

Lessons learned

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This study is expected to make an important contribution to the complex problem of HIV/AIDS and its impact on the militaries in Africa, as well as on their responses to the pandemic. The study is based on empirical evidence and participation in the project of the armed forces of Botswana, Swaziland and Zambia, with the authority of their governments, as well as contributions from civil society colleagues who have intimate knowledge and experience gained from working on this issue with the militaries of Tanzania and Zimbabwe.

This summary of lessons learned emanates from several dimensions:

- The first is a range of common trends identified in each of the militaries that can provide information and insights to other defence and security institutions.
- The second is what is unique in each of the case studies that the other organisations can learn from.
- The third is that we need to identify what we know from the debate that has not necessarily been previously highlighted, and to seek to bring this to bear as comprehensive lessons learned for Southern African militaries in particular, and Africa in general.

The basis of the knowledge gained revolved around research questions, dialogue with members of the research group through correspondence,

email and other forms of communication during the period of the research, and, finally, other interactions, including participating as the core group in a scenario workshop that took place the day after the completion of the October 2005 conference on the final review of the manuscript. What follows, therefore, are key points and lessons learned from the research, dialogue and interactions over the past year or so.

However, a word of caution. This is not a summary of the very rich and unique country chapter presentations. It is, instead, merely a selection of the more common trends and similarities, without detracting from our initial intention, which is that readers should refer to each of the chapters in this book.

The first lesson to almost jump out of the research was a confirmation of the existence of the HIV/AIDS pandemic in all the countries represented. This is an important lesson, in which the incidence, threats and challenges of HIV/AIDS continue to be universal in the countries selected for the study. As a result, there is a morbid reality in which, either individually or in cooperation, the said countries need as a matter of urgency to find similar policy options on how to respond to the debilitating nature of the pandemic.

The 'discovery' of the presence of HIV/AIDS in Southern Africa appears to have emerged within a single decade, around the late 1970s and early 1980s. In alphabetical order, Botswana, Swaziland, Tanzania, Zambia and Zimbabwe are some of the countries grappling with the presence and accelerated impact of the incidence of HIV/AIDS. There is, however, a difference in the prevalence rates. Tanzania exhibits the lowest prevalence rate at national level while Swaziland and Botswana reflect the highest. The other two, Zambia and Zimbabwe, have prevalence rates that lie somewhere in between.

Related to the question of prevalence is the recognition of a similar trend in the methods of transmission of the disease. As John Iliffe asserts in *A History of the African AIDS Pandemic*, more than 90% of African victims have had their infection transmitted from heterosexual activities, while 10% of the transmissions were from blood transfusions or mother-to-child transmissions.¹

This assertion, however, misses out on what we think is a known phenomenon but one that has not been addressed. This is homosexual activities within African communities, including the armed forces. Given the criminalisation and taboos surrounding homosexual practices in African societies, this is not surprising. However, conference participants acknowledged that while homosexual activities existed as a means of

transmission, their extent was difficult to document. This was because whenever homosexual activities occurred and became known, those engaging in them were immediately prosecuted, jailed or even dismissed from the various defence forces in terms of existing regulations.

A consequence of the heavy-handed policing of homosexuals has resulted in the low to very low admitted incidence of transmission compared to the much talked about San Francisco American example. Although in the debates and dialogue with the researchers this question was raised, its practice was noted to be highly secretive and therefore difficult to document.

However, this development provided us with a second important lesson, which was the inability by African states to come up with appropriate counter-measures two decades after the ‘discovery’ of HIV/AIDS within their societies and among the ranks of their defence forces.

In the case studies, most of the policies referred to had been developed but were still awaiting final adoption by the various legislatures. What is the explanation for this common policy freeze? There are two main reasons and perhaps a third secondary reason for this inertia in policy formulation among African states.

REASONS FOR POLICY FORMULATION INERTIA

LACK OF RESEARCH APPROPRIATE TO AFRICA

The first main reason is that HIV/AIDS types and strains have developed along different lines. Europe and the United States (US) are characterised by HIV/AIDS Type 1, while the African continent is characterised by HIV/AIDS Type 2. While Type 2 is more virulent, Type 1 is relatively benign from the perspective of its effects and the survival of those infected with it. Based on this differential—which is also revealed in the global prevalence rates, as published by the Joint United Nations Programme on HIV/AIDS (UNAIDS) annually—the impact of HIV/AIDS has remained within manageable levels in the northern hemisphere (or ‘the West’), while it has escalated to a pandemic on the African continent, where it has caused horrendous fatalities and has threatened national security.

