



HIV/AIDS AND MILITARIES IN SOUTHERN AFRICA



POLICY SEMINAR
HOTEL SAFARI, WINDHOEK, NAMIBIA, 9 AND 10 FEBRUARY 2006
SEMINAR REPORT

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DESIGN: SHEARWATER DESIGN, CAPE TOWN

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PHOTOGRAPHS: DIRK WIESE, WINDHOEK, NAMIBIA

Acknowledgements

The Centre for Conflict Resolution (CCR), Cape Town, South Africa, would like to thank the governments of Denmark, the Netherlands, Sweden, Norway, and Finland, as well as the United Kingdom's (UK) Department for International Development (DFID) and the Rockefeller Brothers Fund (RBF) for their generous support which made possible the holding of the policy seminar in Windhoek, Namibia, on 9 and 10 February 2006.

About the Organisers

The Centre for Conflict Resolution

The Centre for Conflict Resolution (CCR) is affiliated to the University of Cape Town (UCT) in South Africa. Established in 1968, the organisation has wide-ranging experience of conflict interventions in the Western Cape and southern Africa and is working increasingly on a pan-continental basis to strengthen the conflict management capacity of Africa's regional organisations, as well as on policy research on South Africa's role in Africa; the United Nations (UN) role in Africa; African Union (AU)/New Partnership for Africa's Development (NEPAD) relations; and HIV/AIDS and security.

The University of Namibia

The University of Namibia (UNAM), based in Windhoek, Namibia, was established by an Act of Parliament on 31 August 1992 as recommended by a Commission on Higher Education. UNAM aims to provide higher education; undertake research; advance and disseminate knowledge; provide extension services; and contribute to the social and economic development of Namibia. The university comprises six faculties: agriculture and natural resources; economics and management science education; humanities and social science; law; medical and health science; and science. The university's northern campus in Oshakati is dedicated to human development through inclusive education. UNAM's five research, training and outreach centres – the Centre for External Studies; the Computer Centre; the Human Rights Documentation Centre; the Justice Training Centre; and the Language Centre – offer opportunities for scholars and students to deepen and extend UNAM's mission. (See www.unam.na for more information.)

The Rapporteurs

Ms Angela Ndinga-Muvumba and Ms Noria Mashumba are Senior Researchers at the Centre for Conflict Resolution (CCR), Cape Town.

Executive Summary

The Centre for Conflict Resolution (CCR), Cape Town, South Africa, and the University of Namibia (UNAM), Windhoek, Namibia, convened a two-day policy advisory group seminar on 9 and 10 February 2006 on the theme, “*Namibia’s Chair of the SADC (Southern African Development Community) Organ: HIV/AIDS and Militaries in Southern Africa*”.

The Windhoek seminar included presentations on the military HIV/AIDS programmes of Namibia, Lesotho, Tanzania and Zimbabwe. Representatives of the African Union (AU) Commission, the SADC secretariat, the United Nations Development Programme (UNDP) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) provided critical information about the roles of their respective organisations in addressing HIV/AIDS.

The seminar followed an earlier meeting organised by the CCR and UNAM on the theme, “*Strengthening Namibia’s Chair of the SADC Organ: HIV/AIDS and Southern Africa’s Security Architecture*”, in Windhoek, Namibia, in November 2005. This meeting examined ways of supporting and strengthening the government of Namibia’s role as the chair of the SADC Organ. Following the November meeting, the government of Namibia suggested that a follow-up policy seminar to examine prospects for strengthening southern Africa’s response to HIV/AIDS in the defence and security sectors be organised to enhance its leadership and the evolution of SADC’s security architecture. The February 2006 meeting brought together a diverse group of policymakers, representatives of civil society, military experts and HIV/AIDS management and mitigation practitioners. The discussion focused on the following six themes:

- Shaping the Future: SADC’s Response to the HIV/AIDS Pandemic;
- Africa’s New Security Agenda: HIV/AIDS, the AU and SADC;
- HIV/AIDS and the Military: What Works? Lessons in Prevention, Management and Treatment;
- Halting the HIV/AIDS Pandemic: Sub-Regional Approaches;
- Accelerating the Response to HIV/AIDS: The Role of the UN; and
- Southern Africa’s Framework for Security: Constraints and Limitations for Including HIV/AIDS.

The implications of the HIV/AIDS pandemic for security in southern Africa will continue to emerge over the next century. The sub-region is faced with a daunting challenge: mitigating the impact of HIV/AIDS while establishing new institutions for development, democratisation and peace. Southern Africa is the worst-affected sub-region in the world with HIV-prevalence rates of well above 25 percent. Between 4.5 and 6.2 million people are living with HIV in South Africa alone. The most recent UNAIDS and World Health Organisation (WHO) epidemiological report, published in November 2005, notes that between 1990 and 2000, South Africa’s national adult HIV-prevalence increased from less than one percent to approximately 25 percent. Nevertheless, there appears to be a downward trend in the prevalence rates in some parts of southern Africa. For example, Zimbabwe’s HIV/AIDS-prevalence rate of 21 percent has fallen from 29 percent in 2000.

Moreover, prevalence rates, while indicating the overall estimate of the epidemic’s trajectory, fail to illustrate a core concern of the participants at the Windhoek meeting: the human security implications of the pandemic. The term “human security” was first used in a 1994 UN Human Development Report, and encompasses economic, food, health, environmental, personal, community and political security. The AU’s Constitutive Act of 2000 and the African

Common Defence Pact of 2004 define human security as social, political, economic, military and cultural conditions that protect and promote human life and dignity. The AIDS pandemic threatens the life and dignity of individuals, their families and communities, and, ultimately, societal aspirations for democratisation, development and peace.

The 14 SADC countries are moving towards deeper integration with developments such as the signing of the Protocol on the Facilitation of Movement of Persons in 2005. This protocol and other efforts to harmonise trade, to enhance transportation infrastructure, and to connect economies seek to increase the movement of people across southern Africa. However, accelerated integration of southern Africa may also increase the chances of spreading HIV and thus poses a unique human security challenge, which is linked to regional integration. Furthermore, southern African states are also moving towards a more coherent and collective security architecture. SADC, along with four other African regional economic communities (RECs), the Economic Community of West African States (ECOWAS), the Economic Community of Central African States (ECCAS), the Intergovernmental Authority on Development (IGAD) and the Arab Maghreb Union (AMU), aims to operationalise its capacity for supporting peace in the sub-region as part of the African Standby Force (ASF) to be established by 2010. The SADC standby brigade will be drawn from southern African militaries, many of which have developed policies over various HIV/AIDS issues such as mandatory testing, voluntary counselling and the provision of treatment. These policies are still unco-ordinated, effective only at various, though poorly understood levels, and under-resourced.

The Windhoek advisory group strongly urged SADC's member states to begin the process of integrating HIV/AIDS prevention and treatment into their defence and security architecture. Several key strategies for undertaking a broad partnership with southern African militaries and governments; civil society and the academic community; people living with, and affected by, HIV/AIDS (PLWHA); the United Nations (UN) and donor partners; were outlined.

Policy Recommendations

The discussions at the Windhoek seminar resulted in 11 key policy recommendations:

1. **Enriching SADC's Policy Framework on HIV/AIDS and Security:** HIV/AIDS has been declared a threat to security and development by SADC's member states. However, the organisation's key policies do not establish adequate implementing mechanisms. While the Strategic Indicative Plan for the Organ on Politics, Security and Defence Co-operation (SIPO) fails to define coherent activities for addressing the security implications of HIV/AIDS, decision-makers should enhance the document and establish a process for establishing a southern African common policy on HIV/AIDS and security.
2. **SADC and the African Standby Brigade:** Despite the absence of precise figures on the prevalence of HIV/AIDS in SADC militaries, the generally high levels of HIV within southern Africa, and the likelihood that HIV infection rates could be higher among the uniformed services, warrant thoughtful yet urgent action. HIV/AIDS has implications for the overall security of citizens and states. Plans to establish a SADC standby brigade for the African Standby Force could be compromised by weakened militaries across southern Africa. An action plan on HIV/AIDS and militaries in Africa is thus imperative. The experiences of UNAIDS in its collaboration with the UN Department of Peacekeeping Operations (DPKO) to implement an integrated approach to peacekeeping can provide useful learning experiences for SADC and the AU. Moreover, the best practices of SADC militaries regarding HIV/AIDS prevention, care, support and treatment should be examined and integrated into the guidelines for the SADC standby brigade.

3. **The AU and RECs:** Africa's RECs have assumed a critical role as the building blocks for the AU's peace and security agenda. The AU's Abuja Declaration on HIV/AIDS and its HIV/AIDS Strategic Plan of 2005-2007 further acknowledge the indispensable role of RECs in these initiatives. The RECs are critical to translating the continental HIV/AIDS initiatives at the sub-regional level. There is an urgent need for the AU and the RECs to outline clearly their respective roles, particularly since other AU organs such as the Pan-African Parliament (PAP), the Peace and Security Council (PSC) and the Economic, Social and Cultural Council (ECOSOCC) will also be involved in HIV/AIDS initiatives.
4. **SADC Co-ordination of a Common Policy:** At the country level, SADC supports the policy of addressing HIV/AIDS through national frameworks. The SADC secretariat in Gaborone, Botswana, promotes the UNAIDS Three-Ones (3 Ones) principle whereby all countries should have one AIDS strategic plan, one national AIDS co-ordinating body, and one national monitoring and evaluation system. All the SADC countries have adopted the 3 Ones policy. The development of a common SADC policy for HIV/AIDS and militaries should consider how to leverage the 3 Ones framework in future.
5. **Establishing a Consultative Forum on a SADC HIV/AIDS and Military Policy:** A southern African common policy on HIV/AIDS and security would ideally focus on strengthening the HIV/AIDS management and mitigation programmes of member states. The sub-region's governments will have to engage in a consultative process to assess common needs and responses, examine "best practices", and articulate a common approach for collective operations. Already, the SADC Inter-State Defence and Security Committee's (ISDSC) Military Health Services Work Group meets annually to address a broad range of military health issues in the sub-region. This Work Group should be strengthened and perhaps convened to begin the technical aspects of formulating a common policy on HIV/AIDS and the military. SADC governments should also include the following issues in the development of their HIV/AIDS policies: the budgetary implications for defence structures as a result of HIV/AIDS programmes, and the division of labour among SADC, the AU and the UN in devising a holistic HIV/AIDS programme for African peacekeeping operations.
6. **The Role of Soldiers in HIV Prevention:** An important aim of prevention and mobilisation activities within southern Africa is to put in place national strategies that consider ways of utilising the uniformed services to strengthen HIV/AIDS awareness and prevention initiatives. The UNAIDS experience shows that soldiers can be champions of safer-sex and can carry HIV-prevention messages to local populations. Moreover, community support and care for soldiers suffering from AIDS-related illnesses would be enhanced as a result of positive interaction between militaries and civilian populations. SADC militaries and governments should strive to implement military-civilian initiatives which encourage their troops to provide guidance on HIV prevention. Examples include mentorship programmes, fundraising activities and various community service programmes.

