled a woman's risk of contracting HIV infection.[31]

On the positive side, the prevention of mother-to-child transmission (PMTCT) programme is expanding. Indeed, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO report that "in Zimbabwe almost all women testing positive were reported to have received antiretroviral prophylaxis".[32]

However, not all pregnant women are opting for voluntary counselling and testing (VCT). There is still scope for a greater programme uptake. Zimbabwe has also seen a huge upsurge in TB cases as a result of HIV/AIDS, poverty, overcrowding in some urban areas and poor nutrition.

NATIONAL RESPONSES TO HIV/AIDS

The period 1994–98 witnessed the Multi-Sectoral Second Medium Term Plan (MTP2). The plan was intended, *inter alia*, to:

- reduce the transmission of HIV and other STIs;
- reduce the personal and social impact of HIV/AIDS and STIs;
- reduce the socio-economic impact of the HIV/AIDS pandemic; and
- develop a national HIV/AIDS policy.

The Criminal Procedure and Evidence Amendment Act of 1997 saw the creation of Victim Friendly Courts. The government also formulated a policy on home-based care and care of orphans. The 2002 amendment

to the Labour Relations Act of 1998 also contains a code of conduct on HIV/AIDS and the workplace.

The National AIDS Policy was finalised in 1999. The National AIDS Council of Zimbabwe Act was gazetted in 1999, thereby allowing for the establishment of the National AIDS Council (NAC). As a result, the National AIDS Strategic Framework became operational from 2000. Section 4(c) of the Act mandates the Council to enhance and coordinate the capacity and responses of various sectors of the community to the HIV/AIDS pandemic.

Section 32 of the Act provides for the establishment of AIDS action committees from national to village levels. These structures include provincial AIDS action committees, district AIDS action committees, ward AIDS action committees and village AIDS action committees. A variety of government departments and non-governmental organisations (NGOs) participate in these committees as implementation agents at various levels. The NAC is independent of Ministry of Health and Child Welfare and liaises with other government ministries and agencies, including the military, UNAIDS, various donor agencies and civil society, including trade unions, employer organisations and faith-based organisations.

The policy summarised the key public health and human rights principles in relation to the HIV/AIDS pandemic. These included issues of confidentiality and avoiding discrimination and stigmatisation, care for people living with AIDS, reduction in sexual partners and casual sex, condom availability and use, reduction of STIs and blood safety. In a move designed to strengthen the 1999 HIV/AIDS policy, the Sexual Offences Act was gazetted in 2001.

The Act provides for a penalty of 20 years for rapists convicted of infecting their victims with HIV. The Act also criminalises the wilful transmission of HIV between husband and wife. However, there is no compulsory testing and therefore the majority of Zimbabweans do not know their status.

As part of the nation's attempts to raise funds for the control and management of HIV/AIDS, employees pay a tax of 3% called the National AIDS Levy. In this connection, Zimbabwe has been regarded as a leading and best-practice country for creating specific funding to tackle the HIV/AIDS pandemic. The AIDS levy, along with funding from various donor agencies, contributes to the National AIDS Trust Fund, which is administered by the NAC, and recipients include the military.

Against a background of increasing prevalence rates and the impact of the pandemic, the government used the Presidential Powers (Temporary)

Regulations to declare HIV/AIDS a national disaster. This legally empowered Zimbabwe to manufacture generic drugs locally, so as to reduce the cost of various antibiotics, antifungals and ARVs. This was done by collaborating with some Indian pharmaceutical companies. The move was in keeping with the November 2001 Declaration of the World Trade Organisation's (WTO) Fourth Ministerial Conference in Doha, Qatar, regarding the Agreement on Trade-Related Aspects of Intellectual Property Rights.

This provision dramatically increased the effectiveness of the fight against the pandemic in Zimbabwe. For instance, the measure cut the cost of ARVs by nine-tenths, making Zimbabwe the lowest-cost producer of ARVs in Southern Africa, closely followed by South Africa. However, out of the estimated 1.8 million HIV-positive people in Zimbabwe, about 300,000 require ARVs. Unfortunately, only some 20,000 have access to ARVs, or about 5% of those in need. Fewer than half these access ARVs through the public sector, with the remainder accessing ARVs through the private sector and NGOs. Civil society was therefore very concerned when many urban poor people accessing ARVs via NGOs such as the Centre in Harare were displaced during Operation *Murambatsvina* in May–June 2005.[33] It meant that many defaulted on treatment for several days until they could be located, thereby raising the danger of drug resistance. Concerned civil society groups and members also lost contact with many of these patients.

