Conference Report

HIV and AIDS and the African Military

Towards a common and comprehensive approach

Edited by Takawira Musavengana, Tarrin-Rae Oxche and Irene Ndung'u

11-13 March 2009, Jinja, Uganda

INSTITUTE FOR SECURITY STUDIES
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Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ACCORD	The African Centre for the Constructive Resolution of Disputes
ARV	Antiretroviral Therapy
ASF	African Standby Force
AU	African Union
AUC	African Union Commission
AWA	Aids Watch Africa
CCR	Centre for Conflict Resolution
CCAAHM	Common and Comprehensive African Approach to HIV and AIDS in the Military
DRC	Democratic Republic of Congo
EAC	East African Community
EASBRICOM	EASBRIG Coordination Mechanism
EASBRIG	East African Standby Brigade
ECOWAS	Economic Commission of West African States
ESF	ECOWAS Standby Force
FARDC	Forces Armées de la République Démocratique du Congo
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council of South Africa
IDASA	Institute for Democratic Alternatives in Southern Africa
ISS	Institute for Security Studies
JCRC	Joint Clinical Research Centre
KAIPTC	Kofi Annan International Peacekeeping and Training Centre
NARC	North African Regional Capability
NGO	Non-Governmental Organisations
MARP	Most At Risk Population
M&E	Monitoring and Evaluation
MONUC	United Nations Organisation Mission in the Democratic Republic of Congo
OAU	Organisation of African Unity
PLWHA	People Living With HIV and Aids
PSO	Peace Support Operations
PSOD	Peace Support Operations Division
RECs	Regional Economic Communities
RMs	Regional Mechanisms
SADC	Southern African Development Community
SGSA	Second-Generation HIV Surveillance Approach
SSG	Security Sector Governance
STIs	Sexually Transmitted Infections
UPDF	Uganda People's Defence Forces
UNAIDS	United Nations Programme on HIV and AIDS
UNDPKO	United Nations Department of Peacekeeping Operations
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive summary

The Security Sector Governance (SSG) Programme hosts a number of projects including MilAIDS, which focuses on the mitigation of the impact of HIV and AIDS on armed forces in Africa. The purpose of the project is to inform and support the development of appropriate policy responses to the threat of HIV and AIDS to the armed forces of the African continent. The project also assesses the empirical data available regarding the relationship between HIV and AIDS and the armed forces, and HIV and AIDS and peacekeeping operations in Africa, and strives to develop policy options for the mitigation of the effect of HIV and AIDS on the armed forces and security on the continent.

Developing a sector-specific (armed forces) HIV and AIDS policy within the national HIV and AIDS frameworks remains a key focus of the project. Specific issues which are addressed include:

- Aspects of HIV and recruitment in a human rights culture
- Challenges of what to do with soldiers who become HIV positive during service, leading to questions of forced remustering from active to administrative duties
- New skills regarding nutrition and dieting required for supporting in-service victims
- Control of scheduled drugs as part of the quartermaster's responsibility
- Home-based care and welfare policies related to early termination of employment on medical grounds for those HIV-positive cases progressing to AIDS
- Budgetary and cost implications given the fact that armed forces are liable for the cost of anything up to 20 per cent and more of non-effective soldiers
- Finally, policy-related challenges which emerge with regard to peacekeeping deployments, the adherence or not of countries to the guidelines set by the United Nations Department of Peacekeeping Operations (UNDPKO) and the African Union's Peace and Security Department; also the extensive debate around conducting HIV tests before, during and after deployment and how this relates to capacity, and what goals are to be achieved after the tests, given the diverse practice of various countries in not following set international and continental guidelines, the objective being to develop common and good practice.

Introduction

The African Union Peace and Security Department in association with the Uganda People's Defence Forces (UPDF) and the Institute for Security Studies (ISS) through the Security Sector Governance (SSG) Programme organised a regional conference with the theme 'African armed forces and HIV and AIDS: A comprehensive common approach'. The working programme for the three-day conference (11–13 March 2009) consisted of plenary and thematic group work, based on presentations by renowned experts and key personalities on several aspects of the above theme.

CONFERENCE OBJECTIVE

The overall objective of the African conference was to develop a common and comprehensive African approach in addressing the HIV and AIDS pandemic in the uniformed services. This objective was to be pursued within the context of collaborative security and the development of regional brigades as part of the Africa peace and security architecture. The conference focused on HIV and AIDS and on peacekeeping more broadly, while also looking at international, regional and national policies and practices related to managing the impact of HIV and AIDS on peacekeeping operations. One hundred and one participants representing various countries and institutions attended the conference. Most of the finances for the Uganda conference came from the Rockefeller Brothers Fund (RBF) and core funding from the governments of the Netherlands and Sweden. The UPDF met considerable logistical costs.

CONFERENCE THEMES AND SUB-THEMES

The overarching theme of the conference was 'HIV and AIDS and the African military: Towards a common and comprehensive approach', and included sub-themes such as 'HIV and AIDS and the military: A general framework'; 'HIV and AIDS and peacekeeping in Africa – regional case studies'; 'HIV and AIDS and peacekeeping in Africa – country case studies', and 'Managing the impact of HIV and AIDS in the military'.

Welcome and opening remarks

Lieutenant Colonel Dr Godfrey Bwire, the master of ceremonies, introduced the key speakers for the opening session. First was Brigadier Charles Angina, Chief of Staff Ground Forces in the UPDF, who was representing the Chief of Defence Staff, General Aronda Nyakairima. The Chief of Ground Forces then introduced the guest of honour, Professor Peter Mugenyi, as well as Dr Naison Ngoma and the other key conference facilitators, heads of national delegations, and representatives of various militaries and other organisations. He gave an outline of the rest of the morning programme. He followed this by reminding participants that soldiers are trained to anticipate surprise attacks from outside their ranks and that HIV is a similar enemy except that it attacks from the inside. In that sense, it should be viewed as the enemy within. As such he reiterated the need to implement an appropriate strategy to mitigate the impact of the pandemic, given that the military constituted one of the pillars of government. He then invited Professor Peter Mugenyi to give the keynote address.

The opening ceremony, presided over by the guest of honour, Dr Peter Mugenyi, was marked by three speeches: the first was the welcome speech by Brigadier Charles Angina, Commander of the Ground Forces. He was followed by a representative of the general armed forces of Uganda; and finally there were the introductory remarks by Dr Naison Ngoma, Programme Head of the SSG, who said the objective of the conference was to engage the participants in a reflection of ways and means of developing a comprehensive and common African approach towards HIV and AIDS in the armed forces.

Finally, an introductory briefing was given on the work done by Dr Peter Mugenyi, the Director of the Joint Clinical Research Centre (JCRC) and Chancellor of Mbarara University. Dr Mugenyi stated that Uganda had been the first African country to experience HIV and AIDS in 1980 and later, in 1990, had become the country with the highest prevalence rate in Africa. The formation of the JCRC, an initiative by the head of state, had been instrumental in making remarkable progress in the fight against HIV and AIDS. Based on cartographic data, Dr Mugenyi highlighted the seriousness of the pandemic in Africa and noted that the United Nations needed to rethink the subject given the absence of a cure.

Despite having access to drugs, Africa continues to have the highest number of HIV and AIDS cases in the entire world and the cost of the medication cannot be sustained. Dr Mugenyi brought to the attention of the participants that, in spite of its meagre resources, the JCRC had contributed to the fight against the pandemic in the military, where the level of prevalence is six per cent. He also stated that there is much to be done to save the lives of millions in Africa, and continued that to that effect initiatives such as establishing a network for such a cause and sharing information and experiences would be indispensable for the fight to be crowned a success.