7. **Gender and the Military:** The gendered dimensions of HIV/AIDS are critically important to militaries in southern Africa. The sub-region's HIV/AIDS awareness campaigns should be designed to target men and women - including spouses. They should aim to increase knowledge about HIV and Sexually-Transmitted Infections (STIs) and to popularise and distribute male and female condoms equally. Future deployment of southern African troops should address the culture of impunity that prevails regarding sexual exploitation within the military as well as the civilian population. Strict and transparent policies that outlaw sexual harassment and abuse should also be put in place or strengthened. Similarly, efforts should be made to increase the role of women in decision-making and policy development for SADC's sub-regional brigade. Remuneration for deployment on peace operations should be monitored, with a percentage of each soldier's allowance sent home routinely in order to decrease the reliance on commercial sex workers during missions. Simultaneously, it would be useful to consider reducing or regulating the proximity of commercial sex workers to military installations.
8. **Mandatory Testing:** The policy of mandatory testing and routine HIV screening in the military poses important questions about the human rights of people living with HIV/AIDS. Due to the nature of their organisational missions, defence forces must maintain records of the fitness levels of their soldiers and officers. As a result, many armed forces have included HIV screening in their routine and mandatory health examinations. Yet, in all sectors, the stigma attached to HIV/AIDS has led to discrimination against people living with HIV/AIDS. A SADC policy on mandatory testing should be developed, in partnership with people living with HIV/AIDS, and efforts to ensure that militaries protect the human rights of HIV-positive soldiers and their families should also be simultaneously developed and implemented. UNAIDS and a number of the sub-region's militaries argue that voluntary counselling and testing help to counteract HIV/AIDS stigma; activities which promote voluntary counselling and testing such as "Know Your Status" campaigns can be implemented to address this issue.
9. **Home-Based Care:** As the healthcare systems in many SADC countries buckle under the burden of the pandemic, the responsibility to provide care and support to AIDS patients has often been transferred to families. The reality, however, is that most military recruits come from poor communities that are unable to provide basic care for their terminally-ill relatives who are dismissed from official duty. Military home-based care programmes must therefore be scaled up. This would include mobilising human and financial resources to provide transportation for site visits, the provision of psycho-social and spiritual counselling, nutritional support, the administration of referrals and the teaching of problem-solving skills.
10. **ARV Therapy Provision and Adherence:** Medical science shows the need for diligent adherence to highly active anti-retroviral therapy (HAART) to guard against the development of multi-drug resistance and the potential threat of drug-resistant virus strains. While early studies of adherence rates in resource-poor settings in Africa have shown good results, a variety of factors could reduce adherence. These include poverty; lack of transportation to treatment centres; traditional constructs of the origin and development of HIV; reliance on traditional medicine and remedies; HIV/AIDS stigma and discrimination; and gender inequality. There is a need to investigate the specific challenges faced by soldiers who are taking anti-retroviral (ARV) therapy while deployed on peacekeeping missions or in other service. In the meantime, SADC governments should replicate the best practices of existing treatment programmes which provide nutritional support; require patients to undergo multiple adherence-counselling sessions before therapy is started; encourage patients to partner with a family member or friend who monitors their adherence; and expect patients to attend counselling sessions regularly.

- II. **Effective Use of Resources:** SADC, UNDP and UNAIDS are engaging in negotiations to increase the financial resources for southern Africa's fight against HIV/AIDS. SADC's Maseru Declaration of 2003 called for the establishment of a Regional Fund to address the HIV/AIDS emergency. A preliminary feasibility assessment of such a fund has been conducted. Despite an increase in financial and human resources for HIV/AIDS management and mitigation in the last five years, programmes and initiatives are still grossly under-funded and SADC governments must increase their contributions to these initiatives. Future efforts to mobilise funds must be concerted and co-ordinated. Moreover, SADC states must establish transparent and effective practices for managing existing resources, which often do not reach local communities. Implementing mechanisms must have clear, measurable objectives and utilise meaningful planning and monitoring and evaluation systems.



From left: Dr Adekeye Adebajo, Centre for Conflict Resolution, Cape Town; Major-General (Ret) Charles Namoloh, Namibian Minister of Defence, Windhoek; Mr Tomaz Augusto Salomão, Executive Secretary, Southern African Development Community, Gaborone

Introduction

The Centre for Conflict Resolution (CCR), Cape Town, South Africa, and the University of Namibia (UNAM), Windhoek, Namibia, convened a two-day policy advisory group seminar at the Hotel Safari in Windhoek, Namibia, on 9 and 10 February 2006. The theme of the seminar was “*Namibia’s Chair of the SADC (Southern African Development Community)¹ Organ: HIV/AIDS and Militaries in Southern Africa*”. This meeting followed a series of CCR policy meetings which have focused on:

- Supporting South Africa’s role as the chair of the SADC Organ on Politics, Defence and Security (OPDS) held in Tshwane, South Africa, in November 2004;
- Southern Africa’s post-apartheid security agenda, held in Cape Town, South Africa, in June 2005; and
- The African Union’s (AU) strategic plan for accelerating the continent’s response to HIV/AIDS, held in Addis Ababa, Ethiopia, in September 2005.²

On 23 November 2005, CCR and UNAM organised a half-day policy seminar in Windhoek, Namibia, on the theme, “*Strengthening Namibia’s Chair of the SADC Organ: HIV/AIDS and Southern Africa’s Security Architecture*”. The meeting examined ways of supporting and strengthening the government of Namibia’s role as chair the SADC Organ and addressed the policy implications of the SADC HIV/AIDS Strategic Framework and Plan of Action: 2003-2007, adopted in Maseru, Lesotho, in July 2003. The Namibian Minister of Defence, Major-General (Ret) Charles Namoloh, delivered the opening address, which outlined the Namibian government’s objectives as chair of the Organ. Maj-Gen Namoloh subsequently suggested that a follow-up meeting to examine prospects for strengthening southern Africa’s response to HIV/AIDS in the defence and security sectors would enhance its leadership and the evolution of SADC’s security architecture. As a result, the February 2006 seminar was convened by CCR and UNAM to examine the following four issues:

- SADC’s policy frameworks for human security and HIV/AIDS;
- The roles of the African Union, SADC and the United Nations in the area of HIV/AIDS;
- The impact and response to HIV/AIDS in southern Africa’s militaries; and
- Strategies for harmonising national and sub-regional security and defence frameworks for HIV/AIDS management and mitigation.

The February 2006 meeting heard opening addresses by Maj-Gen Namoloh and Mr Tomaz Augusto Salomão, SADC’s Executive Secretary (see Annexes I and II). The seminar evaluated SADC’s 2004 Strategic Indicative Plan for the Organ’s (SIPO) HIV/AIDS objectives and strategies. The Windhoek meeting also provided a platform to consider the work of key actors in the peace and security fields as well as in the area of HIV/AIDS mitigation at the sub-regional and continental levels. The meeting therefore reviewed the AU’s strategic objectives for accelerating a continental response to HIV/AIDS. Dr Grace Kalimugogo, head of AIDS Watch Africa (AWA) at the AU Commission; Dr Antonica Hembe, head of the HIV/AIDS Unit at the SADC secretariat; military officials from five

1 SADC currently comprises 14 member states, namely Angola, Botswana, Democratic Republic of the Congo (DRC), Lesotho, Malawi, Mauritius, Madagascar, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

2 See the reports by the Centre for Conflict Resolution (CCR), *Whither SADC? An Agenda for Southern Africa’s Post-Apartheid Security*, Cape Town, South Africa, 18 and 19 June 2005; CCR, *Building an African Union for the 21st Century: Relations with Regional Economic Communities (RECs), NEPAD and Civil Society*, Cape Town, South Africa, 20 – 22 August 2005; and CCR, *HIV/AIDS and Human Security: An Agenda for Africa*, Addis Ababa, Ethiopia, 9 and 10 September 2005 (available at ccrweb.ccruct.ac.za).

countries in southern Africa; and representatives of donor countries, non-governmental organisations (NGOs), civil society, and universities participated in the Windhoek policy advisory group seminar. The meeting's major output is a critical assessment of the response to the impact of HIV/AIDS on southern Africa's defence and security institutions. The policy advisory group examined HIV/AIDS management and mitigation programmes undertaken by defence forces in Lesotho, Namibia, Tanzania and Zimbabwe.

The following six specific themes and issues were addressed during the policy seminar:

- Shaping the Future: SADC's Response to the HIV/AIDS Pandemic;
- Africa's New Security Agenda: HIV/AIDS, the AU and SADC; and
- HIV/AIDS and the Military: What Works? Lessons in Prevention, Management and Treatment.
- Halting the HIV/AIDS Pandemic: Sub-Regional Approaches;
- Accelerating the Response to HIV/AIDS: The Role of the UN; and
- Southern Africa's Framework for Security: Constraints and Limitations for Including HIV/AIDS.

This report is a summary of the discussions and recommendations from the Windhoek seminar, as well as additional research based largely on the papers presented at the meeting.



Major-General (Ret) Charles Namoloh, Namibian Minister of Defence, Windhoek



TOP: Colonel Gertrude Mutasa, Zimbabwean Defence Force, Harare



ABOVE: Lieutenant-Colonel Petrus Nathing, Namibian Defence Force, Windhoek

1. Shaping the Future: SADC's Response to the HIV/AIDS Pandemic

Southern Africa is the worst affected sub-region in the world, with HIV prevalence rates of well above 25 percent. The sub-region contains more than 30 percent of the 40 million people worldwide living with the disease: over 14 million adults and children are living with HIV/AIDS in southern Africa.³

Between 4.5 and 6.2 million people are living with HIV in South Africa alone. The most recent Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) epidemiological report, published in November 2005, notes that between 1990 and 2000, South Africa's national adult HIV prevalence went from less than one percent to approximately 25 percent. Although the overall prevalence rate in Namibia has slightly declined since 2004, HIV rates vary across the country (from 4.2 percent to 8.5 percent) and adult mortality among women has tripled in the last decade.⁴ Experts have suggested that the southern African sub-region is shifting into the next stage of the pandemic: mortality. Life expectancy has dropped below 40 years in Botswana, Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe.⁵ HIV prevalence among pregnant women is often high: in parts of Botswana, Lesotho, Namibia and Swaziland, rates exceed 30 percent.⁶ In 2002, Angola - which is the anomaly in the region with a median HIV-prevalence rate of 3 percent - had high levels of HIV infection rates among sex workers, estimated at 33 percent.⁷ There appears to be a downward trend in the prevalence rates in some parts of southern Africa. Studies in Zimbabwe note that condom-use has risen by 86 percent among men, and 83 percent among women. More importantly, death rates have remained at the same levels, suggesting that changes in sexual behaviour are the cause of declining HIV rates.⁸ Indeed, the HIV rate among pregnant women decreased from 24.6 percent in 2002 to 21.3 percent in 2004.⁹

Prevalence rates, while indicating the overall estimate of the epidemic's trajectory, also fail to illustrate a core concern of the participants at the Windhoek meeting: the human security implications of the disease. The term "human security" was first used in a 1994 UN Human Development Report, and encompasses economic, food, health, environmental, personal, community and political security. The AU's Constitutive Act of 2000 and the African Common Defence Pact of 2004 define human security as social, political, economic, military and cultural conditions that protect and promote human life and dignity. The AIDS pandemic threatens the life and dignity of individuals, their families and communities, and, ultimately, societal aspirations for democratisation, development, and peace.¹⁰

3 The Southern African Development Community (SADC), "HIV and AIDS in SADC", Gaborone, Botswana (accessed on 7 May 2006 at www.sadc.int/english/hiv_aids/factsheets/aids.pdf).

4 See the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), *AIDS Epidemic Update*, Geneva, November 2005 (available at www.unaids.org).

5 See also Alex de Waal, "How will HIV/AIDS Transform African Governance?", *African Affairs*, vol. 102, no. 406, January 2003, 102, pp. 123; and *AIDS-related National Crises in Africa: Food Security, Governance and Development Partnerships*, *IDS Bulletin*, vol. 33, no. 4, 2002, pp. 120-126, for an examination of the societal impacts of high death rates for life expectancy and food security.

6 UNAIDS/WHO, *AIDS Epidemic Update*, p. 22.

7 UNAIDS/WHO, *AIDS Epidemic Update*, pp. 23-25.

8 A. Mahomva, "Trends in HIV Prevalence and Incidence and Sexual Behaviour", presentation to the UNAIDS Reference Group on Estimates, Modelling and Projections, 15-17 November 2004, Harare, Zimbabwe, cited in UNAIDS, *AIDS Epidemic Update*, p. 20.

9 See *Zimbabwe's HIV infection rate falls, but much still needs to be done*, United Nations Children's Fund (UNICEF) Press Centre, Zimbabwe, 11 October 2005 (accessed 8 May 2006 at http://www.unicef.org/media/media_28660.html).

10 See *Human Security Report 2005: War and Peace in the 21st Century*, The Human Security Centre and the Liu Institute for Global Issues, The University of British Columbia (London and Vancouver: Oxford University Press, 2005), p. VIII; AU, *Common African Defence and Security Policy*, Addis Ababa, Ethiopia, January 2004, par. 6.

The 14 SADC countries are moving towards deeper integration with developments such as the signing of the Protocol on the Facilitation of Movement of Persons in 2005.¹¹ This protocol and other efforts to harmonise trade; to enhance transportation infrastructure; and to connect economies seek to increase the movement of people across southern Africa. However, experts have noted that mobile populations such as migrants facilitate the spread of HIV/AIDS. Therefore, accelerated integration of southern Africa may also increase the chances of spreading HIV and thus poses a unique human security challenge, which is linked to regional integration. Furthermore, southern African states are also moving towards a more coherent and collective security architecture.