The NAC has promoted the VCT and prevention of mother-to-child transmission (PMTCT) programmes. However, Retired Brig Gen David Chiweza claimed in March 2003 that VCT programmes had tested only 110,000 people between the inception of VCT in 1999 and December 2002. This, he said, was out of the then estimated three million HIV carriers.[34]

Chiweza founded the Citizens AIDS Survival Trust in 2001 and has been advocating compulsory HIV testing of all citizens, starting with ten-year olds, if Zimbabwe is to create AIDS-free generations. He has suggested that everyone tested should be given a certificate that they have been tested but that the result would not be displayed on the certificate, and that those who are HIV-negative should be tested annually.

Chiweza controversially recommends that only those with certificates to show that they were tested for HIV/AIDS would be considered for education, marriage and employment. He therefore argues that the Sexual Offences and Health Act is inadequate to deal with the threat posed by HIV/AIDS.[35]

FOREIGN FUNDING FOR HIV/AIDS

The initial decline in foreign aid, which was largely due to the political crisis, has had a negative effect on the control and management of HIV/AIDS. For example, neighbouring Zambia received US$187 in foreign aid for every HIV-positive person in 2004, whereas Zimbabwe received only US$4 per HIV-positive person for the same year. The UN Children's Fund estimated that Southern Africa received US$47 for every HIV-positive person, as compared to Zimbabwe's US$4 per HIV positive person.[36]

There has, however, been a recent policy shift by some international donors to provide funding to help the poor and vulnerable. In particular, significant funding has been released for health in general and for HIV/AIDS in particular. In 2005, the government was granted US$107 million over the next three years by the Global Fund for AIDS, Tuberculosis and Malaria. In February 2006, the assistant director of the US President's Emergency Plan for AIDS Relief (PEPFAR), Dr Mark Dybul, visited Zimbabwe and pledged US$20 million. The funding will be coordinated via the local Centre for Disease Control office and the USAID mission in Harare. (PEPFAR had by then given US$15 billion to control HIV/AIDS to 14 developing countries but to the exclusion of Zimbabwe, which is one of the countries in the epicentre of the HIV/AIDS pandemic.)[37]

In March 2006, the European Union provided the Zimbabwe government with significant funding for health and HIV/AIDS. Also in March 2006, the World Bank announced that Zimbabwe had been chosen, along with Zambia and Malawi, to receive US$87,000 for NGOs, community groups and other civil society organisations (CSOs) working towards solutions in HIV/AIDS. The funding would come from the Bank's Country Development Marketplace, a funding facility launched in 2004 for civic organisations engaged in HIV/AIDS work.[38] The United Kingdom's Department for International Development provided substantial funding in April 2006 for poverty alleviation, health and HIV/AIDS programmes. Sweden's SIDA has also provided some funding for poverty alleviation, health and HIV/AIDS.

The government has of late been insisting on controlling and coordinating HIV/AIDS resources via the UNAIDS 'Three Ones Initiative'; that is, one strategy, one coordinating body and one monitoring system. This is also in keeping with the AU Commission's HIV/AIDS Strategic Plan 2005–07 and the AWA Action Plan (Objective 3 Harmonisation and Coordination, Strategy 30b).[39] However, civil society

is concerned that the government could stifle the independence of private welfare organisations with the resultant loss of further external support for HIV/AIDS.

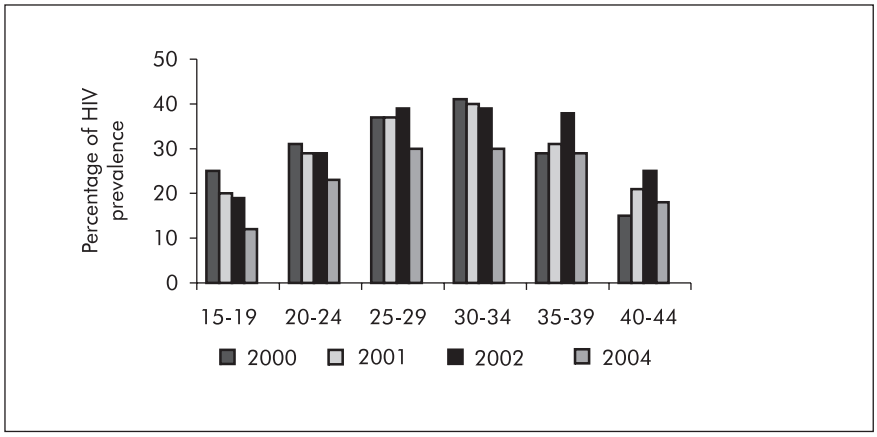
RECENT DECLINE IN HIV PREVALENCE

On a positive note, the latest (2005) figures show some decline in HIV prevalence in the adult population. This is now estimated at 20.1%, compared with 24.6% in 2002 and 31% in 2000.[40]

Figure 2 shows that there has been a significant decline, particularly in the 15–19-year age group. These results have stimulated a lot of enthusiasm and debate. After all, Uganda had until then been the only country in sub-Saharan Africa that had recorded a decline in HIV/AIDS prevalence. The government, along with UNAIDS and other partners, argue that this is a genuine decline attributable to behaviour change as a result of health education and district and community management of HIV/AIDS. More specifically, it is argued that there is an increase in condom use and an increase in the number of young people delaying the onset of their first sexual experience, while both males and females are now having fewer partners.