Panel One

HIV and AIDS and the military

A general framework

Session chair: Professor Hamilton Simelane
University of Swaziland

THE ROLE OF THE AFRICAN UNION (AU) WITH REGARD TO HIV AND AIDS IN THE MILITARY

Ms Bernadette Olowo
Freers, AU

Ms Bernadette Olowo-Freers acknowledged the role of the different partners, in particular the AU, the ISS and the UPDF in organising the conference on HIV and AIDS in the military. She emphasised the AU's commitment to work with other development partners in the operationalisation of the regional brigades. She pointed out that the absence of a vaccine as an intervention measure to save the armed forces meant there was an urgent need to draft a policy based on sensitisation, training and communication in a bid to fight the pandemic. This would remain a challenge for the next 20 years.

Because of this situation, the question of HIV and AIDS had been a serious preoccupation of the Organisation of African Unity (OAU), and was now that of the AU, as evidenced by the Abuja Summit in April 2001, which, among other things, was a major African response to the pandemic. She also highlighted the 2004–2005 strategic plans that put forward six main objectives to accelerate the fight against HIV and AIDS. It was the 2006 Summit furthermore that enabled the review of the implementation of the declarations and conclusions of the Abuja Summit, which had translated into concrete measures to that effect. In addition there is the 2008–2010 Action Plan. Ms Olowo-Freers emphasised that the main objective of the African response is to mobilise and coordinate efforts towards synergising the programmes and policies at all levels in a bid to minimise the impact of HIV and AIDS. In addition, the AU underscores advocacy for African armed forces as well as civilian populations, especially the refugees that these forces are supposed to protect. The speaker also highlighted an urgent need for the AU to expedite the policy on peacekeeping, given that the African Standby Force should be operational by 2010.

Discussion

Mr Dingamadji Madjior as chairman and Dr Innocent Nukuri as rapporteur reported the gist of the discussion voiced in the plenary sessions, and emphasised the need for the AU to take into account the specific cultural and sociological milieu and other aspects regarding particular countries and armed forces. At the same time they described a common and comprehensive approach to this matter, in addition to the efforts of each country currently designing a national strategy.

They also highlighted pertinent issues regarding the sensitisation of the African Standby Force (ASF) to HIV and AIDS, to the activities which the AU intends to implement, as well as to the monitoring and evaluation of such a programme for the benefit of the armed forces. They emphasised the importance, in future, of the development of appropriate methodologies for such a monitoring and evaluation (M&E) programme.

AIDS, POLITICAL STABILITY AND CONFLICT

Mr Kondwani Chirambo
Institute for Democratic Alternatives in Southern Africa (IDASA)

Mr Kondwani's presentation covered leadership attrition and implications, highlighting trends in mortality among elected leaders and the implications for their countries. The second section dealt with electoral management, in which he discussed institutional weaknesses and the consequence

of HIV and AIDS on voter registers, such as disputed electoral outcomes arising from alleged inaccurate voter registers and how HIV and AIDS might feature; and the erosion of political power bases owing to HIV and AIDS.

After outlining the social and demographic consequences of the pandemic in Africa, Mr Kondwani analysed the various ways HIV and AIDS might affect political stability via institutional weakness resulting from the illness and death of leaders and voters, or by creating conditions in which the institution of elections might precipitate conflict.

The main findings of IDASA's research in selected countries (Malawi, South Africa, Tanzania, Zambia and Zimbabwe) were:

- There are worrying trends regarding the loss of elected leaders said to have died after a 'long illness' in national parliaments and local government.
- Majoritarian or constituency-based electoral systems are the most affected in economic and political terms because of frequent, expensive and destabilising by-elections.
- Strategic policy institutions may be populated by less experienced leaders, are less effective and could result in poor service delivery and therefore disaffection among expectant communities.
- Countries without technologically advanced electoral management systems will experience conflict in the age of HIV and AIDS as the voters' rolls become bloated with dead voters and perceptions of fraud mount.

Thus deaths due to HIV and AIDS may negatively impact on all levels of leadership from the local level to the national assemblies and the presidency, as well as on the voters. In all instances the potential for instability will increase.

On the basis of the IDASA findings therefore the speaker recommended that:

- Citizen and voter registration systems should be technologically advanced so that the relevant electoral authorities would not purge dead voters at the last moment. This, of course, implies greater investment by governments.
- Regular information should be provided to political contestants on the integrity and status of the voters' roll.
- Electoral systems should be modified to allow for the appointment of replacements of deceased leaders instead of having to conduct by-elections. This would preserve precious resources and minimise conflict (e.g. in the USA).

Conclusion

There are many reasons why HIV and AIDS is a matter of human security concern for African countries. Although there is no direct role for the military, anecdotal evidence could possibly assist other security wings in identifying potential sources of instability in nations as a result of HIV. The IDASA research therefore challenges the military to discuss and interrogate their own perspectives in this regard.

THE USE OF THE SECOND GENERATION HIV SURVEILLANCE APPROACH IN UNDERSTANDING THE HIV AND AIDS EPIDEMIC IN THE MILITARY: LESSONS FROM OTHER EMPLOYMENT SECTORS

Professor Leickness Simbayi
Human Science Research Council of South Africa (HSRC)

After commenting on the work of the HSRC in the study of HIV in society, Professor Simbayi noted that HIV prevalence rates among most-at-risk populations, including African armed forces, are mostly a matter of speculation and not based on concrete data. For example, in South Africa the prevalence of HIV infection among soldiers was estimated to be as high as 60 per cent in 2000 without the security implications of such estimates irrespective of the methods used. The research methodologies adopted by Dr Simbayi's team, especially the Second Generation HIV Surveillance Approach (SGSA), also recommended by UNAIDS and WHO, marks a vast improvement on the selective screening of women attending antenatal clinics and involves population-based surveys of both men and women of all ages. This approach combines biological and behavioural surveys and thus allows for a better understanding of the magnitude and scope of the HIV epidemic (both prevalence and HIV incidence) among members of the general population as well as the determinants of the epidemic.

Professor Simbayi then outlined the findings of some case studies. The first case study had looked at HIV prevalence and risk behaviours among educators in South Africa. This study showed that, owing to the strong support provided by the teachers' union, there had been almost complete buy-in from the educators and an anonymous, bar-coded questionnaire and HIV test had been administered nationwide. On the day of testing 21 358 educators had been present, of whom 97 per cent had agreed to be interviewed, while 83 per cent had given a specimen for HIV testing. The results refuted some of the speculative reports in the media: they revealed no significant gender differences, but confirmed racial differences in prevalence rates.

The second case study had dealt with HIV prevalence, HIV incidence and risk behaviours among private security guards in South Africa. This study had confirmed the suspected differences according to gender, age, marital status and category/strata of employee. Higher prevalence rates were noted for those who had been widowed, the 25–49 age group, labourer and service worker categories as well as for black Africans. Those working shifts and those staying in single-sex hostels also recorded higher prevalence rates. It is recommended that the SGSA be used to help understand the HIV epidemic in the military: based on information gathered from other employment sectors, the SGSA can be a valuable research, planning and alleviation instrument in understanding the drivers of the pandemic and its magnitude in the military by extrapolating information pertaining to other sectors but not the military per se.

Current statistics on HIV prevalence in the military are based on speculation, and the assumed average age, virility, and so on of the soldier has been used to invent all sorts of prevalence rates. The value of the SGSA is that it not only works with real and accurate samples, but takes into account national security sensitivities by guaranteeing individual anonymity and by respecting the confidentiality of any group that participates. Furthermore, it is able to provide sector-specific testing and profiling which can be used for appropriate interventions in the military. Professor Simbayi stated further that the HSRC had studied the whole population and not just women attending antenatal clinics. The SGSA had been used and the studies had established that prevalence rates were lower than those claimed by the newspapers in the 1990s.