SADC, along with four other African regional economic communities (RECs), the Economic Community of West African States (ECOWAS), the Economic Community of Central African States (ECCAS), the Intergovernmental Authority on Development (IGAD), and the Arab Maghreb Union (AMU), aims to operationalise its capacity for sub-regional peace support as part of the African Standby Force (ASF) to be established by 2010.¹² The SADC standby brigade will be drawn from southern African militaries, many of which have developed policies over a broad range of HIV/AIDS issues such as mandatory testing, voluntary counselling and provision of treatment. These varied policies are still unco-ordinated, effective only on various, but poorly-understood, levels and are under-resourced. Meanwhile, because soldiers generally fall within the age range of the most vulnerable group for HIV (15 - 49 years), the pandemic's impact on the military has long-ranging and nuanced impacts. Senior officers within militaries, who are central to political life and have important skills and knowledge, are also particularly vulnerable. The early illness or death of these officers can hamper the building of national forces. The further weakening of national defence forces could undermine efforts to build an effective SADC standby brigade for African peacekeeping. Moreover, fragile defence structures could potentially compromise the security of states and of citizens. Finally, HIV/AIDS mitigation strategies are competing for, and diverting resources from, other programmes such as poverty alleviation and food security, which are also critical to ensuring human security. These long-term implications of HIV/AIDS require the leadership of SADC governments to address the pandemic as more than a health issue.

A summit of SADC heads of state and government on HIV/AIDS held in Maseru, Lesotho, on 4 July 2003 noted the adoption of the SADC HIV/AIDS Strategic Framework and Plan of Action: 2003-2007. The Framework aims not only to enhance existing efforts to address HIV/AIDS, but also to tackle the various social, economic and political effects of the pandemic. Indeed, Maseru promises a move towards a more co-ordinated and muscular response to HIV/AIDS.¹³ SADC's Regional Indicative Strategic Development Plan (RISDP) of 2001 provides further clarity on the organisation's strategy for combating HIV/AIDS. SADC's peace and security plan - encapsulated in its Strategic Indicative Plan for the Organ on Politics, Security and Defence Co-operation - also acknowledges the impact of HIV/AIDS in the sub-region. SIPO notes that the HIV/AIDS pandemic poses a challenge to SADC and to the objectives of the Organ.¹⁴

11 SADC, *Protocol on the Facilitation of Movement of Persons*, Gaborone, Botswana, August 2005 (accessed 8 May 2006 at www.sadc.int).

12 AU, *Roadmap for the Operationalisation of the African Standby Force, Experts Meeting on the Relationship Between the AU and the Regional Mechanisms for Conflict Prevention, Management and Resolution*, March 2005, Addis Ababa, Ethiopia, EXP/AU-RECs/ASF/4(I), and AU, *Draft Framework for a Common African Defence and Security Policy* (see www.africa-union.org).

13 SADC, *SADC Declaration on HIV/AIDS*, Maseru, Lesotho, July 2004 (accessed on 31 March 2006 at www.sadc.int).

14 SADC, *The Regional Indicative Strategic Development Plan*, Windhoek, Namibia, March 2001 (accessed on 31 March 2006 at www.sadc.int); and *Strategic Indicative Plan for the Organ on Politics, Defence and Security Co-operation*, August 2004 (accessed on 31 March 2006 at www.sadc.int).

Several policy advisory group members noted that the SADC policy documents were too broad and general in their prescriptions for the organisation's HIV/AIDS and security challenge. In his opening remarks at the Windhoek seminar, Namibia's Minister of Defence, Charles Namoloh, called for a major shift in SADC's approach to addressing the impact of HIV/AIDS on security.¹⁵ He noted that the physical fitness of military personnel is central to deterrence and to ensuring security. Moreover, HIV/AIDS exacerbates the conditions for conflict in situations where civilian populations are displaced and rendered vulnerable to disease, hunger and poverty. The SADC Executive Secretary, Mr Thomas Augusto Salomão, called for agreement among SADC states on their HIV/AIDS management and mitigation strategies in the context of defence and security.¹⁶ Others noted that in order to formulate a common response to HIV/AIDS in SADC militaries, the starting point should be a review of the sub-region's current national and regional frameworks and utilisation of the best practises of member states. Finally, in an effort to stay focused on the interdependence of human and state security, there is a fundamental need to ensure availability and sustainability of resources for civilians and defence forces alike.



ABOVE: (from left) Dr Grace Kalimugogo, African Union Commission, Addis Ababa; Major-General (Ret) Charles DNP Namoloh, Namibian Minister of Defence, Windhoek; Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town; Professor Andre du Pisani, University of Namibia, Windhoek

LEFT: Major Mariane Muvangua, Namibian Defence Forces/Ministry of Defence, Windhoek

¹⁵ See full version of speech attached as Annex I in this report.

¹⁶ See full version of speech attached as Annex II in this report.

2. Africa's New Security Agenda: HIV/AIDS, the AU and SADC

The African Union's HIV/AIDS Strategy

Since its creation in Durban, South Africa, in 2002, the AU has laid out a comprehensive framework for managing conflicts in Africa and for responding to the HIV/AIDS crisis. Recognising that HIV/AIDS created a “state of emergency” on the continent, African leaders met in Abuja, Nigeria, in April 2001 to develop strategies to stem this trend.¹⁷

The outcome of the 2001 summit was the Abuja Declaration and Plan of Action, which, among other goals, committed leaders to allocate at least 15 percent of their annual budgets to fight HIV/AIDS, tuberculosis and other infectious diseases.¹⁸ Thus far, only Botswana has met this health expenditure target. However, African countries such as Gambia, Ghana, Tanzania, Uganda and Zimbabwe have all made progress towards reaching this goal by devoting between 12 and 14.5 percent of their national budgets to the health sector.¹⁹ The AU's progress reports on the implementation of the 2001 commitments made in Abuja emphasised the importance of increasing the numbers of people with access to prevention, care, support and treatment. Although most African governments have failed to meet the targets set, modest improvement in these countries has galvanised support for universal access to these services by 2010.

The mid-term review of the implementation of the Abuja Declaration took place during a special AU summit in Abuja in May 2006. At this meeting, governments adopted an African Common Position²⁰ for the June 2006 mid-term review of the UN Declaration of the 2001 General Assembly Special Session (UNGASS).²¹ The African Common Position prioritises the reduction of HIV-prevalence among people between 15 and 24 and pledges that African governments will lower HIV levels by 25 percent, by the year 2010. Also, the AU has promised to foster inter-country and sub-regional approaches across national frontiers and within war zones. The position of the AU was based on policy documents such as the Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care of October 2005; and strategies from the AU's Continental Consultative Meeting on Universal Access to Prevention, Treatment and Care and Support in Africa, held in Brazzaville, Congo, in March 2006.²²

The AU's HIV/AIDS Strategic Plan 2005-2007 is to be implemented in partnership with the RECs such as ECOWAS, ECCAS, IGAD, AMU and SADC, as well as UN agencies and external donors. Through its HIV/AIDS plan, the AU positions itself as an advocate and co-ordinator of a continental response to the emergency posed by the pandemic. The plan has six key objectives with corresponding strategies:

17 AU, *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, Abuja, Nigeria, April 2001, OAU/SPS/Abuja /3, par. 22, p.4.

18 AU, *Abuja Declaration*, par. 26, p.5.

19 AU, *Progress Report on the Implementation of the Plan of Action of the Abuja Declaration for Malaria, HIV/AIDS and Tuberculosis*, Addis Ababa, Ethiopia, October 2005.

20 AU, *African Common Position to the June 2006 UN General Assembly Special Session on AIDS*, Abuja, Nigeria, May 2006, SP/Assembly/ATM/3 (II).

21 UN, *Declaration of Commitment on HIV/AIDS*, UN General Assembly Special Session on HIV/AIDS, New York, New York, June 2001.

22 AU, *Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care*, Gaborone, Botswana, October 2005, CAMH/Decl.I; and AU, UNAIDS and WHO, *Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010*, Brazzaville, Congo, March 2006.

- Leadership and advocacy;
- Accountability;
- Harmonisation and co-ordination;
- Mobilising human resources and capacity-building;
- Programme priorities for the Millennium Development Goals (MDGs); and
- Mobilisation of financial resources.²³

The AU Department of Social Affairs will involve RECs in its HIV/AIDS strategy. The policy advisory group agreed with the architects of the AU's plan, particularly the initiative to include the RECs in the strategy since they are closer to sub-regional dynamics and can be useful partners for harmonising national programmes.

The AU Commissioner of Social Affairs, Ms Bience Gawanas, together with civil society, governments and partners, is seeking to mainstream the AU's activities regarding HIV/AIDS and to enhance Africa's response to the pandemic.²⁴ Other AU institutions such as the Pan-African Parliament (PAP), the Peace and Security Council (PSC) and the Economic, Social and Cultural Council (ECOSOCC) will carry out their own activities. The AU Commission's representative at the Windhoek seminar and head of Aids Watch Africa, Dr Grace Kalimugogo, highlighted the importance of utilising existing resources to respond to Africa's communicable diseases effectively. She underscored the concern of many experts that financial resources to fight HIV/AIDS are not reaching communities as quickly and efficiently as possible.

Regarding the AU's efforts to integrate HIV/AIDS into its peace and security agenda, the ASF's five sub-regional brigades of between 3 000 to 4 000 troops will be developed under corresponding RECs. An additional sixth brigade is expected to be located at the AU's headquarters in Addis Ababa, Ethiopia.²⁵ Policy formulation for the ASF, including policies and practices relating to HIV/AIDS and security, is evolving. While HIV/AIDS has been shown to constitute a security threat, more work on the conceptual and operational implications of the pandemic for Africa's peacekeeping must still take place within the AU Commission and the RECs.²⁶ The AU Commission's Department of Peace and Security is taking steps to address HIV/AIDS issues for the AU's peacekeepers. It is important to implement a plan on HIV/AIDS and militaries in Africa. This new policy should reflect ongoing harmonisation initiatives by the RECs, and resonate with strategies already evolving at the sub-regional level.

SADC and HIV/AIDS: The Development Focus

The operational mechanisms necessary for the implementation of the SADC HIV/AIDS Strategic Framework and Plan of Action: 2003 - 2007 are expressed in specific elements of the 2003 Maseru Declaration. SADC member states declared that the Framework would be supported through the establishment of a Regional Fund. In addition to committing new resources, southern African leaders pledged to pursue the delivery of resources already promised. In particular, they agreed to urge western donors - on the principle that the pandemic constitutes a

23 Grace Kalimugogo, "The African Union", presentation at the CCR/UNAM policy advisory group seminar, "Namibia's Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa", Windhoek, Namibia, 9 and 10 February 2006.

24 AU, *The AU Commission HIV/AIDS Strategic Plan 2005 - 2007; and AIDS Watch Africa (AWA) Strategic Plan*, Sirte, Libya, 28 June - 2 July 2005. EX.CL/194 (VII).

25 See E.A. Thorne, "The African Standby Force Takes Shape: An Observation of Needs and Necessary Action", *African Armed Forces Journal*, July 2003; and T. Neethling, "Realising the African Standby Force as a Pan-African Ideal: Prospects and Challenges", Centre for International Political Studies (CIPS) Electronic Briefing Paper, University of Pretoria, no. 48, 2005.

26 AU, *Draft Framework for a Common African Defence and Security Policy*, January 2004, Addis Ababa, Ethiopia, MIN/Def&Sec.3. (I) 20/21.

humanitarian crisis - to increase support substantially through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative; and the Multi-country AIDS Programme (MAP).

Structural challenges such as pervasive poverty, social exclusion and gender inequalities in southern Africa have also increased the vulnerability of populations to HIV/AIDS. These are also “indirect” contributors fuelling the pandemic. SADC’s RISDP links HIV/AIDS to underdevelopment and inequality. For example, the RISDP highlights the acute poverty in southern Africa among child-headed or elder-headed households, which are increasing due to the AIDS pandemic.²⁷ The process of delivering relief to those suffering from HIV/AIDS within the context of entrenched and deepening poverty has highlighted four inter-related challenges:

- Weak capacity of relevant institutions to respond effectively to HIV/AIDS’ societal impacts;
- Poor management of insufficient resources;
- New challenges such as the provision of ARV drugs; and
- A continuous need to review, refine and scale up existing strategies and policies.²⁸

Despite these complex challenges, SADC countries are still coming to terms with the major “direct” causes of the spread of HIV: unprotected sexual intercourse, mother-to-child transmission, and infections through blood transfusions. Effective responses to indirect and direct causes of the sub-region’s HIV/AIDS epidemic will depend on long-term planning; efficient management; and allocation of resources to the health sector, as well as enhancing food security; poverty alleviation; good governance; and security.