With HIV/AIDS remaining a public health issue in the West and falling in the realm of the various health ministries, there has been a lack of appropriate policy formulation by skilled and experienced institutions in the West from which Africa could copy and paste.

This absence of policy focus in the West has also not been helped by the differences in viral types. Research has generally not concentrated on the African Type 2 virus, which has been regarded as exotic. Instead, resources and attention have been concentrated on the Type 1 that is more prevalent in the developed world.

WEAK STRUCTURES WITHIN AFFECTED GOVERNMENTS

Second, African states are going through a period of considerable political reform, nation building and reconstruction, after the removal of the strictures of the Cold War and its replacement by the 'winds of globalisation'. In this context, HIV/AIDS has left most African countries in a state of near-collapse, weak and barely able to manage a rudimentary development agenda.

COMPLEX NATURE OF THE DISEASE

A third, secondary, reason for the lack of an emergence of appropriate policies has been the nature of the disease. HIV/AIDS has been described as "silent [and] hypocritical and visible only when the damage is irreparable".²

Stated differently, the incidence, evolution and impact of HIV/AIDS is complex and demands the dedication of huge amounts of resources, as well as multiple and sector approaches that are beyond the capacity of most African countries. The challenges include how to:

- benefit from a mature pharmaceutical industry;
- raise the significant amount of resources required;
- provide basic food security for diverse nutritional needs;
- train skilled medical and social science human resources supporting research, and administering new regimes of drugs as well as care and treatment; and
- develop a health system that includes private and public entities as well as host research and development capacity.

To this end, there are points and periods in the evolution of HIV/AIDS

in which the absence of counter-measures may appear superfluous but be proved not to be so only when it is too late.

For the above three reasons therefore—an absence of similar impact in the North and therefore no policy effort that could be appropriated by Africa; the weak structures within affected governments on the African continent; and the complexity and multi-dimensional challenge of HIV/AIDS—African people have been left floundering.

SOUTHERN AFRICA'S RESPONSE

Against this debilitating background, attempts by Southern African states studied to come up with effective and timely policy options have been characterised by fits and starts, and eventually inertia. Each of the countries has traversed three steps in its attempts to come up with HIV- and AIDS-related policies:

- Faced with the 'discovery' of HIV/AIDS during the 1980s, a common trend was to establish a unit within the Ministry of Health charged with investigating the disease and providing the country's Cabinet with options.
- When this failed, the unit was expanded to a National Commission with the same mandate and expectation.
- Finally, the National Commission managers have since gone back to each sector—such as agriculture, mining, tourism, education and labour—and encouraged the sectors to come up with specific sector-oriented policies that together will form the national framework.

This last is the stage reached by most of the countries examined in this study. The national commissions in Botswana, Swaziland, Zambia, Tanzania and Zimbabwe may therefore benefit from the summary contained in this study. It must be pointed out, however, that the failings at national level described in the case studies are not unique. Similar evidence is also available at the international level. In this regard, the experience of the World Health Organisation (WHO) before 1995–6 and the successor United Nations (UN) cluster approach through UNAIDS is striking. Each of the countries has followed similar criteria and processes in their attempts to come up with policies that respond to the threat of HIV/AIDS, both at national and at institutional levels.

LESSONS SPECIFIC TO THE ARMED FORCES

In 2001, the International Labour Organisation published a code guiding the recruitment and employment of individuals suffering from HIV/AIDS.³ This provided for non-discrimination on the basis of HIV/AIDS for anyone being recruited, including in the military, as well as support for those who become affected during their working lives. Then there is the question of human rights regimes, which provide individuals with protection against any violations of their personal liberties.

These are issues that confront defence and security institutions when they recruit personnel or reassign personnel away from physically demanding posts in, for example, the air force or the commandoes.⁴ One of the by-products of this protection of HIV/AIDS sufferers is an unforeseen economic cost. While armed forces' budgets are usually calculated on manpower requirements, the HIV/AIDS pandemic has led to an increased turnover of personnel. Unit commanders now have to carry a number of people on their books who are operationally incapable but who are given home sick leave on humanitarian grounds, and who in the process reduce the effectiveness of sections, platoons and companies.