A recent study of HIV prevalence in eastern Zimbabwe during the period 1998–2003, and published in the reputable journal *Science* in

Figure 2: HIV prevalence among pregnant women attending antenatal clinics by age group, 2000–2004



Source: Adapted from UNAIDS/WHO AIDS, AIDS pandemic update, (UNAIDS/05.19E), Geneva, December 2005, p 21.

February 2006, supports the view that the decline is genuine and that it is due to behaviour change.[41] The study reveals the following startling results: HIV prevalence has declined by 49% in women aged 15–24 years and 23% in men aged 17–29 years. The reduction was more prevalent in more educated people. Sexually experienced men and women reported a decline in casual sex of 49% and 22% respectively. Delayed sexual debuts were also recently reported.

The authors argue that these spectacular results were most probably due to, *inter alia*,:[42]

- a well-educated population;
- a change of behaviour due to fear of dying from AIDS;
- a relatively good communications and health services infrastructure;
- radio and TV dramas;
- early control of STIs;
- social marketing of condoms;
- the VCT programme; and
- the positive impact of the Zimbabwe AIDS Trust Fund.

A comprehensive review of epidemiological and behavioural data released by UNAIDS in November 2005 concludes that both HIV prevalence and incidence rates have fallen in Zimbabwe over the past five years.[43]

Others doubt whether there has been a real decline. Even Gregson and colleagues note that "owing to the long average incubation period of HIV infection, HIV prevalence reflects the accumulation of infection over a period of more than ten years and is therefore insensitive to behaviour change".[44]

There are some thoughts that this could be because of a change in the method of collecting data on sero-prevalence. Others, including Gregson et al, concede that the decrease in prevalence could also be due to a higher number of deaths among AIDS sufferers.[45] Furthermore, prevalence rates alone tell us little about the potential reasons behind the figures.

The Demographic and Health surveys in Zimbabwe include both HIV prevalence and behavioural indicators. The latest Demographic and Health Survey results are due in mid-2006. Thus, it will be possible to further elucidate the impact of behavioural indicators on the latest national HIV prevalence rates. However, even if the recent results are a genuine reflection of a decline in HIV/AIDS infection, a prevalence rate of 20.1% is still too high.

ZIMBABWE DEFENCE FORCES (ZDF)

BRIEF OVERVIEW OF ORGANISATIONAL AND COMMAND STRUCTURE

The security agencies in Zimbabwe consist of the Zimbabwe National Army (ZNA), the Air Force of Zimbabwe (AFZ), the Zimbabwe Republic Police (ZRP), the Zimbabwe Prisons Service (ZPS) and the Central Intelligence Organisation (CIO).

From the civil society perspective, and taking into consideration HIV/AIDS, the role of the military in training and possibly arming the ZNWVA and some graduates of the national youth training programme (popularly referred to as the 'youth militia') needs to be questioned. These two organisations played a significantly negative security role during the parliamentary and presidential elections of 2000 and 2002, with some of their members accused of rape. Our emphasis here, however, will be on the ZNA and the AFZ, which constitute the Zimbabwe Defence Forces (ZDF).

The Defence Forces Act governs the ZDF, which does not fall under the Public Service Act. Zimbabwe's president is commander-in-chief of the ZDF. He appoints the commander of the ZDF, who is the equivalent of the chairman of the Joint Chiefs of Staff. Below the ZDF commander are the commander of the ZNA and the commander of the AFZ. The president appoints all the officers of these two forces, on the recommendation of the ZDF commander. Civilian control of the military is structured via the Ministry of Defence, with the Minister of Defence answerable to parliament.

ZDF's INTERNAL AND EXTERNAL SECURITY ROLE

The principal role of the ZDF is to safeguard the borders of the country against external threats. The very long borders therefore pose a challenge for deployment. The ZDF also complements the ZRP in ensuring internal security when called upon. The ZDF may be called upon to implement some of the country's foreign policy objectives. It was in this connection that the ZDF was deployed in Mozambique's civil war soon after independence, from 1982 to 1992, in particular in the provinces of Manica and Sofala. The intervention was codenamed 'Operation Butterfly' and was initially aimed at protecting Zimbabwe's rail, road and fuel pipeline to the Indian Ocean. Thereafter, the ZDF became more involved in the civil war and supported the Frelimo government against the Renamo rebels.