The seminar in session, addressed by, from left: Major-General Solly Mollo, South African Ministry of Defence, Tshwane; Dr Kaire Mbuende, former Executive Secretary, Southern African Development Community, Windhoek; and Ms Victoria Lonje, Alliance of Mayors’ Initiative for Community Action Against HIV/AIDS at Local Level, Windhoek

27 The Regional Indicative Strategic Development Plan, 2003, p. 9.

28 Andre du Pisani, presentation at the CCR/UNAM policy advisory group seminar, ‘Namibia’s Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa’, Windhoek, Namibia, 9 and 10 February 2006.

SADC and HIV/AIDS: The Security Focus

SADC's politics, defence and security plan, SIPO, was adopted in 2004 to provide a comprehensive framework for implementation of the Protocol on Politics, Defence and Security Co-operation of 2001. SIPO puts forward 28 objectives in four priority areas: the political sector; the public security sector; the state security sector; and the defence sector.

According to Namibian Defence Minister Charles Namoloh, SIPO is a "roadmap with signposts". The policy document recognises the challenge that HIV/AIDS poses to SADC members and to the objectives of the Organ on Politics, Defence and Security. However, SIPO fails to address the link between HIV/AIDS and defence security. Moreover, while the Maseru Declaration of 2003 and SADC's HIV/AIDS Strategic Framework both stress the need for devising concrete strategies for integrating national initiatives into a sub-regional framework, SIPO does not specify implementation mechanisms for a harmonised approach to managing HIV/AIDS and security concerns. The broad and vague language in the SIPO document should, however, not deter further efforts to conceptualise and implement an HIV/AIDS and security framework. The fact is that the process for drafting SIPO began as early as 1996, shortly after South Africa's first democratic elections in 1994 and the dawn of a new era for southern Africa. At the time, SIPO was intended to provide guidelines for implementation of an instrument adopted to address traditional security issues. An issue such as HIV/AIDS thus presented new challenges for SADC. Consequently, SIPO must now address the human security threats facing southern Africa. It is not necessary to rewrite the policy document, but instead future HIV/AIDS and security strategies should be based on the political will of member states to combat HIV/AIDS as illustrated by the SADC Framework, the RISDP and SIPO.

The policy group discussed how best to leverage financial and human resources, and agreed that it was critical to ensure that there was sufficient capacity to use them. Securing future resources would depend on how effectively existing resources are being utilised. In this regard, efforts to plan for, budget, disburse, monitor and evaluate the use of existing resources must be urgently enhanced. Beyond financial resources, it is important to engage communities at the grassroots level and to integrate efforts to interact with local populations and traditional leaders in order to demystify HIV/AIDS and its causes. Social mobilization - including relevant cultural practices and value systems - will be critical to empowering safer-sex behaviour among vulnerable groups.

Military populations and their interactions with civilians were also highlighted as a key target for future interventions. The defence forces in Angola, Mozambique, Zimbabwe and South Africa comprise relatively new armies: following the apartheid era and respective conflicts, several countries have sought to introduce a more humane face to their militaries. The emergence of a "new soldier" in southern Africa will require sustained interaction between civilians and the defence forces, adherence to the rule of law, and continued rejuvenation of democratic principles. Nevertheless, the qualities of soldiers - who frequently, at senior ranks, are better paid and enjoy more power and prestige than their civilian counterparts - could be harnessed in the fight against HIV/AIDS. As a captive audience to HIV prevention programmes, the military sector is in a pivotal position to assist this battle. Soldiers can be champions of safer-sex and can carry HIV-prevention messages to local populations. This new paradigm would also promote community support and care for soldiers suffering from AIDS-related illnesses. For example, home-based care programmes would benefit from positive engagement between militaries and civilian populations.

3. HIV/AIDS and the Military: What Works? Lessons in Prevention, Management and Treatment

One of the current challenges facing African actors and institutions is how best to develop government and military structures that effectively combat the HIV/AIDS pandemic. HIV/AIDS poses a unique threat to the stability of traditional defence structures, which, in turn, affects steps being taken to build Africa's peace and security architecture.

There are a number of implications relating to the impact of the virus on militaries, and to how HIV/AIDS relates to efforts made by RECs such as SADC to ensure stability, and, ultimately, sustain the continent's peacekeeping capacity. Country-level programmes are faced with the task of implementing a number of programmes to promote HIV/AIDS prevention, care, support and treatment. Addressing the AIDS epidemic within the armed forces has thus been a pioneering effort.

The Windhoek policy seminar included presentations on military HIV/AIDS programmes in Namibia, Lesotho, Tanzania and Zimbabwe. The presentation on Namibia captured the broad components of a holistic HIV/AIDS programme. The Lesotho case provided useful information about the issue of testing and the challenges of home-based care. The Tanzanian presentation illustrated the challenges of providing ARVs and securing resources. A fourth presentation from the Zimbabwe Defence Forces (ZDF) highlighted the role of the SADC Military Health Services Work Group, which is governed by the SADC Inter-State Defence Committee; it also provided useful perspectives on the relationship between gender and HIV/AIDS in Zimbabwe's defence force.

Namibia²⁹

Namibia's HIV prevalence among pregnant women was approximately 4.2 percent in 1992. By 2004, the rate was estimated to be 19.7 percent. The Namibian Ministry of Defence (MOD) and the Namibian Defence Forces (NDF) estimate that the overall prevalence of HIV in the country's armed forces is higher than 19.7 percent. The NDF believes that this is due to a number of factors which include patterns of deployment; the culture of risk-taking in the military; alcohol abuse; myths and misconceptions about HIV/AIDS; and the fact that soldiers are generally of an age of high sexual activity and it is thus common practice to have multiple sexual partners. The military is concerned that widespread illness caused by HIV/AIDS will impact negatively on its operational readiness.

The Namibian government's Strategic Plan on HIV/AIDS 2004 – 2009 (Third Medium Plan) sets out the country's response to the epidemic. The Plan aims to reduce and effectively manage HIV/AIDS, STIs, tuberculosis and malaria. The NDF promotes the use of the female and male condom; provides intensive information, education and communication services; strengthens already established voluntary counselling and testing (VCT) services; facilitates treatment of opportunistic infections through ARV therapy, as well as care and support for affected and

29 Maj Marianne Muvangua, 'HIV/AIDS and the Military: Lessons in Prevention, Management and Treatment in the Namibian Defence Force', presentation at the CCR/UNAM policy advisory group seminar, 'Namibia's Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa', Windhoek, Namibia, 9 and 10 February 2006.

infected members; carries out home-based care services; and monitors and assesses the magnitude and impact of the epidemic through research and surveillance studies. The NDF's Directorate of Medical Services works with the Ministry of Health and Social Services and the Social Marketing Association. Its HIV-prevention awareness programme has developed a programme which includes an HIV-prevention video - "Remember Eliphaz" - which has reached 10 000 uniformed-personnel. Senior defence sector managers have been informed of the national plan and the role of ARVs in responding to HIV/AIDS. The prevention programme conducts training programmes for peer educators; counsellors; home-based care-givers; and the HIV/AIDS co-ordinator. It also includes a training-of-trainers component. About 40 unit co-ordinators had been trained by February 2006. Voluntary counselling and testing (VCT) facilities have been established in all NDF sites, and efforts have been made to provide post-exposure prophylaxis (PEP) to military health workers. The NDF is committed to providing both female (femidom) and male condoms, and has recently purchased three pelvic dolls for femidom demonstrations.

Currently anti-retroviral therapy is available to members of the defence ministry and the military who meet the national standards for treatment. Treatment regimens are administered through public hospitals or the private sector. The defence ministry and the armed forces operate treatment literacy programmes for ARVs and treat opportunistic infections. Unit commanders and health workers in the military services directorate are trained in treatment; counselling and testing; prevention of mother-to-child transmission; and home-based care. Two military doctors have been trained in ARV therapy management.

The NDF identified four obstacles to scaling up its response to HIV/AIDS:

- The absence of a comprehensive HIV/AIDS policy for the defence ministry and the armed forces;
- Inadequate budgetary allocations that impede the sustainability and scope of the government's efforts to mitigate and manage HIV/AIDS in the military;
- A shortage of human resources that undermines the effectiveness of the existing HIV/AIDS programmes; and
- A lack of transportation for home-based care which severely limits visits by HIV/AIDS unit co-ordinators to infected and affected members and their families. In February 2006, the military had only one vehicle devoted to home-based care.

Despite these challenges, the Namibian military is committed to implementing a broad vision for addressing HIV/AIDS. Its members are exposed to a robust HIV-prevention message: HIV is avoidable, HIV/AIDS is a chronic disease requiring life-long treatment with multiple medication and frequent side effects; and HIV-positive individuals have a responsibility not to infect others.

Lesotho³⁰

The government of Lesotho acknowledged that the incidence of sexually-transmitted infections is higher among uniformed personnel than in the general population. The Lesotho Defence Force's (LDF) HIV/AIDS programme undertakes disease surveillance; prevention programmes; care and support, including counselling and home-based

30 Lieut-Col Paul Kuenane, "Makoanyane Military Hospital", presentation at the CCR/UNAM policy advisory group seminar, *Namibia's Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa*, Windhoek, Namibia, 9 and 10 February 2006.

care. The LDF's prevention programme includes health education and the distribution of condoms, as well as an HIV-prevention team which visits peripheral military posts and provides an HIV/AIDS diploma course. These teams provide counselling before and after each HIV test and also target soldiers deployed outside Lesotho. The majority of clients are male. In its first year, the LDF's ARV programme has enrolled 129 patients which includes uniformed personnel and their dependents. Six children are among those on treatment. There have been two deaths and a 98 percent rate of adherence to the drug regimen since the programme started.

Since December 2004, the Makoanyane Military Hospital in Lesotho has provided free ARV therapy. All active-duty personnel are screened periodically for HIV. HIV-positive personnel are referred to the hospital for a comprehensive medical evaluation, advised to refrain from donating blood, and asked to disclose their HIV status to all sexual partners. Disclosure is not entirely voluntary: the hospital staff is obliged to report the HIV-positive status of LDF patients to spouses if members refuse to disclose their status to their partners. Active-duty personnel who are HIV-positive are categorised solely according to their levels of fitness for duty: only individuals classified as unfit are placed on "light duty" and deployed within the vicinity of army headquarters.

The policy of mandatory testing and routine HIV-screening in the military poses important questions about the human rights of people living with HIV/AIDS. Due to the nature of their organisational missions, defence forces must maintain records of the fitness levels of their soldiers and officers. As a result, many armed forces have included HIV-screening in their routine and mandatory health examinations. Yet, in all sectors, the stigma attached to HIV/AIDS has led to discrimination against people living with, and affected by, HIV/AIDS (PLWHA). Militaries must pay careful attention to the human rights of their members who are diagnosed as being HIV-positive. The LDF states that evidence of HIV infection (unless it affects physical and mental fitness) cannot determine the appointment or eligibility of an individual to military service. The HIV-positive status of a member can also not be logged as an unfavourable entry in personnel records, and disclosure is prohibited unless a medical need is established. The LDF maintains that information obtained from its members during epidemiological interviews may not be used as the basis for any disciplinary action and is inadmissible in court-martial proceedings, administrative or punitive reductions of grades, and assessments of promotion.