The Zimbabwe case study reveals that its country's air force was the first to announce that "persons applying for pilot's training must first be tested because of the high cost of this education".⁵

The Tanzanian approach is also pragmatic when it argues that:

prolonged periods of recruit training are strenuous. This endurance training goes on by day and night, in deliberately harsh terrain during cold, wet, humid, dusty environments coupled with enforced lack of adequate rest, [food and drink] and sleep. The effect of this strenuous training on asymptomatic HIV patients accelerates the HIV illness conditions and predisposes the affected recruits to continual respiratory infections, diarrhoea, and dehydration. Eventually, the affected recruits die.⁶

Medical evidence supporting this statement is referred to in the Swaziland case study, which claims that militaries in all five of the countries surveyed are testing recruits for HIV/AIDS and rejecting those suffering from the disease on medical grounds. All the countries appear to have adopted the same approach, citing victims of HIV/AIDS as having been rejected on medical grounds in the same way as potential

recruits would be if they had flat feet, an asthmatic condition, diabetes, or squint eyes.

There is, however, a second aspect related to recruitment that appears to require further serious consideration. This is that HIV prevalence rates may generally be lower among 17–18-year old recruits, and that there is therefore a need to mount aggressive programmes in order to maintain the HIV-negative status of these recruits once they are taken into the armed forces. When the debate on this issue was focusing on the dimensions of personal and institutional responsibility, evidence relating to the testing of recruits in Swaziland came to light, revealing an astonishing low rate among the 17–18-year olds. Based on this finding, are institutions now facing up to the challenge of how to maintain the negative status of these young recruits who are in the prime, productive and sexual age group?

The focus on the testing of recruits in all the case studies also revealed an interesting aspect that demonstrates the power relations and social class struggles which underlie the seeming pragmatic approach. According to a survey undertaken in 1996 by the UN Civil Military Alliance (CVA) to combat HIV and AIDS, “only 46% of serving senior officers actually submit themselves for testing”.⁷ The reasons why most middle and senior officers do not ‘volunteer’ included the:

- fact that there was no real reason to subject them to testing as they were in largely administrative posts;
- fear of stigmatisation and reclassification once the results were known; and
- basic cost and availability of medical personnel required to undertake such an extensive exercise.

This phenomenon of low rates of voluntary testing among the hierarchy extended to include personnel on deployment—for which the CVA survey quoted only a 55% success rate—and lower rates for those on scheduled periodic testing (31%) and for those going on new assignments within their own countries (26%).

In the same CVA survey, a much higher rate (88%) was noted for officers going on overseas courses and duties, where the recipient countries had stringent requirements. These countries would insist on testing for all members being sent for courses or, in the case of the

quoted example of Zimbabwean officers going to China for training, once the officers arrived in that country, they were tested and the results were sent back to the despatching country. A similar incident occurred when senior Ugandan officers went for advanced training in Cuba. They were, on arrival, subjected to HIV/AIDS tests and the results were sent back to Uganda's commander-in-chief, who was President Museveni.

In most armies, there are at least four points at which mandatory testing appear to happen. These are:

- the entry point when recruits join;
- the annual fitness tests;
- on deployment for peacekeeping operations—and, on paper, on their return from such peacekeeping operations, either when these are completed or when personnel members are rotated; and
- when a member retires, as provided for in the normal retirement packages.

Accordingly, there is no testing when troops are deployed on urgent national interest operations, such as during the just-finished African war in the Great Lakes in the Democratic Republic of the Congo, or even during the fading Ethiopian-Eritrea war.

Yet another common factor that appears to have been almost drowned out of the debate is the place of traditional medicine and the role of cultural precepts in African armies. It is a fact that most military personnel come from backgrounds that have long-running and successful experiences with the use and application of traditional medicine.

In the HIV/AIDS debate, what is apparent is the fact that, in relation to the core challenge of the virus that causes AIDS, neither modern science nor traditional medicine have been able to come up with a cure. However, in relation to the treatment of some of the symptoms—such as diabetes, tuberculosis, fever and asthma—both modern and traditional medicine have had some success in controlling or slowing down the massive replication of viruses that represents the evolution of the disease within humans.

John Iliffe provides a basic social science understanding of the medical transformation that takes place in victims:

Like all viruses, HIV has no life of its own but is a parasite of cells, the most important being the CD4 helper T cells that activate the body's immune system. [When] the virus enters a cell and integrates its generic information into its host's, using the cell's life to reproduce an immense number of new viruses . . . up to 10 billion new viral particles destroy up to two billion of the host cell each day—and hence ultimately the immune system—while producing an immense number of new viruses to attack further cells . . . and the reproduction is prone to error⁸

To try to counter the above, both modern science and traditional medicine disciplines have struggled to come up with effective drugs and medicines along the lines of what has been termed a 'silver bullet'. Some attempts have achieved some relief on aspects of the impact of the virus, without serious side-effects but also without success in eliminating the basic cause. Faced with this inability to reverse the effects of HIV, proponents of scientific and traditional medicines have resorted to debilitating in-fighting, accusations and counter-accusations, and by so doing have undermined the concerted effort that needs to be made to fight this still-growing pandemic in sub-Saharan Africa.