More controversially, the ZDF was deployed from August 1998 until October 2002 in the Democratic Republic of the Congo (DRC) civil war in support of the regime of the late Laurent Kabila. This intervention was codenamed 'Operation Sovereign-Legitimacy'. The Zimbabwean troops were joined by troops from Angola and Namibia. The rebels were supported by Rwanda and Uganda. Thus began Africa's so-called First World War.

ZDF's INTERNATIONAL PEACEKEEPING ROLE

ZDF personnel have been deployed to several trouble spots around Africa under the umbrella of the UN in Angola, Rwanda and Somalia, and with the Organisation of African Unity Observer Group in Burundi. ZRP personnel have also been deployed in international peacekeeping exercises.

Zimbabwe has become the leading country for peacekeeping training in the SADC region via the SADC Organ for Politics, Defence and Security and the Inter-State Defence and Security Committee. The training has been coordinated by the Zimbabwe Staff College in Harare. The first joint command and staff course was held in 1996.

These external missions, whether offensive in nature (as in Mozambique and the DRC) or peacekeeping (as in Angola and elsewhere), have a bearing on the transmission of STIs, HIV/AIDS and other infections within the armed forces and to and from civilian populations, both at home and abroad. There is a particular concern about the possibility of introducing new strains of HIV and other dangerous diseases such as Ebola.

ZDF AND HIV/AIDS

HIGH HIV AND STI PREVALENCE

It is understandable that militaries are often reluctant to divulge figures on HIV/AIDS prevalence for fear that this would tip off potential enemies as to their perceived strategic weaknesses due to illness. For instance, the high attrition rates associated with the recent maturing of HIV/AIDS has resulted in the "loss of continuity at command levels and within the ranks, increased recruitment and training costs for replacements, and a general reduction in preparedness, internal stability, and external security".[46]

There is some evidence that "ST[I] infection rates among military populations are between two and five times the infection rates of the civil societies in which they reside".[47] As noted previously, STIs significantly increase the risk of contracting HIV/AIDS.

Like the civilian population, militaries in the Southern African region are the most affected by, and vulnerable to, HIV/AIDS.[48] UNAIDS and other sources estimate that military personnel have a two to five times higher risk of contracting HIV than the general population during peacetime, and an even greater risk during conflict.[49] Postulated reasons for this, including in Zimbabwe, include that:

- those in the military are predominantly in the most sexually active age groups;
- young recruits may be socially inexperienced;
- military culture tends to favour risk-taking behaviour;
- there is stress during wartime and boredom during peacetime;
- there is abuse of alcohol and drugs;
- the militaries are highly mobile populations and are often away from their families for long periods;
- the militaries are often surrounded by opportunities for casual sex;
- those in the military have steady incomes, privileges and power, thereby creating potentially unbalanced sexual relations with local civilian populations;
- there is the possibility of occupational infection through caring for the wounded and the possibility of receiving contaminated blood during emergency transfusions; and
- there is a lack of HIV/AIDS intervention programmes, including a general lack of adequate HIV testing and monitoring equipment, especially under field conditions.[50]

Retired Brig Gen Chiweza revealed that when he was Zimbabwe's

military attaché in China in the 1990s he was shocked by the high number of Zimbabwean military officers who were HIV-positive and who had STIs and had been sent for training. (China has a policy of mandatory testing for all foreigners coming for training.) In 1990, 13 out of every 60 ZDF officers sent to China for training were HIV-positive (that is, 21.7%) and 30 out of 60 had STIs (50%).[51]

In South Africa, it was noted in 2002 that:

> the greatest prevalence of HIV/AIDS was found among the 25–33-year age bracket. . . . When considering that this comprises the mean middle-management, from lieutenant to lieutenant-colonel for officers and from sergeant to warrant officer for other ranks, the implications with respect to force preparation and application (deployment) as well as budgetary considerations, become obvious.[52]

There is no reason to believe that the situation would be any different in the ZDF.