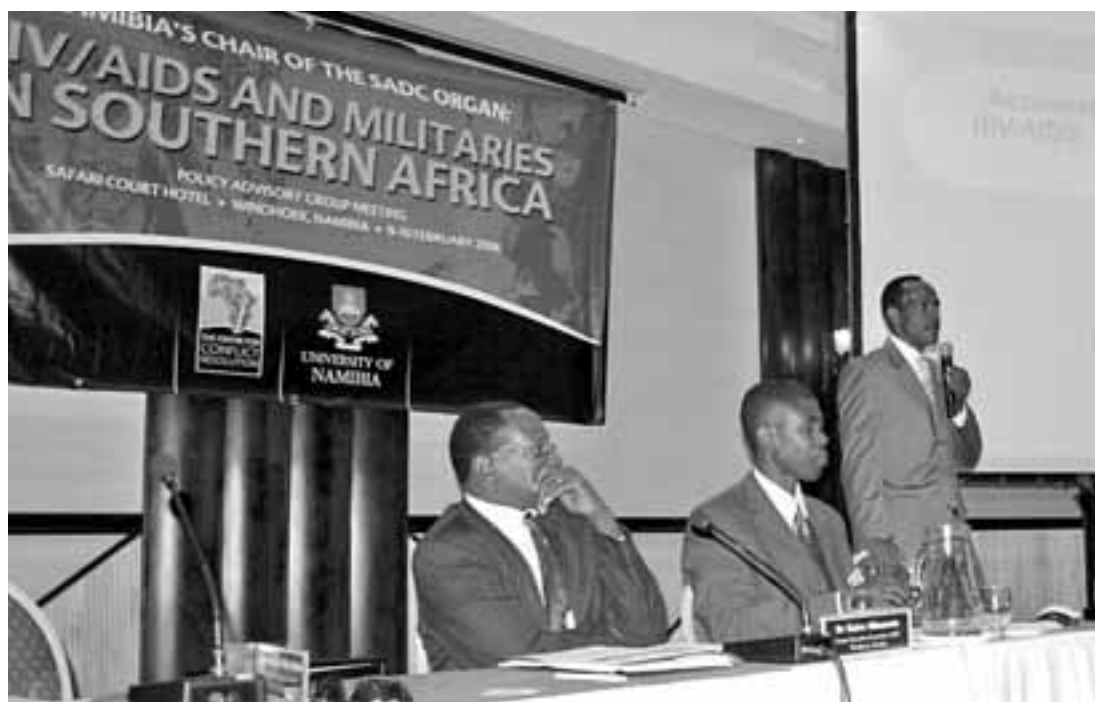
The LDF's home-based care programme was initiated in 1999 due to an increase in the number of HIV/AIDS patients that resulted in a shortage of hospital beds. The programme targets soldiers and their families, and has adopted a holistic approach to HIV/AIDS care, support and treatment. The home-based care programme is managed and administered by a team comprising the LDF's HIV/AIDS co-ordinator; a public health nurse; a physiotherapist; 15 counsellors; policymakers in the LDF; and the patient and his or her care-givers.

Home-based care is initiated following an assessment of the home environment. Hospital-bound patients are involved in devising a discharge plan. Once at home, a designated care-giver is expected to visit patients every Wednesday. A central aim of site visits is to address challenges from a holistic perspective. In addition to the bio-medical concerns regarding AIDS-related opportunistic infections (OIs), counsellors are involved in helping the family and community respond to the spiritual, mental, psychological and physical challenges posed by HIV/AIDS. If it becomes necessary, a transfer to a hospital is arranged. The LDF aims to support patients by involving family members and the community in multiple ways. This includes teaching problem-solving skills in the context of HIV/AIDS; making resources easily accessible and available; strengthening the existing referral system to ensure continuity of care from hospital to community; and exploring alternative models of community care. Between 1999 and 2004, 104 patients have been enrolled in the home-based care programme. The LDF reports a decline in the number of patients needing home-based care since the initiation of its ARV programme in 2004.

The LDF has identified a number of challenges for sustaining its HIV/AIDS programme, particularly its home-based care programme. These include a lack of counselling rooms; inadequate human resources; resistance within communities; and misconceptions about HIV/AIDS due to cultural beliefs. Most significantly, the LDF has limited resources for transportation and home-based care counsellors are unable to visit patients regularly. This last obstacle is a source of frustration for many of southern Africa's military HIV/AIDS programmes.

Tanzania³¹

Tanzania's HIV-prevalence rate is estimated to be 7 percent, although in urban centres such as Dar es Salaam, prevalence rates are as high as 11 percent. The Tanzanian People's Defence Force (TPDF) maintains a military hospital in Dar es Salaam and is accelerating its prevention, care and treatment programme. The TPDF's prevention services carries out a broad range of activities including voluntary counselling and testing, prevention of mother-to-child transmission programmes; advocacy seminars for commanders; and procurement and distribution of condoms. The TPDF also conducts HIV screening for its recruits, personnel and all troops before deployment outside the country.



From left: Dr Kaire Mbuende, former Executive Secretary, Southern African Development Community, Windhoek; Mr Salvator Niyonzima, Joint United Nations Programme on HIV/AIDS, Windhoek; Mr Benjamin Ofosu-Koranteng, United Nations Development Programme, Namibia

31 Col (Dr) Grayson Idinga, "Prevention, Care and Treatment of HIV/AIDS Patients in the Tanzanian People's Defence Forces", presentation at the CCR/UNAM policy advisory group seminar, *Namibia's Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa*, Windhoek, Namibia, 9 and 10 February 2006.

In October 2004, the Tanzanian ministry of health, the United States Agency for International Development (USAID) and US President George W Bush's Emergency Plan for AIDS Relief (PEPFAR) supported the funding of a military hospital for free ARV therapy. The TPDF adopted the ministry of health's 2002 and 2004 ARV guidelines, and offers second line medications for AIDS treatment at a military hospital in Dar es Salaam. A total of 1,500 individuals are currently enrolled in the programme which treats between 20 and 40 patients each day. Military personnel as well as their dependents are eligible for the treatment programme. Patients are placed on ARV therapy once their CD4 cell count is below 200 cells/uL or when they start exhibiting AIDS-related opportunistic infections. The TPDF hopes to establish two more treatment sites in its other hospitals by the end of 2006.

The medical community has emphasised the importance of anti-retroviral therapy adherence to guard against the emergence of a drug-resistant virus and the potential threat of such a virus being spread through sexual transmission. While early studies of adherence rates in resource-poor settings in Africa have shown good results, a variety of factors could reduce adherence. These include poverty; a lack of transportation to treatment centres; traditional constructs of HIV's origin and development; reliance on traditional medicine and remedies; HIV/AIDS stigma and discrimination; and gender inequality. The financial burden of costly ARV treatment can often result in irregular use of these drugs which must be taken consistently and permanently. Where free treatment is provided and healthcare is easily accessible, adherence rates can be as high as 90 percent.³² Other factors, such as awareness campaigns to reduce stigma and the dissemination of simple and accurate information about HIV transmission, may also help to encourage patient adherence to ARV therapy. The TPDF's treatment programme requires patients to undergo three sessions on understanding the importance of adherence before therapy is started. Patients are required to visit the hospital two weeks after beginning therapy. They then visit the hospital once a month and adherence sessions are conducted during each visit.

The TPDF's medical services include the following personnel to implement its HIV/AIDS programme: nine clinicians; 10 counsellors; five pharmacists; eight laboratory technicians; four home-based care staff; and eight support staff. All staff members (except the support staff) have undergone a six-day training course. These members are also responsible for other medical services and are therefore allotted a small fee for working beyond official hours. The programme has relied on USAID/PEPFAR for partial support of its training, procurement of laboratory chemicals, and adherence sessions for PLWHA. The government of Tanzania has relied on a Global Aids Fund grant to augment training and in order to establish a second voluntary counselling and testing centre. PharmAccess has facilitated the procurement of second-line AIDS drugs from Roche, Smith-Kline Beecham and Abbot pharmaceutical companies.

A number of challenges underline the need to develop durable and predictable sources of funding and paradoxical concerns about reducing the Tanzanian government's dependence on foreign donations. The TPDF reports that the dangers of staff burnout will require new measures to recruit, train and keep additional staff. In February 2006, the hospital in Dar es Salaam had only one FACS (CD4 cell count machine) and needed a standby machine; indeed the frequent breakdown of lab equipment poses a critical challenge. As with other military health services in the SADC sub-region, home-based care is a challenge. The TPDF has also experienced difficulties in procuring condoms, and reports a growing concern that the need to devote urgent attention to HIV/AIDS has drawn resources away from other diseases. A lack of research and meaningful data, due to inadequate human and financial resources and poor co-ordination with partners, have also undermined the effectiveness of the TPDF's early efforts to mitigate and manage HIV/AIDS.

32 D. Wilson and L. Fairall, "Challenges in Managing AIDS in South Africa", in S.S. Abdoul Karim and Q. Abdoul Karim (eds.), *HIV/AIDS in South Africa*, (Cambridge: Cambridge University Press, 2005), pp. 484 - 489.

Zimbabwe

SADC has established a Military Health Services Work Group under its Inter-State Defence and Security Committee (ISDSC) to address a broad range of military health issues in the sub-region.³³ The military health services group meets annually and was chaired by the government of Lesotho in 2006. The group made a number of observations about the role of SADC's militaries in addressing HIV/AIDS. The previous chair of the Work Group was Zimbabwe.

The HIV/AIDS pandemic has provided a new perspective on civil-military relations. Initially, HIV awareness and prevention programmes in many southern African militaries were introduced by external donors, which prescribed strategies that did not always reflect the characteristics of the military environment. Military officials viewed these external actors as needlessly pre-occupied with statistics and were concerned that they might compromise the security of their defence structures. External and internal civilian actors - including local civil society groups - viewed the military's unwillingness to share information about prevalence levels as unnecessary and frustrating. Human rights activists have criticised other issues such as the policy of mandatory testing.

More recently, southern Africa's defence structures have formulated their own responses to HIV/AIDS and have engaged in wider military-to-military partnerships at the sub-regional, continental and international levels. SADC countries are now more likely to engage with civil society actors to tackle common problems. Militaries have also promoted multi-sectoral HIV/AIDS programmes. For example, the Zimbabwe Public Services Commission and the Zimbabwe Defence Service Commission collaborate in devising national policies.

In undertaking these initiatives, defence forces have acknowledged that HIV/AIDS in southern Africa's militaries can be examined at the individual and organisational levels. Experts have noted that conversion to HIV-positive status is at a rate of between 3 and 55 percent in the first year of service, and that the vulnerability to STIs and HIV accelerates during service. Active-duty personnel diagnosed as HIV-positive are usually not discharged, but reassigned according to their levels of fitness. The length of deployment; type of accommodation; location of postings; availability of recreational spaces that are free from alcohol and other drugs; and continued prevention and behaviour-change programmes, all affect the rates of HIV infection. The ISDSC Work Group advocates addressing these conditions in all operational planning.

The Work Group has also noted that most southern African militaries are attempting to care for the dependents of military members in order to avoid a potentially disastrous situation in which service members with access to ARVs tend to share their treatment medications with family members who are unable to access treatment through public hospitals. Consequently, the Work Group strongly encourages the sub-region's militaries to provide treatment to members, their spouses and all dependents. The budgetary implications of this policy will strain military budgets throughout the sub-region, but nevertheless, a number of militaries have reported the positive effects of ARV therapy in conjunction with voluntary counseling and testing services. Furthermore, increased availability and prevention of mother-to-child transmission has helped to reduce infections as well as the stigma associated with HIV/AIDS.

33 This section is based on the presentation by Brig-Gen (Dr) G Gwinji, 'HIV/AIDS and the Military: What Works? Lessons on Prevention, Management and Treatment', at the CCR/UNAM policy advisory group seminar, 'Namibia's Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa', Windhoek, Namibia, 9 and 10 February 2006.

Broader lessons in HIV/AIDS management and mitigation are discernable here. Nutrition, stress and previous exposure to STIs can increase the level of HIV viral loads. Militaries should examine prospects for revising standard military ration scales and regulation diets in order to accommodate the needs of those infected with HIV. Military members also have to contend with the challenge of physical, emotional and mental stress due to intense physical training and combat. Uniformed personnel frequently manage this stress by resorting to alcohol and drug abuse, as well as casual sex with multiple partners, including sex workers. These indirect strategies are unsatisfactory in the short- and long-term. Alcohol and substance abuse increases the likelihood of unprotected sex, and casual sex with multiple partners accelerates the spread of HIV and other STIs. Militaries in southern Africa must therefore acknowledge the negative impacts of these behaviours in order to enhance HIV-prevention programmes and reduce rates of HIV transmission. The ZDF military health service has also emphasised the critical need to bolster the capacity of HIV/AIDS health professionals to carry out action-based research.

Gender and the Military

The gendered dimensions of HIV/AIDS are critically important to militaries in southern Africa. A number of the sub-region's defence forces, including the Zimbabwe Defence Force (ZDF), the Namibian Defence Force (NDF), and the South African National Defence Force (SANDF) have incorporated former liberation armies. Contrary to the structure of colonial militaries, women played important roles in liberation struggles as cadets and officers and became part of national defence forces after liberation. While several governments have established legal instruments to protect and promote the equal rights of women, lingering cultural and societal norms have entrenched the subordination of women and the domination of men in military structures. The Zimbabwe Army



The Hon Victor Simunje,
Deputy Minister of Defence, Windhoek



Dr Kaire Mbuende, former Executive Secretary, Southern African Development Community, Windhoek, left; and Mr Tomaz Augusto Salomão, Executive Secretary, Southern African Development Community, Gaborone

Wives and Women's Association (ZAWWA) was thus established to integrate the views of female soldiers and the spouses of the ZDF's serving members into policy-formulation and social organisation. ZAWWA's input in the military's fight against HIV/AIDS has been instrumental in designing effective programmes.

