What we know about HIV and AIDS in the armed forces in Southern Africa

Martin Rupiya*

This paper is a summary of some of the key findings of an eighteen-month MilAIDS research project that focused on how militaries in the Southern African countries of Botswana, Swaziland, Tanzania, Zambia and Zimbabwe had coped with the impact of the HIV epidemic since it had been identified amongst the ranks in the 1980s. As a result, there is a single major source for citation, which is ‘The enemy within: Southern African militaries’ quarter-century battle with HIV and AIDS.’ The summary does, however, contain other information related to developments that have emerged since the completion of the larger study, bringing us up to date with the contemporary discourse in the field.

The purpose of highlighting some of the elements in the larger study is twofold: to distil its main findings for easier consumption and to draw our attention to salient factors that are considered worthy of replication. A second objective of this brief paper is of course to whet readers’ appetite to read the more detailed work referred to above.

* Martin Rupiya is a senior researcher in the Defence Sector Programme at the Institute for Security Studies.
‘Discovery’ of HIV in the armed forces in Southern Africa

The point of departure has to be the question whether the human immunodeficiency virus (HIV) is present amongst the ranks. The available evidence confirms that HIV was ‘discovered’ in the African military in the early 1980s. Precise country data show that the virus was identified in the following periods:

<table>
<thead>
<tr>
<th>Country</th>
<th>Discovery date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>1985</td>
</tr>
<tr>
<td>Swaziland</td>
<td>1987</td>
</tr>
<tr>
<td>Tanzania</td>
<td>1983</td>
</tr>
<tr>
<td>Zambia</td>
<td>1984</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>1985</td>
</tr>
</tbody>
</table>

The available evidence does not necessarily indicate when the virus was identified in the armed forces, but reflects the national presence of the virus. It is important to realise that the current methodology is deficient in gathering accurate details about national prevalence rates.

Three areas of investigation form the crucial part of the methodology: surveys at antenatal clinics, followed by an analysis of blood transfusions and voluntary blood tests. An advanced medical infrastructure, knowledge and capacity are required in order to arrive at a national prevalence rate. However, in war-torn Southern African countries such as Angola and the Democratic Republic of the Congo these are largely not in place, making any claims associated with such countries mere guestimates. Given this background, the current debate is characterised by assumptions, some of which may need adjustment to reflect empirical reality.

Returning to the years of discovery, it is evident that HIV was identified almost simultaneously in the Southern African countries examined in the five-year period 1983–1987. By implication, and based on the incubation period of HIV, it is safe to say that the virus had already been present in the region in the early 1970s.

In the case of Tanzania, the genesis of HIV has been associated with the country’s military involvement in the war with Uganda. This started in late 1978 and lasted until the early 1980s, when Idi Amin was forced to go into exile. In that war, the physical deployment of the Tanzanian People’s Defence Force (TPDF) was through the Kagera Salient, a region that had been annexed by Idi Amin before Tanzania launched a counter-offensive.
The mode of spreading the disease in Southern Africa and among the militaries in the region is through heterosexual practice. Although the case studies refer to anecdotal incidences of homosexual practice, homosexuality has been criminalised in all the above states following attacks on the practice by the political elite.

As a result, when strategies are considered to combat the various modes of transmission, there is a muted debate and no credible options are put forward. This is an area that has now been culturally and deliberately swept under the table.

**Global statistics compared with Southern African statistics**

HIV prevalence in Southern Africa – specifically amongst the ranks – was in line with the global trend, as has been documented by the World Health Organisation (WHO) since. According to WHO statistics for the period 1980–2002, HIV prevalence rates in Africa rose at a much higher rate than in the rest of the world. Figure 1 is a graphic representation of this trend.

But more significantly: of the 70 per cent of global HIV in sub-Saharan Africa, the majority of cases occurred, and have continued to occur, in Southern Africa (see Figure 2).

*Figure 1: Trends in number of people living with HIV infection 1980–2002 by WHO region*
For instance, 20 per cent of the infected global adult population aged between 15 and 49 is found in the nine Southern African countries of Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The debilitating impact of this phenomenon was soon reflected in the life expectancy rates, as reflected in Figure 3.