In conclusion Professor Simbayi reiterated the value of the SGSA and urged that African militaries should be encouraged to adopt this approach for several reasons:

- It provides information on both the magnitude and scope of the HIV epidemic.
- It facilitates an understanding of the drivers or risk factors underlying the epidemic.
- This information can inform the response elicited regarding the provision of Antiretroviral Therapy (ART) and care for People Living with HIV and AIDS (PLWHA) who need treatment, as well as interventions to both control and prevent new HIV infections.
- If SGSA is repeated periodically, say once every five years, it will provide a means for undertaking essential monitoring and evaluation (M&E) of the response which, in turn, can further inform any additional response.
- The confidentiality of the whole process means that no outsiders need know the results. However, the commanders and health officers will need the relevant information in order to plan strategically for both the long-term needs of the security forces and for the country's security as a whole.

Discussion

During the ensuing discussions it was acknowledged that the lack of research data allows speculation about the extent of the HIV and AIDS problem in the security sector. Some expressed hesitation about outside researchers and funders filling the gap in research expertise that currently faces the armed forces of many African countries. Other political and ethical challenges concerning the adoption of the SGSA in the military were also highlighted, although its advantages were recognised. It was further noted that civilians also serve the nation, and that where confidentiality is demanded, it would be respected. At the same time, however, the advantages of transparency are also well known and should not be jettisoned in the name of state security because HIV is a more comprehensive security threat than external military threats.

PROSPECTS FOR AN AFRICAN HIV AND AIDS AND MILITARY COMMON POLICY

Ms Angela Ndinga Muvumba
ACCORD

Ms Muvumba argued that the need for a common African approach to HIV and AIDS in the uniformed services fits into the context of the increasingly significant role militaries play in peacekeeping and peace building in Africa. She stated that the need for a common African approach is, as such, an urgent and growing one as HIV and AIDS continues to threaten the sustainability of these militaries.

As the AU undertakes the process of establishing an ASF and regional brigades, it has to think critically about addressing the HIV and AIDS scourge in the militaries. The fact that several national governments have already undertaken interventions to fight against HIV and AIDS in their respective militaries provides fertile ground for learning from these initiatives and building upon them ultimately to culminate in a common African approach on HIV and AIDS. While some conflicts in Africa have taken on a regional perspective and have been addressed jointly by the respective countries, there are only two regions that have a regional approach towards addressing HIV and AIDS in the military, namely the Economic Community of West Africa (ECOWAS) and the Southern African Development Community (SADC).

ECOWAS had a plan of action for 2004–2006 regarding the control of sexually transmitted infections (STIs) and HIV and AIDS within the armed forces sector.

However, the implementation of the plan remains a big challenge since it has not been incorporated into the regional conflict management and strategic planning. SADC, on the other hand, is trying to formulate a concrete policy on HIV and AIDS for the defence sector. This being the case, a common African approach to HIV and AIDS in the military (CAAHM) is important if African militaries are to sustain their human resources.

A CAAHM should, among other things, focus on:

- Scaling up HIV and AIDS treatment in the context of Africa's weak health systems, increasing creativity and the sharing of resources to improve responses as well as reinvigorate prevention approaches
- Extending creative avenues for HIV mitigation and management through the defence force structures, improving civil-military collaboration in resource allocation and utilisation, addressing cross-cutting issues such as drug abuse and gender issues, as well as becoming champions of change
- Establishing a regional path/policy structure in the context of the ASF through the dissemination of knowledge and building of collaborative initiatives among policymakers and experts in the security and health sectors
- Accelerating the implementation of HIV and AIDS plans through subregional, continental and international cooperation by building on existing best practices and integrating the principles, processes and programmes of the ASF

The development of a CAAHM should involve the participation of the regional economic communities (RECs) spearheaded by national governments that have much experience in addressing HIV and AIDS in uniformed services.

Panel Two

HIV and AIDS and peacekeeping in Africa

Regional case studies

Session Chair: Professor Agokla Kossi Mawuli
Togo

HIV AND AIDS CHALLENGES: A PERSPECTIVE, ECOWAS STANDBY FORCE (ESF)

Lieutenant Colonel Ola Abiodun Falade
Staff Officer, 1Medical, USDF, Swaziland

Lieutenant Colonel Ola Falade focused on the themes of the ESF concept, the challenges and strategies. The vision of the ESF is to define, build, organise and maintain an ECOWAS standby regional military capability of self-sustaining troops and logistical support for peacekeeping and humanitarian assistance in order to respond to internal or external regional crises or threats to peace and security, including terrorist and/or environmental threats. Based on the ECOWAS military strategy, the ESF will comprise highly trained and predetermined regional standby units, equipped and prepared for deployment as directed in response to a crisis or threat to peace and security. The ESF Task Force will comprise 2 773 soldiers in predetermined units, which, upon order, will be prepared to be deployed within 30 days and be fully self-sustaining for 90 days. The ESF Main Brigade will comprise 3 727 soldiers (totalling 6 500) in predetermined units, which also, upon order, will be prepared to be deployed within 90 days and be fully self-sustaining for 90 days.

The main challenges as far as HIV control and management are concerned include:

- Divergent approaches
- Integration of HIV and AIDS control measures in the operational preparation of troops prior to deployment
- Absence of a common policy on control and prevention of HIV and AIDS
- Absence of policy guidelines from the African Union Commission (AUC) on this issue

The ESF will rely on the strategy of interpersonal peer communication, and training and awareness campaigns, including the use of centres of excellence such as the Kofi Annan International Peacekeeping and Training Centre (KAIPTC).

In conclusion the presenter noted that the ESF's AIDS policy is guided by and follows national policies, heads' of states orders and pre-deployment briefings to highlight HIV control measures. So far ESF has not been deployed, but when it is, an integrated HIV policy will be needed. In closing, Lieutenant Colonel Falade urged the World Health Organisation to take the lead in this regard so that all that would remain for the ESF to do would be to ask: What do they want us to do? The challenge is, therefore, for the civilian control of the military, which extends to the formulation of an AIDS policy, to provide instructions which the ESF awaits.

THREATS OF HIV AND AIDS TO REGIONAL INTEGRATION EFFORTS AND PERFORMANCE OF AFRICAN STANDBY BRIGADES: THE CASE OF EASBRIG

Captain Amanda Magambo
EASBRIG

The presenter divided her presentation into three main parts:

- HIV and AIDS threat to regional integration and performance
- EASBRIG approach to HIV and AIDS
- Recommendations and conclusion

Captain Magambo outlined the background of the ASF and explained that EASBRIG was one of the five regional

standby brigades of the ASF. EASBRIG is drawn from 13 member countries in East Africa and, like other ASF units, has had to develop responses to the HIV threat.

HIV and AIDS is a threat to regional stability and security in East Africa, and should be considered a regional emergency. The pandemic's potential damaging impact on the health of EASBRIG peace support operations (PSO) personnel is considerable and has already undermined social and economic development across the region. A major policy problem confronting EASBRIG member countries is whether to effect mandatory or voluntary pre-deployment testing. Member states are divided on this issue.

Important questions to consider are whether EASBRIG forces in deployment areas would pose a threat to the civilian population or would the EASBRIG forces be the ones threatened. In short, are the peacekeepers to be viewed as having a high potential of contracting or spreading HIV? Another question would be whether the HIV and AIDS threat was greater than the danger posed by military confrontations in conflict/post-conflict settings, that is, whether HIV should be considered a real risk or a perception of risk. The answer to these questions, she suggested, had operational implications. For example, should a peacekeeper who contracts HIV be repatriated or be allowed to continue serving perhaps until he or she succumbs to death?

Although EASBRIG is not yet operational, its members should prepare for eventual deployment, bearing in mind always that the most high-risk areas of HIV transmission are those areas in conflict. Gender and children's rights must also always be respected and EASBRIG should implement zero tolerance of sexual abuse. Noting that Kenya does not deploy seropositive soldiers as a matter of policy, she wondered why some other countries do, since such soldiers are sick. Since a common policy had as yet not been agreed upon, she wondered whether it was because some militaries appear more concerned about the health of their own soldiers than that of the population in operations zones or countries of deployment.