Through ZAWWA, the ZDF has noted that existing strategies for HIV/AIDS management and mitigation have prompted a review of the experiences of gender relations in its military.³⁴ There are six important dimensions of this issue. First, women's social and sexual identities are, at worst, demeaning and, at best, disempowering. Women are viewed, by some, as ineffectual "maidens of beauty" to be pursued by assertive men; their power to negotiate sex is nominal; and stereotypes promote the view that when a woman says "no" to sex, she really means yes. Second, women in the Zimbabwean military have observed that HIV/AIDS awareness campaigns were originally targeted at men who may not have shared information about prevention with their sexual partners. Third, the male condom was described as disadvantageous to women in the military. Male condoms require co-operation from men, and women are often unable to force their partners to wear them. The female condom is not widely publicised as an alternative to the male condom. It is in short supply; expensive; restricts sexual foreplay; and is thus not popular with male partners. Fourth, women serving in the Zimbabwean military also reported that the rank structure of the armed forces places most women in subordinate positions. Accordingly, there is an overwhelming fear that reporting sexual harassment and sexual abuse would hinder professional advancement. Fifth, long periods of deployment have a gendered dynamic: men tend to find alternative sexual partners either through consensual relationships or commercial sex workers, yet, as a result of cultural taboos, women soldiers often refrain from these sexual practices. Finally, the economic power gained from allowances for deployed troops encourages men in the Zimbabwean military to visit sex workers.

Gender issues should be incorporated into the planning of the SADC standby brigade of the African Standby Force, and in the formulation of a southern African HIV/AIDS policy. A number of policy proposals emanating from women's experiences in the ZDF were recommended for adoption by SADC governments. It is critical to dismantle gender stereotypes and to educate military personnel about the impact of negative stereotyping. SADC's HIV/AIDS awareness campaigns should be designed to target men and women - including spouses - in order to increase knowledge about HIV and STIs. There is also a need to popularise and distribute male and female condoms equally.

Future deployment of southern African troops should further address the culture of impunity for sexual exploitation within the military as well as the civilian population. Strict and transparent sexual harassment and abuse policies should be in place. Similarly, efforts should be made to increase the role of women in decision-making and policy development for the sub-regional brigade. Remuneration for deployment should be monitored, with a percentage of each soldier's allowance sent home routinely in order to decrease their reliance on commercial sex workers during missions. Simultaneously, it would be useful to consider implementing measures to reduce or regulate the proximity of commercial sex workers to military installations. As the cases of Namibia, Lesotho, Tanzania and Zimbabwe show, countries within the SADC sub-region have instituted important HIV/AIDS management and mitigation strategies. Twelve of the challenges they face are:

34 Col Gertrude Mutasa, "HIV/AIDS and Women in the Military in Zimbabwe: A Review of Response Activities Hitherto", presentation at the CCR/UNAM policy advisory group seminar, *Namibia's Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa*, Windhoek, Namibia, 9 and 10 February 2006.

- Implementing troop-level HIV/AIDS education and behaviour change communication strategies;
- Increasing testing of all military personnel;
- Nurturing value-based life-style and decision-making skills;
- Providing prevention training for HIV testing and counseling staff;
- Securing and maintaining medical infrastructure and equipment for HIV management;
- Facilitating home-based care for military personnel and their dependents;
- Strengthening traditional leadership for HIV prevention and addressing AIDS-related illnesses;
- Supporting vulnerable communities (the elderly, widows, women and girl children) as well as people living with HIV/AIDS;
- Scaling up healthcare capacities and systems;
- Utilising international support for accelerating access to treatment;
- Managing treatment regimens during service; and
- Planning contingent responses to imminent treatment challenges.



From left: Major-General Solly Mollo, South African Ministry of Defence, Tshwane; Dr Kaire Mbuende, former Executive Secretary of the Southern African Development Community (SADC), Windhoek; Ms Victoria Lonje, Alliance of Mayors' Initiative for Community Action Against HIV/AIDS at Local Level, Windhoek



Ms Anne Anamela, Development Co-operation Ireland, South Africa



Ms Nadira Omarjee, People Opposing Women Abuse, Johannesburg

4. Halting the HIV/AIDS Pandemic: Sub-Regional Approaches

The Role of the SADC Secretariat ³⁵

Ultimately, SADC's political commitments will fall to member states for implementation. The SADC secretariat, based in Gaborone, Botswana, is responsible for translating the organisation's political will into action. The SADC secretariat is focusing its activities on facilitating the harmonisation of southern Africa's HIV/AIDS policies; establishing a mechanism for monitoring and evaluation; and assisting member states in their efforts to address HIV/AIDS. At the country level, SADC supports the policy of addressing HIV/AIDS through a national framework.

The head of SADC's unit, Dr Antonica Hembe, noted that an important aim of prevention and mobilisation activities within southern Africa is to put in place national strategies that consider ways of utilising the uniformed services to strengthen awareness and prevention initiatives. The secretariat promotes the UNAIDS Three-Ones (3 Ones) principle, which is that all countries should have one AIDS strategic plan, one national AIDS co-ordinating body, and one national monitoring and evaluation system. All 14 SADC countries have adopted the 3 Ones policy, which will facilitate their national responses and harmonisation.

The SADC secretariat has developed a business plan to operationalise the 2003 Maseru Declaration which is carried out co-operatively among member states, donor partners and the secretariat's HIV/AIDS unit.³⁶ The five priority areas of the Maseru Declaration which require urgent attention are: prevention and social mobilisation; care, treatment and support; development and mitigation; resource mobilisation; and monitoring and evaluation. SADC's HIV/AIDS unit has developed guidelines and a framework for sub-regional monitoring and evaluation. It has also designed indicators to monitor HIV responses, including among uniformed services in SADC countries, and has mobilised funding for operationalising the framework for the military service sector. The unit will further undertake activities to collect data for a sub-regional analysis on uniformed services.³⁷

SADC's HIV/AIDS unit is also supporting 14 southern African NGOs through pilot programmes for the management and mitigation of HIV/AIDS. The budget for these pilot programmes exceeds \$15 million and is provided by the United Kingdom's Department for International Development (DFID) and the European Union (EU). The unit is also taking steps, with the support of its external partners, to harmonise regulations on AIDS medicines.

SADC's progress since 2003 has included the following five initiatives:

- The development of an HIV-mainstreaming framework;
- The design of instruments for mainstreaming HIV in environmental impact assessments;
- The provision of support to the University of Botswana for mainstreaming HIV/AIDS issues into water resources management;
- The establishment of an annual forum for southern Africa's national AIDS authorities; and
- The creation of an ethics and principles forum for SADC editors.

³⁵ Antonica Hembe, "Halting the HIV/AIDS Pandemic: The Role of SADC", presentation at the CCR/UNAM policy advisory group seminar, *Namibia's Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa*, Windhoek, Namibia, 9 and 10 February 2006.

³⁶ SADC, *SADC HIV and AIDS Business Plan: Strategic 5-Year Business Plan 2005 - 2009*, Gaborone, Botswana, November 2004.

³⁷ SADC, *SADC Framework for HIV and AIDS Mainstreaming*, Gaborone, Botswana, July 2005.

The SADC HIV/AIDS unit has presented member states with a model called "Circles of Support" for the care, support and education of HIV/AIDS orphans and other vulnerable children. Further, the unit is working to strengthen southern Africa's network of people living with HIV/AIDS and networks of healthcare workers such as nurses and midwives. As part of its efforts to facilitate these technical networks, the SADC secretariat convened a partners forum in April 2006 and is establishing a regional database.

Although financial and human resources for HIV/AIDS management and mitigation have increased in the last five years, programmes and initiatives are still grossly under-funded. SADC has committed itself to mobilising funds for southern Africa's response to HIV/AIDS. A preliminary assessment of the SADC Regional Fund for HIV/AIDS has been conducted. South Africa has contributed a million Rand and Swaziland has also made a pledge to the fund. In order to support its HIV/AIDS business plan, the SADC secretariat entered into a Joint Finance Technical Co-operative Agreement (JFTCA) in 2004 with four international donor partners for \$5.3 million. It was noted that the African Development Bank (ADB) has agreed, in principle, to lend \$30 million to SADC to address HIV/AIDS, tuberculosis and malaria. While resource mobilisation for national programmes is critical, the AU and SADC should increase their advocacy initiatives for Africa's HIV/AIDS response with the Global Aids Fund and bilateral donors.

There are significant constraints and challenges for the implementation of the Maseru Declaration. Communication between the SADC secretariat and member states needs to be strengthened. Best practices for HIV/AIDS management and mitigation are still relatively unexamined. The SADC secretariat needs information about effective initiatives for preventing mother-to-child transmission; providing voluntary counselling and testing and ARV therapy; and improving nutrition. The central challenge is how to scale up existing successes across all sectors in southern Africa. Additionally, scaling up the response to HIV/AIDS will require enhanced co-ordination. The SADC secretariat is still relatively under-staffed. The head of its HIV/AIDS unit is not permanently contracted and the unit relies on consultants paid by donor funding to undertake most of its work. Furthermore, while monitoring and evaluation has been identified as a priority, there are few tools to measure the progress of the unit or to identify advancements in HIV/AIDS management and mitigation efforts initiated through the operationalisation of the Maseru Declaration. The SADC secretariat plans to launch a monitoring tool and an annual report on the state of HIV/AIDS in 2006. Concurrently, SADC is drafting guidelines for conducting household-based population surveys on HIV/AIDS for use in southern African countries.



ABOVE: Dr Antonica Hembe, Southern African Development Community, Gaborone

LEFT: Mr Theo-Ben Gurirab, National Assembly of Namibia, Windhoek

5. Accelerating the Response to HIV/AIDS: The Role of the UN

The UN and Local Networks: AMICAALL

In contributing to the debate towards the development of a common, people-centred policy for SADC, the case study of the Alliance of Mayors' Initiative for Community Action Against HIV/AIDS at Local Level (AMICAALL) provided some useful insights to the Windhoek policy meeting. The organisation is a network of local government authorities, municipal leaders and mayors whose objective is to develop and implement HIV/AIDS intervention programmes for urban dwellers. AMICAALL provides a platform for local stakeholders to work towards reducing the social and economic impacts of HIV/AIDS in urban communities in 13 African countries. Its strategies emphasise a holistic approach and incorporate the perspectives of local communities and policymakers in order to develop tools that are adaptable to the needs of individual communities. The strength of AMICAALL's strategies is the active involvement of local communities in its work. HIV/AIDS thus becomes the personal responsibility of every individual in the community. It is critical for individuals to be HIV/AIDS-"competent" and to be acquainted with their rights and responsibilities in regard to access to prevention, treatment, care and support.³⁸ As the healthcare systems in many SADC countries buckle under the burden of the pandemic, the responsibility to provide care and support to AIDS patients has often been transferred to families under the home-based care system. With the pandemic not showing signs of abating, the possibility of integrating home-based care initiatives into mainstream HIV/AIDS mitigation strategies must be seriously considered. This raised a critical issue in terms of the allocation and utilisation of resources. Families and communities may not be equipped in terms of resources and expertise to shoulder this burden. Contrary to the general perception that military personnel are financially secure, most recruits are, in fact, from poor communities that are unable to provide basic care for their terminally-ill relatives once they are dismissed from official duty.

AMICAALL's work and other initiatives across Africa suggest that financial resources to combat HIV/AIDS are, in fact, available, particularly with the increasing number of commitments that have been made by various international actors. Proper utilisation of resources requires further interrogation, and highlights the importance of effectively managing resources.

The presentation by AMICAALL highlighted four key challenges:

- The importance of strategic planning when disbursement of funds from donors is unpredictable;
- The need to correct poor absorption of funds which also hinges on lack of planning;
- An unclear division of roles and responsibilities of the various players; and
- The lack of a transparent monitoring and evaluation mechanism.

Although these shortcomings were discussed within the context of AMICAALL's strategies, they are generic and can be utilised to inform SADC's policies.

38 *HIV/AIDS and Human Security: An Agenda for Africa*, CCR Policy Advisory Group Report, Addis Ababa, 9 and 10 September 2005 (available at ccrweb.ccruct.ac.za).