The Southern Africa HIV/AIDS Information Dissemination Service, an NGO, reported in 2002 that about half of Zimbabwe's soldiers were HIV-positive and that "this obviously has serious repercussions on military preparedness and functions, individual soldiers, their families and the civilian populace with whom they interact".[53] The report further says, "widespread illness in the ranks threatens the ability of the military to respond to external threats or to fulfil its other functions".[54]

The US Defence Intelligence Agency is cited by Mock as estimating that the ZDF has a sero-prevalence of 70–75%.[55] Others estimated that 80–90% of Zimbabwean troops engaged in the DRC war were HIV-positive.[56]

More recently, a study by the Poverty Reduction Forum, the Zimbabwe Institute of Development Studies and the UNDP—the *2003 Zimbabwe Human Development Report*—estimated that the ZDF had an HIV/AIDS sero-prevalence of 55%.[57] The study also reported that about 75% of ZDF personnel die within one year after discharge and that 72% of all prison deaths are due to HIV/AIDS.[58]

IMPACT OF EXTERNAL DEPLOYMENT

As previously noted, ZDF personnel have been deployed to several countries on the African continent. "Deploying large numbers of soldiers and peacekeepers around the planet adds new complications to the

spread of HIV/AIDS."[59] Sarin and UNAIDS also warn that peace often exacerbates the problem as demobilised forces return home and mingle with the local civilian population.[60]

Of particular concern to civil society in Zimbabwe is the potential impact of deployment to the DRC, where Zimbabwean troops spent four years. The Los Alamos Laboratory in New Mexico, US, keeps genetic details of every HIV strain. A *Newsday* article of 9 July 2000 quotes Dr Bette Korber from the laboratory noting with concern that "... something strange is going on in Congo. It's as if all the African HIV clades (subtypes) are mixing there, forming strange recombinants. We are seeing variants never seen before".[61]

The Lake Victoria region adjacent to the DRC, where the HIV/AIDS pandemic is thought to have originated, predominantly has the D and A clades. Southern Africa, where the pandemic is newer, has predominantly the C clade. Korber concluded that "recombination is happening so fast that we see the clade distinctions beginning to blur".[62] Having exposed Zimbabwean troops to the DRC means that the troops could have introduced new strains to that region, and also that they could have brought back new HIV strains, along with other communicable infectious diseases such as Ebola.

MILITARY, GENDER AND HIV/AIDS

We have already noted that in the civilian population, women and young girls in particular are at greater risk of contracting HIV/AIDS.[63] In relation to the military, risks are present from three fronts:[64]

- Women and young girls are at increased risk of sexual abuse by armed personnel during both peacetime and times of conflict. In the milder form, this can take the form of poor and vulnerable women and girls being drawn to military barracks and resorting to survival sex in search of money and food. Military personnel often have higher incomes than the people in the surrounding communities. This is further exacerbated by the fact that many military barracks are single-sex accommodation facilities. Also, when away from home for long periods, military personnel may visit local brothels. In the more extreme form, this may include rape in exchange for allowing women, especially cross-border traders with no documents, to cross checkpoints and borders. During conflict, even more violent forms of rape occur (rape as a tool of war).

- The partners of military personnel are at increased risk of contracting STIs and HIV/AIDS when the troops return home from both internal and external deployment.

- Young female recruits in the military are also at great risk of sexual abuse from their male superiors. As in other militaries, the UNDP report notes that the same risks are also present in the Zimbabwean scenario.[65]

IRREGULAR PARAMILITARY FORCES AND HIV/AIDS

Civil society was very concerned that sections of the war veterans' movement and young recruits from the national youth training centres, popularly known as the 'youth militia', were engaged in election-related violence, including allegations of rape, during the 2000 and 2002 general and parliamentary elections.

There has also been anecdotal evidence of young female recruits in the national youth training centres being subjected to sexual abuse by their male peers. Several authors and organisations have warned that young boys and girls, including young combatants, are highly vulnerable to sexual violence and exploitation.[66]

Although the situation in Zimbabwe was not as bad as the very sad case of child soldiers witnessed in the DRC, Southern Sudan, Sierra Leone, Liberia and other parts of Africa and elsewhere,[67] it is nevertheless a worrying development that needs to be nipped in the bud. Such practices put these young people at higher risk of contracting STIs and HIV/AIDS.

ZDF RESPONSE TO HIV/AIDS

HIV/AIDS POLICY AND COORDINATING STRUCTURES

The ZDF's HIV/AIDS policy is informed by the national policy as promulgated by the NAC. However, the ZDF has its own structures to respond to the HIV/AIDS challenge. On a positive note, the ZDF has not relegated HIV/AIDS as a purely public health challenge to be handled by the health division. Instead, the ZNA launched its AIDS Coordinating Committee in 2002. This is headed by a high-ranking officer, Brig Gen Douglas Nyikayaramba. The committee has introduced the HIV/AIDS programme to all the army's units. The programme includes distribution

of educational material, home-based care, and more recently VCT, for both army personnel and their dependants.