The main recommendations made by Captain Magambo were:

- Close cooperation with military staff (MS), RECs/RMs, donors, NGOs, UNAIDS and other agencies active in the field of HIV and AIDS
- Development of a long-term policy and strategy for HIV and AIDS education, prevention and treatment in EASBRIG
- Harmonisation of prevention strategies of the different militaries
- Organisation of regional forums on HIV by EASBRIG and other standby forces

In conclusion, Captain Magambo reiterated that HIV and AIDS is a threat to stability in the region, that

EASBRIG acknowledges this threat and therefore incorporates it in all its training activities, and that HIV constitutes an unresolved challenge that calls for a committed effort and a harmonised approach.

Discussion

In response to the reference to seropositive soldiers as sick, commentators pointed out that the perception of HIV is different across cultures. A heated debate then followed with participants from different countries arguing either that HIV soldiers should not be deployed for their own and the general good or with participants suggesting that disaster zones have other health challenges such as malaria, cholera or meningitis, and that, since these diseases can rapidly kill more people than HIV, the question of deployment should consider all health problems and not just focus on HIV.

THREATS OF HIV AND AIDS TO REGIONAL INTEGRATION EFFORTS AND THE PERFORMANCE OF AFRICAN STANDBY BRIGADES: THE CASE OF HIV AND AIDS IN EAST AFRICAN MILITARIES: DEFENCE SECTOR POLICY ISSUES AND GAPS

Mr Peter Edopu
Director, ISS Nairobi

The presenter examined the following issues:

- Causes and effect of HIV and AIDS in the military
- Policy and legal framework in Eastern Africa
- Issues to consider when developing policy and legal frameworks
- Responses to HIV and AIDS by militaries in East Africa
- Imperative for adequate HIV and AIDS framework for the militaries

Mr Edopu reported that, although the threat of HIV is widely recognised as a security challenge, there is at present no regional legal and policy framework on HIV and AIDS, either for the military or the general population. Only Tanzania has a specific law to address HIV and AIDS. Although other East African countries have broad national HIV policies and strategic frameworks for HIV control and management, most do not have a clear defence-specific policy which takes into account the various vulnerabilities as well as opportunities for impacting on the extent of vulnerability in the military.

Even Tanzania's national policy on HIV and AIDS, the National Multi-Sectoral Strategic Framework on HIV/Aids, 2008–2012, and the HIV and AIDS Prevention and Control Act, 2007, passed in February 2008, fail to address the military specifically. Uganda's National HIV and AIDS Strategic Plan of Uganda (2007/8–2011/12) describes the army as a mobile occupational group who face frequent or extended family separation, which increases the risk of contracting or spreading HIV infection through risky sex. However, while acknowledging the peculiar situation of the military, the Ugandan Strategic Plan does not make any specific policy recommendations for the military. Kenya, like Uganda, does not have fully developed national HIV and AIDS policies, but uses national strategic frameworks to provide the action framework and context within which sectoral and institutional HIV and AIDS budgets, strategies and implementation plans are formulated, monitored and coordinated. The plans identify the military as the most vulnerable group, but do not make provision for prioritised intervention. However, Kenya's HIV and AIDS Prevention and Control Bill (2008), currently before Cabinet, marks an important improvement. Nevertheless, as it currently stands, the Bill falls short of establishing a policy framework to provide the necessary support for the military as a most-at-risk population (MARP).

The presenter concluded his presentation by recommending:

- Developing a comprehensive and harmonised regional policy and legal framework on HIV within the RECs/standby brigades and also at the AU level, since HIV and AIDS, like environmental threats, knows no boundaries
- Promulgating national legislation regarding HIV and AIDS to address the prevention and control of HIV and AIDS protection, counselling, testing, and care of persons infected and affected by HIV and AIDS; providing a code of conduct for service providers, employers, and persons in authority, and affirmative action for MARPs
- Criminalising deliberate/intentional spreading of HIV and AIDS
- Upholding the rights and obligations of persons infected with HIV and AIDS, including the prohibition of discriminatory practices against PLWHA in recruitment, deployment, promotion, training, insurance, schools, credit facilities, and so on
- Mainstreaming HIV and AIDS in all core government and military activities
- Enhancing collaboration between the military and other actors in addressing HIV and AIDS – prevention, treatment, coping, and so forth
- Utilising the military to deliver HIV and AIDS services and preventive campaigns
- Establishing networks with a secretariat for collaboration in each region and also at the continental level to enhance coordination, cooperation, information sharing, and so on

Discussion

The ensuing discussion was robust and animated and the following were highlighted:

- Now is the time to act. Tanzania, for example, already has an HIV policy and with more communication between the different militaries it should lead to the making of an integrated policy or CAAHM.
- The need to empower women living under customary law was highlighted as a major human rights challenge which would undermine any new progressive policy that did not take this fact into account.
- Although there may not be a comprehensive policy on HIV as such, many militaries had been active in controlling AIDS for a long time, so there was no need to lament the lack of policy but rather to build on what was already in operation.
- In similar vein it was argued that, if the UN already has a policy, the AU member states could study and domesticate it to suit African conditions.

THE CHANGING FACE OF THE EPIDEMIC MOST-AT-RISK POPULATIONS

Dr David Kihumuro-Apuuli
UPDF

Dr Apuuli started by pointing out that although the HI virus evolves rapidly, most African countries do not take this into account when planning their interventions. What works in one country, may fail in another context. He reported that there were approximately 1,1 million people living with AIDS in Uganda, but an estimated 2,6 million people were infected with the virus. However, only 21 per cent of those infected know their sero status. Over the past decade the gender profile of the PLWA has changed; the orphan factor has continued to grow and the macroeconomic profile of the pandemic, such as its negative impact on GDP, is better understood. Unfortunately, previous successes may have been eroded by a number of new developments such as rising poverty. AUC data on prevalence trends and post-2004 trends suggest new infections are on the rise, probably owing to the arrival of ARVs and people becoming complacent. He also stressed that most donor funds now go to financing treatment, and

so, because of the lack of funds to continue with education and prevention campaigns, the momentum to fight new infections has been lost in Uganda.

Discussion

During the discussion it was asked whether it was correct to describe those who are seropositive as sick as one of the presenters had said. The answer was that this was not correct. The next question was whether countries sending their troops on peacekeeping duties were concerned about their soldiers becoming infected or posing a health threat to the population in the operation zone. The answer was that soldiers will be deployed to different kinds of disaster zones and be faced with cholera or meningitis or malaria in those areas. These are more likely to kill them than HIV, so the deployment debate should address all health problems.

Panel Three

HIV and AIDS and peacekeeping in Africa

Country case studies

Session Chair: Professor Agokla Kossi Mawuli
Togo

GENERAL HIV AND AIDS IN THE DRC

Dr Djiferdin Masudi Djuma
DRC

Dr Djiferdin pointed out that the DRC is a country that had suffered armed conflict in 1998 in which the east, north and north-east of the country had been affected. This attracted regular armed forces, rebel forces and a large contingent of United Nations Organisation Mission in the DRC (MONUC), all of which events resulted in human rights violations and the spread of HIV and AIDS especially in the armed forces. The HIV and AIDS pandemic has led to three issues: the social (poverty in particular), the economic (collapse of businesses and low productivity), the political (lack of manpower). The Maniéma province is a case in point where voluntary testing was carried out: the prevalence rate among 1 400 soldiers was 9,4 per cent, with 90 per cent of the infected being men in the 20–25 age group. North and South Kivu were the most affected areas.

HIV AND AIDS AND PSO: A CASE STUDY ON EASTERN DRC

Masudi A
DRC
Dr. Djiferdin Masudi Djuma
DRC

The second presentation established an obvious correlation between the presence of the military and the spread of HIV and AIDS in the eastern region of the DRC. On the basis of geographic, demographic and epidemiological data, the study gives an infection rate among the military of about 5,7 per cent in 2000 for the whole of the DRC. With regard to the situation of the military in the North and South Kivu, where there are about 350 000 soldiers of the regular armed forces (FARDC), the soldiers of MONUC and others, the average prevalence rate of 20 per cent is high compared to the national average of 5,7 per cent.