The UN Development Programme

The UN Development Programme views HIV/AIDS as an “unprecedented development and leadership crisis”. HIV/AIDS reverses human development gains; kills people in their most productive years; entrenches poverty; erodes governance capacity to provide services; deepens gender inequalities; and corrodes social cohesion.

In 2000, the UNDP established regional projects on HIV and development in Dakar, Senegal, and Tshwane, South Africa. The agency initially focused on three areas: political activity through the UNDP’s Human Development Report and other research; capacity-building for impact assessments within selected sectors; and the development of instruments and tools for HIV mainstreaming and supporting the formulation of national strategic plans on HIV/AIDS. In response to the Maseru Declaration, the Abuja Declaration and UNGASS, the UNDP has redefined its policies on HIV/AIDS and is applying its lessons from previous activities in Africa and beyond. The UNDP notes that less attention has been paid to the socio-economic causes that exacerbate the spread of HIV such as inequality, the lack of access to sanitation, water and housing. Governments will not be able to mitigate the impact of HIV/AIDS effectively without mainstreaming HIV/AIDS; establishing an enabling economic climate for poverty reduction; accessing global markets and increasing trade; and developing the resources and infrastructure for universal access to ARVs. These challenges will take time to overcome.

Nevertheless, the UNDP is advocating change in a number of areas. First, the organisation has prioritised the mainstreaming of HIV/AIDS into national programmes and strategies, including poverty reduction strategy papers (PRSPs). Second, in order to guide financing for the HIV/AIDS response, the UNDP is supporting efforts to cost and budget for HIV/AIDS in macro-economic policies. Third, in terms of trade and the World Trade Organisation’s (WTO) TRIPS (Trade-Related Intellectual Property Rights) clause and access to treatment, the UNDP is sponsoring African efforts to strengthen their negotiating capacity in multilateral, regional and bilateral trade negotiations, and promoting South-South co-operation for importation and production of low-cost quality ARVs. The drive to manufacture AIDS drugs must be mediated by lessons from the past: African governments have, for example, not taken steps to manufacture condoms, despite their documented importance to preventing the spread of HIV.

The Joint United Nations Programme on HIV/AIDS (UNAIDS)

The activities of UNAIDS operate in tandem with Africa’s continental, sub-regional and national HIV/AIDS management and mitigation initiatives. At the continental level, UNAIDS supports the work of the AU as it monitors the implementation of the Abuja Declaration and the AU Commission’s Strategic Plan. UNAIDS is also working at the sub-regional level with RECs under the framework of the Maseru Declaration, the Great Lakes Initiative (GLIA) in Central Africa, and the activities of ECOWAS. UNAIDS is working with SADC’s Inter-State Defence and Security Committee to help harmonise the sub-region’s programmes and policies.³⁹ The UN’s support to national governments, however, remain central to UNAIDS’ mission. UNAIDS’ most important role is its leadership and advocacy role for an effective response to HIV/AIDS. As an umbrella programme, UNAIDS brings together the

39 UNAIDS, Office of AIDS, Security and Humanitarian Response, Progress Report, Addis Ababa, Ethiopia, July 2005, p. 4.

capacities of 10 UN organisations and a secretariat around a common agenda on AIDS. The UNAIDS secretariat, based in Geneva, Switzerland, provides information, and facilitates knowledge-sharing, co-ordination, advocacy and monitoring and evaluation. The division of labour and co-ordination on HIV/AIDS among UN organisations demonstrates how HIV/AIDS can be mainstreamed or embraced by a range of institutions and actors.⁴⁰ As a development partner, UNAIDS provides tracking and monitoring assistance, and continues to mobilise political, technical and financial resources. It also engages civil society organisations in country-driven approaches. The programme further promotes the 3 Ones policy.

Since July 2000, in response to UN Security Council Resolution 1308, UNAIDS' Office on AIDS, Security and Humanitarian Response has been working with the UN Department of Peacekeeping Operations to implement an integrated approach to AIDS and security. Six years later, each major UN peacekeeping operation has a full-time AIDS advisor, supported by trainers and counsellors, while all smaller missions have an AIDS focal point. Half of the UN's current 17 peacekeeping missions are in Africa. Actions undertaken by these key personnel include awareness training for behaviour-change before deployment and during missions; the promotion and provision of condoms; voluntary counselling and testing services; the provision of post-exposure prophylaxis kits; and outreach to local communities. UNAIDS and DPKO have also demonstrated that AIDS can be mainstreamed into overall peacekeeping strategies, and peacekeepers can play a positive role as HIV/AIDS champions. In the Democratic Republic of the Congo, peacekeepers have organised World AIDS Day events with local community AIDS groups; in Sudan, the UN mission is developing strategies for involving AIDS activists as part of its disarmament, demobilisation and re-integration programme; while in Côte d'Ivoire, the UNAIDS advisor is seeking to integrate AIDS prevention into rule-of-law prison programmes.⁴¹

In the course of its work, UNAIDS has identified key challenges for integrating HIV/AIDS into defence structures. Significant among these is the challenge of generating durable and adequate levels of human and financial resources for defence structures to provide HIV/AIDS prevention; voluntary counselling and testing; and care and support. UNAIDS is particularly concerned with the importance of voluntary counselling and testing, and inculcating a culture of HIV/AIDS awareness into militaries. A second challenge is to ensure consistency with the implementation of HIV/AIDS programmes in Africa. In the midst of conflicts, and in sub-regions that are poorly resourced, like southern Africa, or where there is no political will, the vulnerability of troops and civilians to HIV/AIDS multiplies.

40 The UN Development Programme (UNDP); the World Health Organisation (WHO); the International Labour Organisation (ILO); the UN Population Fund (UNFPA); the UN Children's Fund (UNICEF); the UN Educational, Scientific and Cultural Organisation (UNESCO); the UN Organisation for Drug Control (UNODC); the World Food Programme (WFP); and the Office of the UN High Commissioner for Refugees (UNHCR) are the core member agencies of UNAIDS. The World Bank has integrated HIV/AIDS into its support for national and sectoral planning, financial management and infrastructure development.

41 UNAIDS, *On the Frontline: A Review of Policies and Programmes to Address AIDS among Peacekeepers and Uniformed Services*. (Geneva: UNAIDS, 2005), p. 24.

6. Southern Africa's Framework for Security: Constraints and Limitations for including HIV/AIDS

As SADC and the AU begin to implement their strategic plans for HIV/AIDS, two key issues will have to be addressed. Both the RECs and the AU have critical resource limitations. SADC faces a shortage of relevant expertise, as well as human and financial resources. The SADC secretariat is struggling with the implementation of SIPO and the RISDP, which urgently need to be further developed into coherent, practical and complementary strategies for implementation. The AU's Department of Social Affairs - which has approximately six professional staff - is also expected to implement the AU's initiatives related to population and development; migration issues; health and nutrition; the social welfare of vulnerable or disadvantaged groups; children; adolescents; the disabled and the aged; the promotion of sports; scouting and family life; drug control and crime prevention; and the promotion of African art and culture.

External linkages and partnerships with civil society are important in order to support SADC and the AU to ensure that HIV/AIDS is effectively addressed in their work. Moreover, there may be untapped resources, strategies and opportunities for synchronising HIV/AIDS initiatives with a broader human security agenda, which will subsequently provide additional operational capacity. Commitment is needed from all stakeholders in order to maximise opportunities for such collaboration.

Another shortcoming related to efforts to develop a common SADC policy on HIV/AIDS management in the defence and security sectors is the ability to sustain political will and action. Both SADC and the AU are organisations governed by their member states. Each body is constrained by the many, and at times, conflicting interests of governments. In turn, governments frequently have to contend with multiple challenges related to economic development and poverty; democratisation and "good" governance, and trade and free movement of peoples and goods; the environment and food security, as well as peace and security. These obligations sometimes pull governments in various directions, yet they are also critical to human security. Moreover, because HIV/AIDS has historically been relegated to the social and health sectors, a multi-sectoral response has only recently emerged as the preferred strategy for combating the pandemic. These limitations affect the capacity of states to translate continental and sub-regional commitments into national frameworks. Dynamics at the national level also continue to slow the implementation of these commitments: various ministries and other governance structures such as parliaments and the judiciary may not be adequately informed or empowered to implement legal frameworks.

Further constraints such as Africa's economic marginalisation and a heavy external debt burden of \$290 billion have also limited the continent's response to HIV/AIDS. Consequently, implementation of a continental AIDS advocacy and harmonisation programme will need sustained political will and resources. Various factors must also be urgently addressed in the fight against HIV/AIDS. For example, the production of AIDS treatments and the price of drugs, disputes over patent laws and the clash over the promotion of abstinence vs. faithfulness and condom-use in prevention programmes are examples of the politics of AIDS. Unresolved tensions at the national level will ultimately shape sub-regional and continental approaches to managing and mitigating HIV/AIDS.

7. Conclusion – The Way Forward

The implications of HIV/AIDS for security in southern Africa will continue to emerge over the next century. The sub-region is faced with a daunting challenge: mitigating the impact of HIV/AIDS while establishing new institutions for development, democratisation and peace. The Windhoek advisory group strongly urged SADC's member states to begin the process for integrating HIV/AIDS into their defence and security architecture. Several key strategies for undertaking a broad partnership with southern African militaries and governments; civil society actors and the academic community; people infected and affected by HIV/AIDS; the United Nations and donor partners were outlined.

Policy Recommendations

The discussions at the Windhoek seminar resulted in 11 key policy recommendations:

1. **Enriching SADC's Policy Framework on HIV/AIDS and Security:** HIV/AIDS has been declared a threat to security and development by SADC's member states. However, the organisation's key policies do not establish adequate implementing mechanisms. While the Strategic Indicative Plan for the Organ on Politics, Security and Defence Co-operation (SIPO) fails to define coherent activities for addressing the security implications of HIV/AIDS, decision-makers should enhance the document and establish a process for establishing a southern African common policy on HIV/AIDS and security.
2. **SADC and the African Standby Brigade:** Despite the absence of precise figures on the prevalence of HIV/AIDS in SADC militaries, the generally high levels of HIV within southern Africa, and the likelihood that HIV infection rates could be higher among the uniformed services, warrant thoughtful yet urgent action. HIV/AIDS has implications for the overall security of citizens and states. Plans to establish a SADC standby brigade for the African Standby Force could be compromised by weakened militaries across southern Africa. An action plan on HIV/AIDS and militaries in Africa is thus imperative. The experiences of UNAIDS in its collaboration with the UN Department of Peacekeeping Operations (DPKO) to implement an integrated approach to peacekeeping can provide useful learning experiences for SADC and the AU. Moreover, the best practices of SADC militaries regarding HIV/AIDS prevention, care, support and treatment should be examined and integrated into the guidelines for the SADC standby brigade.
3. **The AU and RECs:** Africa's RECs have assumed a critical role as the building blocks for the AU's peace and security agenda. The AU's Abuja Declaration on HIV/AIDS and its HIV/AIDS Strategic Plan of 2005-2007 further acknowledge the indispensable role of RECs in these initiatives. The RECs are critical to translating the continental HIV/AIDS initiatives at the sub-regional level. There is an urgent need for the AU and the RECs to outline clearly their respective roles, particularly since other AU organs such as the Pan-African Parliament (PAP), the Peace and Security Council (PSC) and the Economic, Social and Cultural Council (ECOSOCC) will also be involved in HIV/AIDS initiatives.