External support received by the countries whose case studies appear in our document has been similar. There has been direct support from the US to the militaries in the form of training medical staff and supplying laboratory facilities, condoms and medicines. Other support has been through the various countries' own ministries of health, to which the militaries have been able to refer the diverse maladies arising from the HIV/AIDS condition. There has also been external support from the Global AIDS Fund. Botswana has had the unique support of philanthropic bodies such as Microsoft's Bill and Linda Gates Foundation. However, in this respect, authorities have not lost sight of the need to develop local resource support capabilities for the long term.

Because the countries in Southern Africa have been recipients, they have not been able to coordinate the nature, focus and extent of the donations, whose effect may or may not alter intended regional cooperation programmes.

A final observation concerns the policy documents produced by the five countries. There has been no concerted attempt to come up with regional policies that would address the regional security aspects of the African Union (AU) or the Southern African Development Community (SADC) region. For example, the aspect of acquiring cheap supplies of

drugs has not benefited from an integrated regional approach to the dominant foreign pharmaceutical companies. Based on the World Trade Organisation (WTO) provisions and the declaration of HIV/AIDS as an emergency by the UN, only Zimbabwe and South Africa have embarked upon the production of affordable generic drugs.

The following summary includes salient recommendations from the five country studies.

RECOMMENDATIONS

- Southern Africa needs to move beyond the rhetoric and to coordinate country programmes at the regional level, given the fact that the spread and transmission of the pandemic is located around sexual networks that traverse the whole region and beyond.
- There needs to be a harmonising of the institutional policies of the militaries as they relate to HIV/AIDS, given the desirability of an integrated regional brigade under the auspices of the AU's Standby Force. To this end, aspects of testing before deployment and 'take-aways' of antiretroviral (ARV) prescriptions for victims for 90 days, such as is the case in Botswana, need to become standard operating procedures for all the region's forces. Stated differently, those national armies lacking, for any reason, the required drugs while deployed on external operations need to be provided with these drugs in line with Botswana Defence Force best practice.
- The prevalence statistics produced by the militaries are incomplete and therefore undermine comprehensive policy response initiatives. Policy makers must be aware of the power relations around the testing that has now been established within the armed forces. Recruits are subjected to the highest standards possible, even with the limited resources available, in order to deflect attention away from demands for a more comprehensive and thorough programme that periodically examines and evaluates the full complement of military personnel. Without political intervention at the highest level, the current status quo is likely to remain, resulting in a cover-up on the real impact of HIV/AIDS on the human resources of the various defence forces.
- There is need for a close civil-military approach to tackling the complex HIV/AIDS challenges. The impact of HIV/AIDS on the

armed forces has demonstrated the old adage that no sector survives in a vacuum. Owing to the intimate linkages of prevention, transmission, care and treatment, counselling, nutritional support, home-based care, spouses and other partners, no approach will succeed unless it embraces contributions from, and collaboration between, civil society and the military. One case study refers to this as expanding and intensifying an outreach programme that includes support for and input from dependants, civilians and other stakeholders.

- There is a need to coordinate regional responses to the supply of generic drugs and to create a constructive environment in which to engage the pharmaceutical industry. After the UN declared the pandemic a global emergency, normal WTO rules could be renegotiated. In Southern Africa, Zimbabwe and South Africa have sought to suspend normal trade relations in the pharmaceutical industry with a view to producing generic drugs in collaboration with like-minded Brazil and India. For some reason, however, their initiative has not enjoyed further regional support. This needs to change as new negotiations with international drug companies can only benefit from a coordinated regional response. Southern Africa represents a market of some 230 million people, of whom perhaps 20% are infected with HIV and require medication. Viewed from this perspective, it makes sense for the region's health and medical industry to consider providing locally produced drugs to combat the threat to the region's working population. This is in line with the SADC HIV/AIDS regional strategy, which has pointed out that:

the HIV pandemic is concentrated in the working age population, affecting both men and women, skilled and unskilled labour. . . . The protection of human capital from HIV and its impact forms an integral component of all SADC policies and programmes.⁹

- Homosexual relationships exist in Southern Africa and the implications of this fact need to be considered as part of any HIV/AIDS strategy. Homosexual relationships are taboo or frowned upon or even criminalised in all the countries in Southern Africa, except South Africa. The existence of homosexual relationships is a fact that most African armies have so far refused to acknowledge. The continuing denial is based on the region's cultural sensibilities.