After confirming the presence of HIV amongst the ranks, the next step was to combat the incidence, effects and propagation of the virus.

For instance, 20 per cent of the infected global adult population aged between 15 and 49 is found in the nine Southern African countries of Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The debilitating impact of this phenomenon was soon reflected in the life expectancy rates, as reflected in Figure 3.

After confirming the presence of HIV amongst the ranks, the next step was to combat the incidence, effects and propagation of the virus.

Figure 3: Life expectancy at birth in selected most affected countries, 1980–1985 to 2005–2010
Policy response to HIV in Southern Africa during the 1980s

Following the discovery of HIV amongst the ranks in Southern Africa militaries, during the 1980s and 1990s, all the states studied were either slow or unable to come up with policy-guiding institutional responses to the vagaries of HIV and AIDS. This phenomenon was not unique, as it was informed by dynamics that were playing themselves out at international level. At the time the WHO and the World Bank (WB) were the anointed torchbearers on providing guidance on international and national policies responding to the effects and spread of the virus. However, this leadership was soon discredited and ‘deposed’ in 1995/96 following widespread international dissatisfaction with the policy options that the two institutions were offering.

One of the basic challenges is the uneven impact of HIV as reflected in national prevalence rates, for example 1 per cent in the United States versus 40 per cent in Botswana and Swaziland. As a result of this disparity, there are differences in the national responses and the urgency of these responses. Second, the HIV types and strains are different, demanding different strategies and medicines. Third, states have different welfare, public and private health systems.

Evidence has shown that in the wealthy North, public and private health systems have generally been able to respond effectively because of the lower rate of infection. In contrast, in the drug-importing South – a region characterised by double-digit prevalence rates and a poor health infrastructure – the impact has been devastating. It created an emergency and demanded a similar response from policymakers who generally do not have adequate resources at their disposal, nor the necessary scientific support. This, in turn, has informed and influenced global state policy response.

Following the discrediting of the WHO and WB’s global leadership on policy, the ‘cluster approach’ was created to replace it. This approach drew its guidelines from the United Nations agency system led by UNAIDS (the Joint United Nations Programme on HIV/AIDS). The latter was and continues to be headed by Dr Peter Piot, one of the first scientists to work on HIV in Kinshasa, to wit during the 1990s. However, in the 2006 Report on the Global AIDS Epidemic, Piot has admitted to a lack of policy coherence and clarity at the international level. This development has therefore not provided any firm policy guidelines that states could integrate with their national policy(ies) on HIV & AIDS.

The initial reaction by ministries of health in the above countries was to treat the virus as yet another epidemic (after sexually transmitted diseases, STDs) before attempting to align national policies with the external influence of the WHO/WB, and later, with suggestions from UNAIDS. Therefore there is a noticeable trend in the policy evolution that shows that HIV at first did not receive any special attention and that this
complacency only changed following the severe effects of acquired immunodeficiency syndrome (AIDS) in the 1990s.

With states left floundering on HIV policy, militaries have been placed in the invidious position of having to maintain and prepare for their primary task while absorbing the incidence and effects of HIV. Below we cite some of the areas in which the military became involved.

*Mandatory HIV testing of new recruits*

Every country studied admitted that, in the absence of a guiding policy, armies have been implementing mandatory HIV testing of new recruits. Anyone found to be HIV positive is rejected on medical grounds and will not be recruited.

The above policy violates not only individual human rights, but also International Labour Organisation (ILO) employment guidelines. While states are aware of these transgressions, it is apparent that policymakers feel it is a small price to pay in order to deliver on their primary role.

Curiously, there have been unforeseen challenges in the implementation of the mandatory testing of new recruits that require an even more nuanced policy response:

- The first ‘discovery’, even in countries with high prevalence rates, is that most 17–19 years olds are HIV negative. The challenge is how to maintain this precious status. The responsibility rests on the individual, as well as the institution, to provide incentives or punishment, in a balanced fashion, so as to ultimately achieve the primary objective of an HIV-free soldier.

- A related challenge brought about by the mandatory testing of recruits is the notion that ‘HIV-negative’ posts should be created, considering the huge investment in training pilots, tank operators, and other personnel with specialised skills.