The high prevalence rate can be explained by the lack professionalism, rape, as well as moral and material bankruptcy among the affected people. In the east of the DRC, mitigation measures were spearheaded by the national programme in the fight against AIDS and the United Nations Children's Fund (UNICEF) at the national level. With regard to a more specific response, it is necessary to sensitise people to, or even better, to strengthen their morals, civic competence and patriotism during recruitment, with the ultimate objective of professionalising the armed forces.

HIV AND AIDS: THE CASE OF CHAD

Général de Brigade Dingamadji Madjior
Conseiller principal en DDR et SSR

This presentation pointed out that HIV and AIDS in the armed forces has become a major preoccupation of the state since 1994.This is evident from the high-level planning of activities, especially information sharing, sensitisation, advocacy, field surveys, voluntary testing of 2 517 soldiers in 2008, and the care taken of affected soldiers, psychosocially and medically.

The challenges in Chad are legal (gap between the law and the practice), financial (mainly the suspension of aid from the World Bank), and sociological (influence of tradition). Post-conflict Chad is characterised by the presence of peacekeeping forces and rebels that continue their fight.

HIV AND AIDS IN A POST-CONFLICT COUNTRY: THE CASE OF BURUNDI

Dr Innocent Nukuri
Burundi

Burundi is a country that has just emerged from conflict with about 50 000 soldiers. The prevalence rate is about 2,86 per cent and the most affected age group is that of 35–49 years. The existing social data, that is the data on poverty, sexual violence, polygamy and the proximity of the residences of soldiers and civilians, explains this. Efforts to contain the pandemic have been undertaken by the government and include the putting in place of unit, sensitisation to voluntary testing, liberalisation of the supply of ARVs, and support initiatives to the affected soldiers. Nevertheless, there is low involvement by the armed forces in this fight.

HIV AND AIDS: SWAZILAND

Lieutenant Colonel Tsembeni Magongo
Principal Programme Officer, ECOWAS Standby Force

Despite being a small country, Swaziland has a prevalence rate of 25 per cent, to the extent that HIV and AIDS was declared a national disaster in 1999, as was anticipated by all. In 2002, a campaign entitled 'Guerre pour la vie' was launched. This translated into government efforts to reduce the negative effects of HIV and AIDS in the armed forces by putting in place certain structures and partnerships. In this regard, affected soldiers are discharged from their duties only if they can no longer perform their tasks and on recommendation of the medical commission.

With regard to specific responses, strengthening the capacity of peer educator sessions should be emphasised, sensitisation programmes drafted, information and communication material produced, infected soldiers properly followed-up, the positive behaviour of every soldier in the armed forces and the permanent presence of antiretroviral drugs, and so on, highlighted. If the mortality rate has fallen to 22 per cent in the last two years, the government should formulate recommendations with regard to the expected behaviour of the affected individuals, undertake the extension of care facilities within the newly created structures, as well as research into new communication strategies, and an increase in circumcision for future generations.

HIV AND AIDS: CÔTE D'IVOIRE

Général André Guéhi
Directeur du Service de Santé des Armées de Côte d'Ivoire

Général André Guéhi began by describing the history of the fight against HIV and AIDS in the Ivory Coast. This was started way back in 1998 by UNAIDS, followed by a project in the armed forces supported by the World Bank in 2001. This action, which was started as a national priority, translated into the creation of a ministry to spearhead a multisectoral and decentralised attack. A sectoral committee was thus given the responsibility of fighting HIV and AIDS in the armed forces. Currently, the prevalence rate stands at 4, 7 per cent and about 1 000 peer educators have been trained in sensitisation campaigns to cater for about 250 000 soldiers. Eight testing centres have been created. The 2008 estimates, according to Général Guéhi, indicate that there are about 2 000 infected soldiers of whom a quarter have received palliative care.

With regard to challenges, he stated that the various actions of the different sectoral committees engaged in the fight against HIV in the army should be coordinated or harmonised, and there should be a further extension of this coordination to the continental level. With regard to the future, there is a need, among other things, to establish an epidemiological database and to coordinate the capacities of the actors involved in the fight by establishing, harmonising and disseminating information in a bid to intensify the fight against HIV and AIDS both at the national and continental levels.

Panel Four

Managing the impact of HIV and AIDS on the military

Session Chair: Major General Simon Karanja
Kenya Armed Forces

EFFECTS OF HIV AND AIDS ON MILITARY CAREER PLANNING

Brigadier General Charles Angina
Chief of Staff Land Forces (UPDF)

The theme of the address by Brigadier General Charles Angina was 'Career planning and HIV in the military profession'. He focused on soldiering as a dynamic career, noting a high turnover in personnel and high mobility at several stages. Currently at recruitment most militaries do mandatory testing of recruits so as to attract healthy youth for the rigorous army life, and only the healthy are admitted. Thus in provinces of high HIV prevalence regional quotas may not be filled, consequently creating an ethnic imbalance.

The UPDF draws recruits from the 18–25-year-old target group, which is also the most active age group and likely to have high HIV prevalence, that is it is a vulnerable group. Furthermore, screening for HIV is not foolproof because of the 'window of incubation' of HIV, and since the UPDF also has policy of absorbing forces from former insurgents without screening, the army is bound to have seropositive soldiers in its ranks. In addition, army instructors who joined before screening for HIV was made mandatory may take advantage of the seronegative recruits even though the army discourages sex across ranks, although recruits may take opportunities with other recruits or with trainers.

Harsh training has a negative effect on HIV-positive trainees and they may also be excluded from overseas training thus affecting their career paths. Many may be bypassed for promotions because they missed out on special training, a certain tour of duty or may be considered irresponsible because they contracted HIV. Nevertheless, where medical facilities are available to these men, they may be deployed in active duty areas. Retirement on the basis of seropositivity is not legal, and in any case remaining in the army ensures better care than that available in civilian life. However, in this process military resources are diverted to treatment and the soldiers' career paths are altered when they are found to be seropositive.

Discussion

Asked whether HIV-positive soldiers have a (secure) career, the Brigadier General replied that if early identification is followed by treatment and care, soldiers' careers can continue, but he stressed that strong morals and discipline were essential for health.

LIVING WITH HIV, HUMAN SECURITY AND THE AFRICAN MILITARY

Mr Derrick Fine
Trustee, The Openly Positive Trust, South Africa

Mr Derrick Fine stated that he had followed the Uganda experience for a long time and visited the country in 1993. On that occasion he had been impressed by Uganda's training programme and the Ugandan government's progressive policies. He then went on to outline the need for PLWA to live open, healthy and positive lives, and not to be continuously conceptualised as sick people or victims because society needed positive role models – people who could go for voluntary counselling and testing (VCT) and disclose their status. Mr Fine reminded the meeting that in the 25 years since HIV was first diagnosed, society's focus had shifted from state security to human security, thus the fact that 70 per cent of PLWA do not have access to ARVs is very much a human security problem. The

experience of Botswana, for example, had shown that the early use of ARVs saves lives, whereas shame, blame and stigmatisation kills people by generating various kinds of stressful living conditions. In contrast, South African policy was characterised by confusion causing many in South Africa to be misled into denialism. Consequently, ARVs were not made available even after their efficacy had been proved in many other countries and even in South Africa among those sections of the population fortunate enough to have access to private medical care and able to have access to ARVs.