One of the challenges facing HIV/AIDS in militaries has been the incorrect perception that militaries in Africa are well funded. This often leads to their exclusion from civil society resources. In July 2003 the ZDF did, however, receive ZW$30 million from the National AIDS Trust Fund. Receiving the money on behalf of the army, a very senior military commander, Maj Gen Amoth Chimombe, was quoted as saying "the ZNA will by the end of the year include HIV/AIDS education as part of military training".[68] This development—the mainstreaming of HIV/AIDS-related issues in the military curriculum—is crucial for countries seeking to communicate the effects of HIV/AIDS at an early age.

HIV/AIDS AND RECRUITMENT POLICY

In principle, the ZDF provides 'voluntary' testing with counselling. Confidentiality of one's HIV/AIDS status is also assured.

The recruit undergoes a variety of tests. These include gruelling fitness tests, interviews and medical tests. It is probable that all new recruits are screened for HIV/AIDS. In the past, around 1996, recruits who passed the fitness test but were found to be positive but generally physically healthy would be recruited.[69] Currently, it is probable that HIV-positive potential recruits are not admitted into the military. However, it appears that potential recruits are not told why they were not successful. The failed recruit is thus left to ponder the reason for exclusion. This could be failure of the fitness test, the medical examination or the interview. This has obvious ethical implications, as it does not fall within the realm of ethical VCT. This apparent new policy of admitting only HIV-negative recruits is likely to be intended to reduce both the financial burden and the security threat posed by high HIV/AIDS prevalence rates.

The AFZ was the first to declare openly that recruits for some specified jobs, such as pilots, must be HIV-negative. This was the case even before 1996—as indicated in the paper by Yeager, who noted that "persons applying for pilot training must first be tested because of the high cost of this education".[70] This was most probably as a result of recommendations from the then Zimbabwe military attaché to China, who was alarmed by the high numbers of pilots who were HIV-positive and had been sent back from China where they had gone for further training.[71]

IN-SERVICE POLICY ON HIV/AIDS

Since the mid-1990s, the ZDF has been providing voluntary counselling and testing.[72] It is not known how many soldiers have gone for VCT. However, judging from the scepticism expressed by Brig Gen Chiweza (who retired from the ZDF in 1995) concerning the very low uptake of VCT in the general population in March 2003, it would be safe to assume that the VCT uptake is also low in the military.[73]

Confidentiality is said to be assured, "with commanders only having to know about their units' aggregate strength. . . . HIV-positive but otherwise fit cases continue in service and are provided with education and counselling".[74]

This is in keeping with ILO Code of Practice 8.3, Epidemiological Surveillance, which states that "anonymous, unlinked surveillance or epidemiological HIV testing in the workplace may occur provided it is undertaken in accordance with ethical principles of scientific research, professional ethics and the protection of individual rights and confidentiality".[75] Soldiers who are HIV-negative are counselled and encouraged to remain negative. "Some HIV-positive officers, for example pilots of high-performance aircraft, may be reassigned."[76]

Exceptions to VCT include those going for further training abroad and pilots. "Personnel slated for overseas training are tested to comply with requirements set by host countries."[77] However, it is probable that colleagues may become aware that those not sent abroad for further training were HIV-positive, thereby compromising confidentiality. Nevertheless, there is no obvious evidence of stigmatisation of such personnel. Pilots undergo regular HIV testing. "HIV-positive pilots are counselled. If there are no apparent symptoms, a pilot may continue flying, but if the pilot becomes HIV-symptomatic, he is grounded and, if AIDS-symptomatic, he is discharged."[78]

Soldiers who are both HIV-positive and ill are treated with the available medication, including ARVs. However, they are encouraged to go on early retirement on medical grounds if their illness persists. "AIDS patients must appear before medical boards and be discharged if found no longer able to perform their duties."[79] This includes health personnel within the ZDF. This is done in order to allow the ZDF to recruit new staff. Recruitment cannot be done when the personnel members concerned are still at their posts.

Soldiers who die of HIV/AIDS (or any other illness) while on the job are provided with full funeral support, including transport of the body to the burial site chosen by the family, no matter how far.

POST-EMPLOYMENT HIV/AIDS POLICY

As noted above, if the medical board determines that the disability due to the illness is permanent, the soldier is recommended to go on early retirement on medical grounds with full benefits, and in fact to "receive a better pension than is normally offered".[80] Processing of the necessary papers is speeded up so that soldiers may obtain their benefits while they are still alive, and also to allow prompt replacement of personnel.

To its credit, the ZDF does not neglect its retired and ill soldiers. "Personnel thus discharged are entitled to free medical care until they die."[81] Furthermore, "dependants of deceased male personnel are provided for until their children mature or their wives remarry".[82]

GENDER

We have already discussed the aspect of the military, gender and HIV/AIDS. In addition, HIV/AIDS among the spouses of male soldiers presents an important challenge. The ZNA Wives and Women's Association has led the battle to break the silence and deal with the issue of stigmatisation.