- The final challenge is the inability of the armed forces as an institution to deal with those found to be HIV positive. At present, there appears to be a perfunctory dismissal of candidates in the expectation that they will be captured by the national safety net – which in many cases does not exist.

*Mandatory HIV testing amongst the ranks*

Armies have also implemented mandatory HIV testing amongst all ranks as part of the annual fitness test regime. However, evidence has shown that only 88 per cent of serving soldiers have been captured in the second net. Some of the reasons accounting for the other
12 per cent were the lack of capacity for medical testing; a reluctance of some of the soldiers to come forward; making themselves unavailable at crucial times; and the lack of prioritisation when targeting this level of serving members. In cases where serving members who have been found HIV positive and operating in demanding roles/functions, they have been reassigned. However, in all cases, being HIV positive has not been viewed as a sufficient reason to stop candidates from operational deployment, including peacekeeping. Many have been and continue to be allowed to serve as long as their status has not been compromised. In all cases the armed forces has supplied the required drugs (including ‘takeaways’ in the case of Botswana – ‘takeaways’ being three months’ supply of HIV drugs).

As with the mandatory testing of recruits, the testing of serving members has produced unexpected challenges:

■ The first challenge that has emerged in impoverished Southern Africa is that serving members placed on drug protocols were found to be ‘sharing’ their medication with their spouses. On recommendation from the Medical Corps the armies saw their constituencies expand to include spouses and dependants. However, this has budgetary implications, a factor that appears not to have been properly taken into account, given the difficulty to quantify.

■ New skills have emerged as new trades. These range from diet and nutrition to quartermaster drug control and distribution; chaplaincy, social and counselling interventions including spouses outside uniform; home-based care; and other demands around HIV and AIDS.

■ In the absence of national guidelines, home-based care and ‘early-retirement’ packages for terminally ill patients have become the norm. As is inevitable with HIV-positive people, their status at some stage becomes compromised and many are forced to stop working. In all the case studies reviewed, commanders at all levels have taken a humane approach along the lines of boarding members but without penalising them, especially where benefits are concerned. However, this ad hoc approach has onerous budgetary implications. In some cases, members discharged/released have survived for years while receiving salaries and having free access to drugs and home-based care. Meanwhile, the armies have not been able to fill the vacated posts, resulting in units operating below strength. The budgetary implications of this approach have not been quantified or fully appreciated by all stakeholders. The financial burden is still being borne through the traditional allocations to defence and security, without taking into account the impact and force reduction implications. Although the role of traditional medicine did not come out clearly in the texts, in practice, traditional medicines play a central role in the culturally rich traditions of Southern Africans. Those affected resort to consulting traditional healers and taking traditional medicines before, during and after taking antiretrovirals (ARVs). Certain notions and practices are rooted in the local
indigenous cultural setting, for example aspects of religious and psychological support that are crucial to the treatment of patients in Africa and Southern Africa, including burials. However, the contribution of traditional medicine has been marginalised in the current debates, which have placed the emphasis on modern and scientific protocols.

In the case of Zimbabwe, the case study in the book, citing submissions by the then Zimbabwean military attaché in Beijing, tells of military officers sent to China who then faced similar circumstances as the Ugandans in Cuba. Based on this development, according to Chiweza, his country had the first empirical evidence of HIV within the ranks, to wit among potential pilots. After these two early events testing of officers undergoing training in armed forces overseas has become commonplace. The exact impact and implication of this is still to be fully understood.

**Access to HIV drugs**

There has been a firm policy on the part of the various state sectors regarding access to HIV drugs, that is, not to create islands of special benefit and attention. All sectors enjoy equal priority, including the armed forces. Given the unique demands related to the primary role and task of the armed forces, as well as the sector’s tendency to be semi-autonomous, this even-handedness has affected the ability of the armed forces to respond effectively to HIV and AIDS.

**Foreign assistance**

There has been foreign assistance supporting the militaries in all five cases studied. This support has come mainly from the US in such areas as awareness campaigns; containment, care and treatment; and research and development. The aim was to build capacity in the Medical Corps (train the trainer concept) and to maximise the impact of foreign assistance. The training has focused on detection, treatment and care; limited research; and infrastructural support. To this end laboratories have been established, hospital facilities expanded, testing equipment made available, and drugs provided.