However, this dimension cannot be wished away or legislated against, but has to be addressed head on. While vector and transmission models for the region have so far not included gays, the experience of San Francisco should make it clear that if the prevention of HIV/AIDS from this sector in Southern Africa is the priority it should be, this reality must be addressed.

- The region's militaries need to come up with a structure that includes people living with HIV/AIDS (PLHA) from among the ranks. As part of its mandate, PLHA should inform policy makers and medical practitioners about aspects of HIV/AIDS, as well as how to maintain operational integrity without compromising the human factor. In the absence of contributions from those affected, all recommendations will lack realism.
- The case studies suggested that militaries in Southern Africa were 'islands of plenty' that were able to enjoy the benefits of formal paid employment while in their sexually active 20–45-year-old prime. This is all the more reason why military personnel need concerted and extensive education and training on HIV/AIDS. Given an impoverished environment, commercial sex is a readily available commodity that offers easy access to several sexual partners and increases the incidence of risky behaviour. Related to this, the research also drew attention to long deployments and postings that separate soldiers' families, while placing both partners in situations where there is no recognised social and peer restraint. Against this background, important strategies were believed to include:
 - investing in more housing within camps to allow married couples to benefit from stable family relationships; and
 - shortening periods of deployment and duty away from home stations.
- Unit commanders should consider seriously how best to use troops' 'free time' when they are not deployed, patrolling and/or in administrative bases. Organised sports and other activities—such as chess, television, concerts and libraries—are antidotes to boredom and risky behaviour outside the camps.
- Given their inherent structure and discipline and their ability to follow set regimes, military organisations can become change agents

in their societies in the fight against HIV/AIDS. The Tanzanian Commission on AIDS has borrowed heavily from the trail-blazing of that country's defence force, including the secondment of retired Maj Gen Lupogo as its chairman. This lesson can be replicated elsewhere, as, among other things, an antidote to the attempts to stigmatise the military as the 'worst affected', and therefore the alleged culprit for spreading HIV/AIDS.

- There is a need to invest urgently and heavily in home-based care and terminally ill administrative discharges. Most commanders now adopt a humanitarian approach that ignores the cost factors but leaves front-line units short of able manpower as a consequence of HIV/AIDS, absenteeism and long periods of illness before personnel members die or are given early retirement. Policy guidelines are required as resources are currently being drawn from other budgets without authorisation or debate. There will eventually, and inevitably, be a negative impact on the ultimate goal of preparedness and integrity of the armed forces in upholding national security.
- It is important that deliberate policies be introduced to increase the representation of women in higher ranks of the armed forces. Such policies will counter the dominant military 'macho' male culture and lead to a better and more sensitive social environment in the military.
- Our researchers recommend that consideration should be given to the short- and medium-term enrolment of young people within the military. The deployment of, say, 16-year-olds would meet rejuvenation goals and be balanced by the need to retain the advantages of seniority and experience that comprise the historical memory of the military institutions.
- There is, finally, an urgent need to undertake a sustained investigation of military institutions in order to determine the nature and complexity of HIV/AIDS since the 1980s. In addition to the contribution that might be made by the present research—which has focused on the history and experience of the military over a quarter-of-a-century—further multidisciplinary and collaborative research initiatives need to be embarked upon if we are determined to come up with long-term solutions to the HIV/AIDS pandemic in the defence forces of Southern Africa.

NOTES

- 1 J Iliffe, *The African AIDS pandemic: A history*, James Curry, Cape Town, 2006, p 139.
- 2 Ibid, p 8.
- 3 International Labour Organization (ILO), *Code of practice on HIV/AIDS and the world of work*, Geneva, 2001.
- 4 See for example the decision on pilots, aircraft engineers and air traffic controllers in Swaziland after undergoing the mandatory annual medical examination that includes HIV/AIDS screening.
- 5 *Code of practice on HIV/AIDS and the world of work*, op cit (case study on Zimbabwean, Chapter Six of this volume).
- 6 The Tanzanian case study researchers, with a medical officer at Lugalo Military Hospital, 23 August 2005.
- 7 R Yeager & S Kingma, The HIV/AIDS pandemic: Programme imperatives and policy issues, in *Civil Military Relations*, Civil Military Alliance to Combat HIV/AIDS, 2005, pp 2-3.
- 8 Iliffe, op cit, pp 7-8.
- 9 SADC, *SADC HIV & AIDS Strategic Framework and Programme of Action: Managing the HIV & AIDS Pandemic, 2003-2007*, July 2003, p 17.