RESEARCH

The Ministry of Health and Child Welfare has conducted several epidemiological studies on HIV/AIDS[83] and has also encouraged other researchers to do the same.[84] The ZDF has a corps of clinical and public health scientists headed by a medical practitioner with a master's degree in public health and the rank of brigadier general. The army has been conducting its own studies on aspects of HIV/AIDS in the military. Unfortunately, these are not in the public domain. However, it is hoped that efforts will be made to get cooperation from the military for future publications, as such studies are in the public interest and are not necessarily a threat to national security.

FUTURE CHALLENGES

Zimbabwe needs to embark on constructive, broad political and socio-economic reforms that will enhance some of the positive public health measures that are being pursued. It is only then that Zimbabwe will be able to achieve some of the targets of the Millennium Development Goals, in particular those that relate to HIV/AIDS.

Since the military is now recruiting largely HIV-negative young people, it is assumed that, in theory, there may come a time when the HIV prevalence in the military is lower than it is in the general adult population. However, the greater challenge is to ensure that HIV-negative personnel remain negative. So long as the factors that put military personnel at higher risk of contracting HIV/AIDS remain, the battle will not be won.

It is important to note that employment policies at national, regional and international levels do not favour discrimination on the basis of HIV-positive results, even at the pre-employment stage. The reforms in the Royal Thai Military in relation to HIV/AIDS demonstrate that it is possible to reduce HIV/AIDS in the military without discrimination and stigma.[85]

The challenge of harmonising HIV/AIDS policies in the military in the region, both within SADC through the SADC Organ on Politics, Defence and Security Cooperation[86] and the Southern Region of the AU Standby Force,[87] still remains. The Zimbabwe military therefore needs to continue to be fully engaged in that regional endeavour.

Finally, the challenge of further developing multidisciplinary HIV/AIDS research in the military remains. One way of achieving this is by developing stronger civil–military cooperation. Such cooperation would not only help to resolve some of the suspicions and misunderstandings, but it would also help in reducing HIV/AIDS in both the military and civilian populations.

SUMMARY AND CONCLUSION

In spite of the enormous socio-economic and political challenges faced by Zimbabwe, the country should be applauded for having taken HIV/AIDS seriously. Credit should particularly be given for the following initiatives:

- An independent national AIDS policy coordinating body, the NAC, a National AIDS Levy and the National AIDS Trust Fund have all been established.

- Overall, with few exceptions, the ZDF's HIV/AIDS policies are consistent with national policy on HIV/AIDS, as promulgated by the NAC.

- The NAC, through the National AIDS Trust Fund, has allocated money to the ZDF's HIV/AIDS campaign.

- The top leadership of the ZDF has tackled HIV/AIDS as a priority challenge, as opposed to just leaving it to the medical department.

If Zimbabwe and other Southern African countries are to achieve the Millennium Development Goals of taking "necessary action to halt and begin to reverse the global AIDS pandemic by 2015", then the active participation of the military will be vital. This calls for active civil–military cooperation.[88]

Nancy Mock noted in 2002 that "the role of the military [in HIV/AIDS] is only a recent concern of the international community" and that "the military is seen as part of the problem, not part of the solution".[89] It is hoped that this publication will help to change this perception both in Zimbabwe and in the SADC region generally.

RECOMMENDATIONS

UNITED NATIONS

The UN Security Council adopted Resolution 1308 in July 2000 in response to the challenge posed by HIV/AIDS in the military.[90] Hence, UNAIDS and the UN Department of Peacekeeping Operations have been working closely to develop further AIDS prevention and education for all peacekeepers.[91]

The UN is still grappling with the controversial question of compulsory pre-deployment HIV testing for peacekeepers. The rights-based approach remains the cornerstone, so as to ensure testing with informed consent and confidentiality, as well as dealing with the implications of HIV-positive results, which include reducing discrimination and stigma. Nevertheless, several countries, Eritrea being one, have demanded that peacekeepers be tested and that only HIV-negative personnel be deployed so as to protect the local civilian population.[92] Zimbabwe has contributed to the UN peacekeeping pool. It is imperative that the UN draws up sound guidelines on this controversial topic.

Major peacekeeping operations have full-time AIDS advisers and smaller missions have AIDS focal points.[93] The ZDF should follow this example and designate AIDS focal points in all its barracks.