Reiterating the fact that stigma can kill, Mr Fine recalled the story of a South African HIV survivor, Gugu, who was stoned to death in Kwa-Mashu, apparently because she was accused of causing shame to her family and community. The stigma that killed Gugu was borne of fear based on ignorance. Women, like soldiers, are vulnerable, as are children, prisoners, commercial sex workers, refugees and others at risk of infection and stigmatisation. In the context of the conference the question is what does human security mean to soldiers. At conferences Mr Fine had attended in South Africa many people spoke of human security in terms of their own safety, freedom, access to basic services, no xenophobia, the right to love and be loved, and to be treated as human beings asserting their productive rights. The fact that many African women cannot refuse to have sex even when they know they should – because such a refusal would threaten their security – means that their human security is compromised by gender inequalities.

As a part of its HIV management and control strategy Mexico has declared unfair discrimination unconstitutional. Thus to retire servicemen because of their HIV status amounts to unfair discrimination. Mandatory testing policies are also regarded as unconstitutional if they exclude soldiers from promotion and service abroad, and question their ability to serve without the medical evidence of individual testing as opposed to the tendency to regard soldiers and other people living with HIV as sick.

In South Africa court action resulted in the South African National Defence Force being given six months to amend policy that promoted stigmatisation. In this regard, and also with regard to some practises of other African armed forces, Mr Fine questioned why militaries continue to treat recruits (who cannot be admitted into the armed services if they test positive) differently from serving soldiers, who are allowed to stay in uniform and receive medical care, as well as from retired soldiers, who may also not enjoy access to adequate medical and other support. Mr Fine argued for individual testing in place of the categoric rejection of potential recruits such as those found to be seropositive.

From the perspective of a plain language practitioner, Mr Fine commented on the 'war talk' that dominates the Aids discourse in Africa, with terms like the 'enemy within' and 'combating AIDS' being commonly used even though they tend to stigmatise and scare people into silence and away from testing. In a similar vein, terms like 'AIDS victims' or 'AIDS sufferers' stigmatise PLWA. He also questioned why society does not speak about cancer orphans whereas 'AIDS orphans' is widely used. Peoples' humanity has been taken away by stigma and to reverse this there is a need to stop regarding PLWA as HIV victims, because it is not the disease that defines them— it is merely one aspect of their identity as human beings.

It is only by involving PLWA in the management and control of HIV in society and in the armed forces that seropositive people can happily provide advice to militaries and help the armed forces to design policies relevant to the human security approach, which is above all about protecting intrinsic human rights.

LEGAL AND HUMAN RIGHTS ASPECTS OF HIV/AIDS IN AFRICAN CONTEMPORARY MILITARY POLICIES

Professor Obijiofor Aginam
United Nations University, Tokyo

Professor Obijiofor began his presentation with a historical review of the links between disease and security, and health and development. Disease has not only existed longer than warfare, it may also have killed more soldiers than enemy armies on the battlefield. Building on a theme that had been mentioned in earlier discussions, he reiterated that in the post-Cold War world, the concept of human security enjoyed far more attention than state security, and included basic human rights – freedom from hunger disease, and oppression – and all human security issues – the people and their planet.

He then spoke about the human rights challenges of education and health, HIV in relation to the human security paradigm, HIV as a major human security challenge, and the problem with securitising HIV and AIDS and how this tends to threaten human rights and even public health. In the human rights discourse, mandatory HIV testing and experimentation with the ability of seropositive soldiers to withstand rigorous training would be considered unethical. He therefore questioned whether current military policies respected human rights and stated that the 95 per cent or more of African armies that practise mandatory screening of recruits on the grounds of expensive treatment that may have to be provided to seropositive soldiers and the belief that such soldiers would seriously compromise the combat readiness of their units seemed to suggest that human rights were not paramount.

Unlike the African armies, UN policy is based on non-discrimination and soldiers undertaking peacekeeping duties are not subjected to mandatory checks. VCT is preferred as it is founded on basic human rights and the belief that if an army is not allowed to discriminate it ought not to insist on tests. Professor Obijiofor ended by calling for a new human rights mindset to be the basis for the future HIV policies. He also noted that with hybrid AU/UN peacekeeping operations likely to become more common in future, the UN strategy will need to be taken on board.

Discussion

The ensuing discussion mainly revolved around the conflict between state and human security. It was noted that for security reasons civilians are not allowed to conduct research on the military. Consequently, essential data for formulating new policy and monitoring future developments are not available. It was also argued that the securitising of HIV reverts to the state security paradigm even though the physical security of the individual (soldier) is a human security issue.

The difficulty of balancing privacy rights and military planning is a question for northern armies as well, and is not only an African problem. Therefore it would need a broader military policy to resolve the dilemma without compromising confidentiality.

In response to a number of questions and comments, Professor Obi stressed that there cannot be human security without state security, and that even the UN Charter refers to the two together. Every country has its recruitment policies and their arguments are valid, but do not apply to UN peacekeeping. There was thus a need, as had already been noted, for the AU member states to broaden the disease and security framework and not focus on HIV only.

Panel Five

Policy Recommendations

Participants to the 11–13 March 2009 conference on 'HIV and AIDS and the African military: Towards a common and comprehensive approach', comprising delegates from Botswana, Burundi, Ethiopia, Egypt, Chad, Cote D'Ivoire, Democratic Republic of Congo, Kenya, Ghana, Malawi, Nigeria, Senegal, South Africa, Swaziland, Togo, Tanzania, Uganda, Zambia, Zimbabwe and some non-governmental organisations, whose details appear in the annex to this report:

- **RECALL** that the OAU acknowledged consistently that HIV and AIDS was a problem for the whole continent and that there was a need to place the fight against AIDS high on its agenda. It consequently called for the development of a partnership with the international community on the mitigation of the HIV and AIDS pandemic. Also recalled is the Abuja Summit in April 2001 on HIV and AIDS, Tuberculosis and Other Related Infectious Diseases; the 2003 Maputo Declaration on Malaria, HIV and AIDS, Tuberculosis, and Other Related Infectious Diseases, and the AUC HIV and AIDS Strategic Plan of 2004–2005
- **FURTHE**R RECALL the outcome of the Abuja Summit in 2006 that set the targets for universal access to HIV and AIDS, malaria and tuberculosis treatment; the Continental Framework for Harmonisation of Approaches among member states and integration of polices on human rights and people infected and affected by HIV and AIDS in Africa; the AUC HIV and AIDS Strategic Plan 2005–2007 and Aids Watch Africa (AWA) Strategic Framework: Accelerating Action to Combat a Continental Emergency; and the Third Session of the African Union Conference of Ministers of Health, 9–13 April 2007, Johannesburg, South Africa under the theme 'Strengthening of health systems for equity and development in Africa'
- **NOTE** the initiatives taken by the various governments and militaries on the African continent in addressing HIV and AIDS in society in general and in the militaries in particular. Further note that research efforts have been undertaken by various national institutions and by some military establishments. Note also the efforts by the West and Central African states to develop a network for the fight against HIV and AIDS in their militaries; as well as that African militaries are playing a significant role in peacekeeping and peace building in Africa despite the prevalence of HIV and AIDS
- **FURTHER NOTE** that in most militaries recruitment policies do not allow exclusion on the basis of health and non-health factors, including HIV and AIDS, and therefore face policy dilemmas as well as grossly diminished soldiers' combat readiness.
- **ENDORSE** the collaborative work undertaken by governmental institutions, international organisations and non-governmental organisations, particularly in Africa, such as the Centre for Conflict Resolution (South Africa), Institute for Security Studies (African region), the Kofi Annan International Peacekeeping and Training Centre (Ghana) and the Joint Clinical Research Centre (Uganda)
- **STRESS** that the goal is to evolve a common and comprehensive African approach to HIV and AIDS in the military (CCAAHM) by focusing on the following:
  - Aspects of HIV and recruitment within a human rights culture
  - Challenges of what to do with soldiers who become HIV positive during service, leading to questions