The institutional capacity that has developed in the armed forces through targeted external support has made the sector the obvious vehicle to champion the fight against the epidemic. Other attributes that are unique to the armed forces include its relative autonomy; strict discipline, especially in the areas of testing and adherence to drug taking; and its unique experience of having to balance living with HIV and AIDS over the last 25 years with its primary role and function of maintaining peace and security. Living with HIV and AIDS over this period has helped the armed forces to document knowledge and experience, including the budgetary implications of the pandemic. This information, if shared nationally and regionally, should result in countries taking a major step forward towards eradicating the disease.
Delayed action

There has been a serious time lag from ‘discovery’ to the roll-out of ARVs. In some cases, a decade passed before action was taken. We can only guess that these inordinate delays were perhaps a consequence of the international policy confusion, compounded by national policymakers’ initial denial or lack of recognition of the effects of the pandemic, particularly on Southern Africa. The poor scientific capacity in the region also did not help. Below we cite the date upon which each of the countries studied rolled out the provision of ARVs:

<table>
<thead>
<tr>
<th>Country</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>2003</td>
</tr>
<tr>
<td>Swaziland</td>
<td>2005</td>
</tr>
<tr>
<td>Tanzania</td>
<td>2004</td>
</tr>
<tr>
<td>Zambia</td>
<td>2004</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>1999</td>
</tr>
</tbody>
</table>

The implication of this delay is that the pandemic had taken its toll before (limited) capacity intervention was attempted.

National versus regional policies

Despite the factors listed below, there are no obvious linkages between national HIV and AIDS policies – most of them are in draft form – and regional intervention strategies policies:

- Regional calls to harmonise HIV and AIDS policies that would for instance benefit large-scale drug production, procurement and distribution;

- The regional nature of transmission in Southern Africa, which is revolving around various major culprits – transport workers, commercial sex workers and armed forces – does not recognise national borders and in fact thrives on cross-border ‘operations’;

- Peacekeeping missions, African Standby Force and Southern African Development Community (SADC) policy options;

- Benefits from shared experience.

New evidence after the study

There is emerging evidence of a levelling off and even reduction of prevalence rates. In Zimbabwe, a national HIV adult prevalence rate of 26 per cent in 2005 has fallen to 18.1
per cent. The reasons are tentative and still unclear, ranging from a positive impact of robust awareness campaigns to the increased use of condoms against previous cultural inhibitions; the impact of the UN’s 3 x 5 initiative that sought to scale up the provision of and access to ARVs; Southern Africa’s personal experiences regarding loss of close family members and loved ones; the provision of generic drugs as a cheap substitute for expensive protocols; and the effective prevention of mother-to-child transmission.

There is also growing evidence of the usefulness of male circumcision, which reportedly has shown as much as 75 per cent protection against infection compared to those not circumcised. This factor has not been captured in the case studies, but can be immediately brought to bear to reduce the incidence of new infections.

**Conclusion**

The above represents what we know in relation to the complex dynamics that have arisen between HIV/AIDS and the armed forces in Southern Africa since the ‘discovery’ of the virus in the early 1980s.

Further studies are required in areas that were not covered by the study. First, one should try and understand the tactical and socio-economic impact of the pandemic on the security sector. One purpose of such a study would be to help commanders to understand the nature and extent of the problem that they are dealing with in relation to their primary task of preparing forces for national security and defence.

Second, there is potential to use the armed forces as a potential change agent as well as a research community. Communities in the epidemic zone of HIV and AIDS in Southern Africa are encouraged to seize the opportunity offered by the empirical interaction that has been opened with the armed forces through this study. The research is clearly of benefit to other Southern African countries that did not participate in the study as a result of time constraints and limitation of capacity and resources.

Finally, the full knowledge of the challenges presented by HIV and AIDS in the armed forces is still elusive and more research is required to enhance our understanding of the complex dynamics that confront societies under siege of the pandemic.

**Notes**

1 HIV/AIDS in the Militaries of Southern Africa Project, funded by the Rockefeller Brothers Fund (RBF).
2 Forces involved in the selected study as a result of resources and time constraints.
4 *Trends in numbers of people living with HIV infection*