AFRICAN UNION

The UN has suggested the creation of regional standby forces. The AU

has already devised plans to create five regional standby brigades that would be part of the Africa Standby Force.[94] Zimbabwe falls within the proposed Southern Africa Standby Brigade. Zimbabwe could use its leading training role in SADC to propagate common policies and standard operating procedures on HIV/AIDS in the Southern African region in keeping with the AU's HIV/AIDS strategic plan.[95]

The AU Commission's HIV/AIDS Strategic Plan 2005–07 and the AWA Action Plan (Objective 5: Programme Priorities, Strategy 34g) recommends that the continent should "accelerate effective implementation of comprehensive HIV/AIDS programmes in AU peacekeeping operations, African militaries and other conflict, emergency and humanitarian responses".[96]

The Zimbabwe military should be an active player in addressing this continental challenge. The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases asks African nations to set a target of at least 15% of their annual budgets to the improvement of the health sector.[97] It is now five years since the Abuja Declaration[98] and five years since the UN General Assembly Special Session on HIV/AIDS.[99]

This is a challenge that the Zimbabwe government should be seen to be addressing. To repeat the situation where more was being spent on defence than health during the DRC campaign would be unacceptable.

SADC/ISDSC

The SADC Protocol on Politics, Defence and Security binds SADC member states to "cooperate fully in regional security and defence . . . [and] develop a regional peacekeeping capacity with national armies".[100] There is therefore a strong need to develop a collective and harmonised HIV/AIDS policy for SADC defence forces, as recommended by the SADC Inter-State Defence and Security Committee. In this regard, Zimbabwe could use its leading role in peacekeeping training to propagate common policies and standard operating procedures in the region for HIV/AIDS in the armed forces.

The SADC Treaty of 17 August 1992 converted the region from a treaty of the executive arms of the states to a treaty of peoples.[101] As such, there is need for greater cross-border collaboration of SADC citizens to combat HIV/AIDS, including regional civil–military initiatives. The initiative by the Institute for Security Studies is therefore appropriate.

The ZDF should continue to improve its "capacity to collect and analyse the data required to generate these (HIV/AIDS) estimates".[102] Since HIV/AIDS knows no boundaries, closer civil–military relations could contribute to this improvement.

During Zimbabwe's participation in the war in the DRC, it was estimated that the country was spending about twice as much on defence as on health.[103] If Zimbabwe is to continue to make a significant impact on the HIV/AIDS pandemic, these figures need to be substantially reversed. The ZDF should expand its information and education programme, in particular the training for peer educators.[104] There should be more targeted information and education on the provision of condoms and their use in the military.

The ILO recommends that "HIV testing should not be required at the time of recruitment or as a condition of continued employment".[105] The ZDF needs to take note of this and also to further promote VCT in the military.

In view of the close relationship between STIs and HIV/AIDS, it is imperative that the ZDF should continue to prioritise STI prevention and treatment. The ZDF should draw some lessons from the Royal Thai Army on early surveillance of HIV within conscripts, treatment and care of military personnel, medical research and development, multi-sector cooperation and the need for a long-term commitment.[106]

On gender and HIV/AIDS in the military, Yeager recommends the need to "overcome sexual harassment in the ranks by empowering women through promotions and other measures".[107] This is consistent with ILO Code of Practice 6.3 on the need for gender-specific programmes. The code recommends that:

> information for women needs to alert them to, and explain, their higher risk of infection. . . . Education should help both women and men to understand and act upon the unequal power relations between them. . . . Harassment and violence should be addressed. . . . Women should understand their rights, both within the workplace and outside, and they should be empowered to protect themselves.[108]

The ZDF should also improve the availability of user-friendly female condoms, the early recognition and treatment of bacterial vaginosis and the promotion and use of microbicides, as recommended at the recent 2006 international conference in Cape Town, South Africa.

The ZDF should continue to address the need to provide family housing for its personnel, as opposed to single-sex barracks that are akin to the old and discredited single-sex hostels in the mining, urban and commercial farming sectors in the Southern African region. Yeager underscores the need to "provide better living conditions for married military couples".[109]

Since a lack of recreational facilities in military barracks has been implicated in increasing the risk of contracting HIV/AIDS, the ZDF should increase the provision of adequate sport and recreation facilities in the armed forces. Already, the ZDF has active sporting programmes in soccer, volleyball, athletics, shooting and other disciplines.

Currently, personnel may be away from home for up to six months. Yeager recommends a maximum period of three months' deployment away from home and family.[110] It is strongly recommended that HIV/AIDS programmes also target war veterans and 'youth militia'.

The ZDF should study seriously the public health impact of male circumcision. Several studies in sub-Saharan Africa have shown that uncircumcised males are highly susceptible to HIV infection, whereas male circumcision is equivalent to a vaccine with a 60+% efficacy.[111] It would therefore appear logical to recommend circumcision and provide free circumcision to military recruits who request it.

Finally, there should be less secrecy pertaining to HIV/AIDS in the military in Zimbabwe and in the region. This is a topic that is in the public domain and is of national interest.

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