of forced remustering from *active* to administrative duties
  - New skills concerning nutrition and dieting required to support people living with HIV and AIDS
  - Control of scheduled drugs as part of the quartermaster's responsibility
  - Home-based care and welfare policies related to early termination of employment on medical grounds for those HIV-positive cases progressing to AIDS
  - Budgetary and cost implications given the fact that armed forces are liable for the cost of anything up to 20 per cent and more of non-effective soldiers
  - The development of common and good practices within policy-related challenges which emerge with regard to peacekeeping deployments; the adherence or not of countries to the guidelines set by the UNDPKO and the African Union's Peace and Security Department; also the extensive debate around conducting HIV tests before, during and after deployment and how this relates to capacity and what goals to be achieved after the tests, given the diverse practice of various countries in not following set international and continental guidelines
  - Acknowledgement that military command has a significant role to play in the management (command, control, communication and coordination) of the HIV and AIDS pandemic at all levels of command, that is, tactical, operational and strategic, which should be by example
- **REQUEST** African member states, in collaboration with the AUC through the African Chiefs of Defence Staff, RECs and other regional mechanisms (RMs) as well as other institutions and selected African NGOs to take all the necessary steps for the effective implementation of the overall objective to evolve a common and comprehensive African approach on managing HIV and AIDS in the military
- **RECOMEND THE FOLLOWING DECISIONS** in evolving a common and comprehensive African approach to HIV and AIDS in the military:
  - The African Union member states to adopt a common policy on control, prevention and management of HIV and AIDS in the African armed forces
  - African militaries to adopt policies for the protection, counselling and care of persons living with and affected by HIV and AIDS
  - African militaries to strive for a common understanding and approach regarding recruitment and deployment of armed forces on peacekeeping operations
  - The AUC through its African partner institutions to harmonise the existing initiatives and practices into a unified and comprehensive policy
  - The CCAAHM to be spearheaded by AU member states and supported by RECs, RMs and the AUC's Peace and Security Department (PSOD) and the Social Affairs Department
  - Experiential learning and sharing among regional and national militaries in Africa to be strengthened through collaborative research, documentation and dissemination of good practices on addressing HIV and AIDS in the military which would, among other things, assist in reducing speculation about the extent of the problem in the military
  - African militaries/governments/Member states to review and complement evidence/research information on the role of the rigorous nature of military training in the increase of HIV seropositivity
  - African militaries/governments/Member states to undertake urgent studies in the general area of recruitment and progress of seropositive personnel in the military.
  - African militaries/governments/Member states to form an African network on HIV and AIDS in the military to spearhead the development and implementation of CCAAHM
  - Member states to identify a technical team/secretariat to support the African network and serve as a link in the harmonisation of the CCAAHM and other HIV and AIDS efforts, including the monitoring and evaluation in African militaries
  - Member states to undertake a study on the existing policy initiatives to identify common areas as well as existing grey areas
  - Member states to adopt the Second Generation HIV Surveillance Approach to generate more accurate data to inform decision making
  - Member states to integrate VCT in pre-deployment testing of peacekeepers
  - Member states to undertake human rights assessments of all HIV-related polices
  - Member states to adopt a comprehensive multipronged and multidimensional approach in the mitigation of HIV and AIDS in the military
- **FURTHER RECOMMEND** that there be a meeting of the Chiefs of Defence Staff of the AU to deliberate on the contents of this conference as well as other AU processes on the matter, mindful of the progress made by other subregions such as ECOWAS, and also propose the mobilisation of the requisite human and material resources under the leadership of the AU for the effective management of HIV and AIDS in the African militaries

- **RE- EMPHASISE** that HIV and AIDS remains a threat to regional security and development, and demand discipline, political consciousness and a team spirit to mitigate the threat
- **ENCOURAGE** AU member states, RECs and RMs to use the relevant AU instruments such as the Abuja Summit in April 2001 on HIV and AIDS, Tuberculosis and Other Related Infectious Diseases and the Third Session of the African Union Conference of Ministers of Health, 9–13 April 2007, Johannesburg, South Africa under the theme 'Strengthening of health systems for equity and development in Africa'
- **RECOGNISE** with gratitude the strategic leadership of the AUC in the convening of the conference and support of the Republic of Uganda, in particular the UPDF, for hosting the conference as well as the Institute for Security Studies for planning and running the conference.

Panel Six

Closing address

HIV and AIDS prevention and care: Looking beyond medical services

General Aronda Nyakairima cgsc (MP)
The Chief of Defence Forces MP UPDF

General Nyakairima began his presentation by thanking the organisers and participants for accepting the invitation to take part in the conference hosted by Uganda. He reminded the participants that, unlike 25 years or so ago, HIV was not front-page news in Uganda anymore, not because the problem no longer existed, but because conditions had greatly improved in Uganda and in other countries. He added that the conference was itself an example of the openness that currently characterises work on HIV in society. Strategies need to be refined further and hence the discussions among conference participants would enhance this process.

General Nyakairima's lecture focused on the commanders' role as part of the multisectoral approach and he started with a question: Is the commanders' role adequately mainstreamed in the policy? He suggested that it apparently is not, even though the role they play is a crucial one. The armed forces need healthy soldiers in all deployments not only in peacekeeping operations. The commanders' roles in most situations start at the grass-roots level. The section commanders, even if structures differ, is normally at the head of a unit of fewer than 20 soldiers, and so section commanders must care for their teams and monitor their health, and report this to the platoon commander. A platoon is also a grass-roots unit and comprises fewer than 50 soldiers. To illustrate the importance of section and platoon level leadership, he cited the example of the Pakistani army, which had been structured to fight a conventional war against India, but failed to respond to terrorism at the level at which insurgency wars are fought, which is the grass-roots level.

The next level is the company and, in practice, company commanders must obtain health reports before going into action. It is at the battalion commander level, however, that decisions to grant sick leave and other interventions are made so that, in the event of deployment, soldiers and their units are ready for action. In Uganda, the 1980s HIV crisis was the worst. The UN Resolution 1308 of 2001 declared HIV a global security threat, but the UN responses were late as usual (as in the case of the Rwanda genocide). However, it was better late than never as the UN has been able to mobilise resources.

Military infection rates are usually deemed to be higher than those of the civilian population. Sub-Saharan Africa is considered to be worse affected than the rest of the world, but clearly the whole world has been affected and there are now grim reports from other parts of the world as well. As President Nyerere once said, "Africa must run in order to catch up with others who are walking." Therefore Uganda can not only learn from other countries, but can also share its knowledge. The General observed that Uganda, as a country, has made much progress in the management of HIV and AIDS, one of the success factors being the high level of openness with which it is managing the pandemic.

The concepts of command and control make it important to have healthy and well-facilitated forces, and because the need for a healthy military is paramount in peacekeeping and peace building, it is without question that the commander has a major role in managing HIV and AIDS in the military. This starts from the lowest level of the military (platoon commander in case of Uganda) and extends to the highest level of command. In view of this, the Ugandan military leadership has undertaken several interventions in managing the epidemic.

Command is a function of all leaders in the military and they should also take command of medical matters in the military. HIV and AIDS grossly diminishes the soldiers' combat readiness. Consequently commanders have to provide leadership and become champions in

fighting HIV and AIDS, leading their troops and peers by example. Irresponsible sexual behaviours and practices such as promiscuity and unsafe sex are unacceptable among commanders. Commanders must practise and promote behaviour that prevents HIV and AIDS among those under their influence and command, including monitoring and providing treatment to those who are positive.

Recalling the periods of failed leadership in Uganda, he emphasised that commanders should never volunteer to be part of failed leadership because of HIV and AIDS. In this regard, the commanders in the Ugandan military have emphasised four fundamentals to soldiering, namely: marksmanship, discipline, political consciousness and team spirit. These fundamentals have been closely linked to the management of HIV and AIDS.

HIV and AIDS has been addressed through a comprehensive multisectoral approach including military training. The UPDF has extended HIV and AIDS management beyond medical practice to areas such as social practices and behaviour, and providing support to soldiers infected with HIV and AIDS. The UPDF command has implemented HIV and AIDS programmes by establishing the proportion of deployable troops and holding them accountable for any acts that place the life of the troops or their families under the threat of HIV. The UPDF command has also directly participated in providing treatment for HIV and AIDS by undertaking research and development through the Uganda Joint Research Centre (UJRC).

In this process, Uganda has learnt a number of lessons in the management HIV and AIDS in the military, namely:

- Top leadership must take the lead. The president, Mr Yoweri Museveni, took the lead in campaigning, creating awareness, mobilising resources and ensuring that programmes were implemented.
- Total openness is important. HIV and AIDS needs to be addressed head-on without any pretence.
- HIV and AIDS management should be multisectoral and involve the participation of all population groups.

General Nyakairima emphasised that African militaries need a common approach to managing HIV and AIDS. He called upon the AU and its stakeholders to formulate a policy that is very clear on the roles and responsibilities of commanders in managing HIV and AIDS in the military, including incentives for good performance and deterrents for the reverse. It is equally important that the commanders contribute towards the formulation of effective policies and programmes on managing HIV and AIDS. The policy should also take into consideration country-specific cultures and experiences and regional policies, with a later focus on a continental policy. Because combating HIV and AIDS is resource intensive both financially and in terms of human resources and expertise, the policy should define mechanisms that will enable the policymakers to allocate adequate resources for programme implementation. Mechanisms also have to be created to monitor policy and programme implementation.

In conclusion, General Nyakairima reiterated that HIV and AIDS continues to threaten humanity and thus the African continent urgently requires a common and harmonised approach to managing HIV and AIDS in its militaries.

Annexure A

List of Participants

HIV AND AIDS AND THE AFRICAN MILITARY: TOWARDS A COMMON AND COMPREHENSIVE APPROACH

11–13 March 2009

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Annexure B

Programme

HIV AND AIDS AND THE AFRICAN MILITARY: TOWARDS A COMMON AND COMPREHENSIVE APPROACH

Jinja, Uganda, 11–13 March 2009

SER	DETAILS	LOCATIONS	DAY/DATE	TIMES	RESPONSIBILITY	REMARKS
(a)	(b)	(c)	(d)	(e)	(f)	(g)
(1)	Arrival and registration of delegates	Nile Jinja Resort – Lobby	Mon. 09/Tues. 10 March		UPDF/ISS	
			DAY 1 Wed. 11 March			
(2)	Breakfast	Hotel Restaurant		0645–0745	Nile Jinja Resort	
(3)	Registration	Hotel – Lobby		0745–0830	Secretariat – ISS	
(4)	Opening address	Conference Room		0830–0945	Minister for Defence, Uganda	a. UPDF to arrange separate opening address programme with details of order of speaking b. Dress: Service/ Formal
(5)	Group photograph	Hotel grounds		0945–1000	Secretariat – UPDF	
(6)	Coffee break	Hotel – Lobby area		1000–1015	Nile Jinja Resort	Special Guests may depart after Coffee Break
(7)	a. Introduction of delegates and participants b. Briefing on conference	Conference Room		1015–1045	Conference Coordinator	Dr. Stephen Kasasira (UPDF)/ Dr Naison Ngoma (ISS)
	PANEL ONE: HIV and AIDS and the military: A general framework			**1045–1300**		**Chair: Professor Simelani, Swaziland**
(8)	Role of the AU in HIV and AIDS in the military	Conference Room			Bernadette Olowo-Freers, African Union	
(9)	Aids, political stability and conflict	Conference Room			Kodwani Chirambo –IDASA	
(10)	The use of Second Generation HIV Surveillance Approach in understanding the HIV epidemic in the military: Lessons from other employment sectors	Conference Room			Prof. Leickness Simbayi – Human Sciences Research Council, South Africa	
(11)	The prospects for an African HIV and AIDS and military common policy	Conference Room			Ms Angela Ndinga-Muvumba – ACCORD	

SER	DETAILS	LOCATIONS	DAY/DATE	TIMES	RESPONSIBILITY	REMARKS
(a)	(b)	(c)	(d)	(e)	(f)	(g)
(12)	Lunch	Hotel Restaurant		1300–1400	Jinja Nile Resort	
(13)	Group discussions: a. b. c. d.	Open breakaway spaces		1400–1530	Conference Coordinator	
(14)	Tea/Coffee	Hotel Restaurant		1530–1600	Jinja Nile Resort	
(15)	Plenary discussion	Conference Room		1600–1700	Conference Coordinator	
			DAY 2 Thurs. 12 March			
(16)	Breakfast	Hotel Restaurant		0645–0800	Nile Jinja Resort	
	PANEL TWO: HIV and AIDS and peacekeeping in Africa – regional case studies			**0830–1000**		**Chair: UPDF**
(17)	a. Subregional approach to HIV and AIDS: Perspectives from the Kofi Annan International Peacekeeping Training Centre b. Threats of HIV and AIDS to regional integration efforts and performance of African standby brigades c. HIV and AIDS challenges: A perspective from the Ecowas Standby Brigade d. Regional framework of HIV and AIDS challenges: The case of East Africa	Conference Room			Samuel Atoubi (KAIPTC) Col. Mohammed Outeh Robleh Lt Col. Ola Abiodun Falade, ECOWAS Standby Brigade Peter Edopu (ISS Nairobi)	
(18)	Tea/Coffee	Hotel Restaurant		1000–1030		
	PANEL THREE: HIV and AIDS and peacekeeping in Africa – country case studies			**1030–1300**		**Chair: Professor Agokla Kossi Mawuli, Togo**
(19)	a. Organising the struggle against HIV and AIDS in the Ivorian Coast military and the need for an African Union network b. HIV and AIDS in a post-conflict country: The case of Burundi c. General HIV and AIDS in DRC d. HIV and AIDS and PSO: A case study of the Eastern DRC e. HIV and AIDS: The case of Chad f. HIV and AIDS: Swaziland				Gen. Andre Guehi Dr Innocent Nukuri Dr Djiferdin Masudi Djuma Mr Faustin Lokasola Bosenge Dr. Dingamadji Madjior Col. Dlamini & Lt Col. Magongo	

SER	DETAILS	LOCATIONS	DAY/DATE	TIMES	RESPONSIBILITY	REMARKS
(a)	(b)	(c)	(d)	(e)	(f)	(g)
	PANEL FOUR: Managing the impact of HIV/AIDS on the military			**1400–1530**		**Chair: Mr. Takawira Musavengana, ISS**
(20)	a. Effects of HIV and AIDS on military career planning for servicemen who get infected in the tour of duty b. Living with HIV, human security and the African military c. Involvement of command in prevention and care: Looking beyond medical services				UPDF Derrick Fine UPDF	
(21)	Tea/Coffee	Hotel Restaurant		1530–1600	Jinja Nile Resort	
(22)	Group discussions: 'Challenges to resource mobilisation and utilisation in implementation of HIV and AIDS in the military'	Open discussion area		1600–1700	Conference Coordinator	
(23)	Reception	Hotel Restaurant		1800–2200	Conference Coordinator	ISS to coordinate programme
			DAY 3 Fri. 13 March			
(24)	Breakfast	Hotel Restaurant		0645–0800		
(25)	Plenary discussion	Conference Room		0845–1000		
(26)	Tea/Coffee	Hotel Restaurant		1000–1030		
	PANEL FIVE: Policy recommendations			**1030–1530**		**Chair: UPDF/ISS**
(27)	Policy recommendations	Open breakaway spaces		1030–1230	Conference Coordinator	
(28)	Lunch	Hotel Restaurant		1300–1400		
(29)	Plenary discussion	Conference Room		1400–1530		
	PANEL SIX: Closing address			**1600–1700**		**Chair: UPDF**
(30)	Closing address	Conference Room		1600–1700	Minister for Health, Uganda	UPDF to arrange separate closing address programme with details of order of speaking.

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