4. **SADC Co-ordination of a Common Policy:** At the country level, SADC supports the policy of addressing HIV/AIDS through national frameworks. The SADC secretariat in Gaborone, Botswana, promotes the UNAIDS Three-Ones (3 Ones) principle whereby all countries should have one AIDS strategic plan, one national AIDS co-ordinating body, and one national monitoring and evaluation system. All the SADC countries have adopted the 3 Ones policy. The development of a common SADC policy for HIV/AIDS and militaries should consider how to leverage the 3 Ones framework in future.
5. **Establishing a Consultative Forum on a SADC HIV/AIDS and Military Policy:** A southern African common policy on HIV/AIDS and security would ideally focus on strengthening the HIV/AIDS management and mitigation programmes of member states. The sub-region's governments will have to engage in a consultative process to assess common needs and responses, examine "best practices", and articulate a common approach for collective operations. Already, the SADC Inter-State Defence and Security Committee's (ISDSC) Military Health Services Work Group meets annually to address a broad range of military health issues in the sub-region. This Work Group should be strengthened and perhaps convened to begin the technical aspects of formulating a common policy on HIV/AIDS and the military. SADC governments should also include the following issues in the development of their HIV/AIDS policies: the budgetary implications for defence structures as a result of HIV/AIDS programmes, and the division of labour among SADC, the AU and the UN in devising a holistic HIV/AIDS programme for African peacekeeping operations.
6. **The Role of Soldiers in HIV Prevention:** An important aim of prevention and mobilisation activities within southern Africa is to put in place national strategies that consider ways of utilising the uniformed services to strengthen HIV/AIDS awareness and prevention initiatives. The UNAIDS experience shows that soldiers can be champions of safer-sex and can carry HIV-prevention messages to local populations. Moreover, community support and care for soldiers suffering from AIDS-related illnesses would be enhanced as a result of positive interaction between militaries and civilian populations. SADC militaries and governments should strive to implement military-civilian initiatives which encourage their troops to provide guidance on HIV prevention. Examples include mentorship programmes, fundraising activities and various community service programmes.
7. **Gender and the Military:** The gendered dimensions of HIV/AIDS are critically important to militaries in southern Africa. The sub-region's HIV/AIDS awareness campaigns should be designed to target men and women - including spouses. They should aim to increase knowledge about HIV and Sexually-Transmitted Infections (STIs) and to popularise and distribute male and female condoms equally. Future deployment of southern African troops should address the culture of impunity that prevails regarding sexual exploitation within the military as well as the civilian population. Strict and transparent policies that outlaw sexual harassment and abuse should also be put in place or strengthened. Similarly, efforts should be made to increase the role of women in decision-making and policy development for SADC's sub-regional brigade. Remuneration for deployment on peace operations should be monitored, with a percentage of each soldier's allowance sent home routinely in order to decrease the reliance on commercial sex workers during missions. Simultaneously, it would be useful to consider reducing or regulating the proximity of commercial sex workers to military installations.

8. **Mandatory Testing:** The policy of mandatory testing and routine HIV screening in the military poses important questions about the human rights of people living with HIV/AIDS. Due to the nature of their organisational missions, defence forces must maintain records of the fitness levels of their soldiers and officers. As a result, many armed forces have included HIV screening in their routine and mandatory health examinations. Yet, in all sectors, the stigma attached to HIV/AIDS has led to discrimination against people living with HIV/AIDS. A SADC policy on mandatory testing should be developed, in partnership with people living with HIV/AIDS, and efforts to ensure that militaries protect the human rights of HIV-positive soldiers and their families should also be simultaneously developed and implemented. UNAIDS and a number of the sub-region's militaries argue that voluntary counselling and testing help to counteract HIV/AIDS stigma; activities which promote voluntary counselling and testing such as "Know Your Status" campaigns can be implemented to address this issue.
9. **Home-Based Care:** As the healthcare systems in many SADC countries buckle under the burden of the pandemic, the responsibility to provide care and support to AIDS patients has often been transferred to families. The reality, however, is that most military recruits come from poor communities that are unable to provide basic care for their terminally-ill relatives who are dismissed from official duty. Military home-based care programmes must therefore be scaled up. This would include mobilising human and financial resources to provide transportation for site visits, the provision of psycho-social and spiritual counselling, nutritional support, the administration of referrals and the teaching of problem-solving skills.
10. **ARV Therapy Provision and Adherence:** Medical science shows the need for diligent adherence to highly active anti-retroviral therapy (HAART) to guard against the development of multi-drug resistance and the potential threat of drug-resistant virus strains. While early studies of adherence rates in resource-poor settings in Africa have shown good results, a variety of factors could reduce adherence. These include poverty; lack of transportation to treatment centres; traditional constructs of the origin and development of HIV; reliance on traditional medicine and remedies; HIV/AIDS stigma and discrimination; and gender inequality. There is a need to investigate the specific challenges faced by soldiers who are taking anti-retroviral (ARV) therapy while deployed on peacekeeping missions or in other service. In the meantime, SADC governments should replicate the best practices of existing treatment programmes which provide nutritional support; require patients to undergo multiple adherence-counselling sessions before therapy is started; encourage patients to partner with a family member or friend who monitors their adherence; and expect patients to attend counselling sessions regularly.
- ii. **Effective Use of Resources:** SADC, UNDP and UNAIDS are engaging in negotiations to increase the financial resources for southern Africa's fight against HIV/AIDS. SADC's Maseru Declaration of 2003 called for the establishment of a Regional Fund to address the HIV/AIDS emergency. A preliminary feasibility assessment of such a fund has been conducted. Despite an increase in financial and human resources for HIV/AIDS management and mitigation in the last five years, programmes and initiatives are still grossly under-funded and SADC governments must increase their contributions to these initiatives. Future efforts to mobilise funds must be concerted and co-ordinated. Moreover, SADC states must establish transparent and effective practices for managing existing resources, which often do not reach local communities. Implementing mechanisms must have clear, measurable objectives and utilise meaningful planning and monitoring and evaluation systems.

Annex I

Welcoming Remarks

The Honourable Major-General (Ret) Charles Namoloh
Minister of Defence, Republic of Namibia

This seminar, *“Namibia’s Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa”*, is a follow-up to the one held here in Windhoek on 23 November 2005, exactly 71 days ago. During that seminar the government of the Republic of Namibia requested the organisers to sponsor another one aimed at examining prospects for strengthening southern Africa’s response to HIV/AIDS in the defence and security sectors. This is the reason why we are here today.

It is a well-known fact that the SADC region is affected by the HIV/AIDS pandemic. In fact, statistics show that it is the most affected region in the world. It is also a fact that military personnel, being part and parcel of the general population, are no exception to the problems affecting the general public. Due to the way the military operates, such as staying away from their families for long periods, they become more vulnerable to the pandemic than the general population.

As a result, the rate of infection in the military is higher than in other professions. When they succumb to the pandemic, their dependants are the first to suffer since in most cases they are the only breadwinners in a typical large African family. Given the importance of their responsibility in their respective nations, the impact does not only affect their immediate families but the whole defence and security system of their respective countries.

When the physical fitness of a force is compromised to a large extent, the element of deterrence is also negatively affected. This creates a window of security vulnerability which could be exploited by adversaries. It creates, therefore, conditions for conflicts, which affect human security, another condition where displaced people and refugees can become more vulnerable to infection, hunger and disease. In this way, a vicious cycle is created and repeated. The possibility of this happening in SADC is, however, remote, given the confidence-building mechanism we have put in place. This is only a worst-case scenario.

It is therefore imperative that we need to adopt a comprehensive total strategy of survival or otherwise we will perish like fools. We know where we are and where we want to be – a state of security and stability free of violence and pandemics. It is our intention that gatherings such as this one will contribute to the conceptualisation of a southern Africa framework for addressing the impact of HIV/AIDS on defence and security.

In my view, our problems in identifying what is to be done lie in how to get where we want to be. Often we have been criticised that our plans are too broad and too general. We therefore need to heed that constructive criticism and come up with workable plans. We should explore all possible avenues and discuss in depth to find solutions. No idea is too simple to be heard.

That is why this seminar has brought together academics, experts and senior military officers from the SADC region, other regions and non-governmental organisations in order to share ideas and experiences with regard to HIV/AIDS. The ultimate aim is to produce policy recommendations that may be used to develop a SADC common policy on HIV/AIDS management in the defence and security sector.

When I discussed the HIV/AIDS pandemic with a colleague of mine, he suggested that awareness campaigns are the cornerstone for fighting HIV/AIDS, but it should move from mere discussions to include showing real pictures of people infected by HIV/AIDS. This can be shown, he said, on TVs and using mobile cinemas in rural areas where people have no access to TV. He based his argument on a Chinese phrase “one picture is worth a thousand words”. He strongly believes that real visual aids are more useful than drama, which he said in many languages means a play and therefore is not taken seriously.

Whether his idea is workable remains to be seen, but I believe such small ideas need to be discussed. I hope during our deliberation we will brainstorm some of these issues in order to come up with workable solutions which will help to reduce the impact of this scourge.

SADC member states have committed themselves to integration and co-operation in the political, economic, social and security sectors. Our vision as SADC is enshrined in policy documents such as the SADC HIV/AIDS Strategic Framework and Plan of Action 2003 – 2007, the SADC Strategic Indicative Plan of the Organ (SIPO) and the Regional Indicative Strategic Development Plan (RISDP). These groundbreaking documents are the blueprints for a holistic approach to ensuring the safety, security and wellbeing of southern Africans. They are only road maps with signposts. They should not therefore be treated as holy cows but they should be enriched and adopt the ever-changing reality of the situation.

Let me therefore take this opportunity to thank the sponsors- the Centre for Conflict Resolution and UNAM - for their kind and prompt response to our request. This shows their concerns about the problems affecting us. Let me also thank all those who have contributed one way or another to making this meeting happen. To the esteemed participants, thank you for coming to share your knowledge and rich experience with us.

Annex II

Opening Remarks

Mr Tomaz Augusto Salomão

Executive Secretary, Southern African Development Community (SADC)

Allow me to express my sincere appreciation to the government of Namibia for having agreed to host this important meeting in this beautiful city of Windhoek, the capital of the Republic of Namibia. Our presence in this room is a confirmation of the commitment and the political leadership to addressing the epidemic, which continues to be a threat to our developmental efforts, to our regional security and to the very survival of our communities as well as families.

As you are all aware, SADC is at the epicentre of the HIV and AIDS pandemic. The number of new infections, illnesses and deaths are still rising at an alarming rate. This has been exacerbated by the combination of poverty and HIV infection which renders most people vulnerable, and with a loss of hope.

Sub-Saharan Africa has just over 10 percent of the world's population, but is home to more than 60 percent of all people living with HIV - 25.8 million. In 2005, an estimated 3.2 million people in the region became newly infected, while 2.4 million adults and children died of AIDS. The diverse factors of vulnerability present in the region include population mobility, poverty, political instability, economic and social change within societies with large numbers of young people and where stigma and discrimination against people living with HIV and marginalised populations are still very much present.

These aspects of vulnerability that are linked to individual behaviour are not always easy to address in this region, but we must find ways to address them and find appropriate solutions that are adapted to the local context. We need to begin to plan for a long-term response, ensuring the overall sustainability of resources and services for both civil society and the uniformed services.

This implies that, for SADC member states, there is no moment to relax, but instead to engage earnestly among ourselves with strategies and options for prevention and mitigating the adverse impacts of HIV and AIDS.

This forum will provide space for the military authorities to share experiences, best practices for HIV and AIDS management and mitigation strategies from a military perspective, and also promote an informed discussion on the most appropriate division of tasks and responsibilities among our institutions.

At this juncture it is my duty to remind all of us that, in April 2003, in Maseru, Lesotho, the SADC Heads of State and Government issued a Declaration on HIV and AIDS and approved the SADC Strategic Framework 2003-2007 on HIV and AIDS.

The Declaration reaffirms the commitment to combating the AIDS pandemic in all its manifestations as a matter of urgency through multi-sectoral strategic interventions as contained in the new SADC HIV/AIDS Strategic Framework and Programme of Action 2003-2007.

The Heads of State have declared five priority areas that require urgent attention and action, namely: Prevention and Social Mobilisation; Improving Care, Access to Counselling and Testing Services, Treatment and Support; Accelerating Development and mitigating the impact of HIV/AIDS; Intensifying Resource Mobilisation; and Strengthening Institutional Monitoring and Evaluation Mechanisms.

Under the first priority, Prevention and Social Mobilisation, the Heads of State have defined a set of specific areas needing intervention, and one of these is: "Putting in place national strategies to address the spread of HIV among national uniformed services, including the armed forces, and consider ways of using personnel from these services to strengthen awareness and prevention initiatives."

Since Maseru, the Secretariat has made some progress towards this.

The HIV and AIDS Unit has developed a five-year HIV and AIDS Business Plan and it includes harmonisation of interventions for uniformed forces. This business plan has been used actively to mobilise resources for combating HIV and AIDS in our region.

In November last year, we signed a Joint Financing Arrangement with like-minded donors and UN agencies to give technical and financial support to the regional HIV and AIDS programme. This initiative seeks to harmonise support from our development partners. This will go a long way towards addressing the resource needs for combating the epidemic and also minimising transaction costs.

Through support from the EU, the SADC Secretariat has supported the implementation of 10 pilot projects. Among these is one implemented by the International Organisation for Migration (IOM), under a project called Partnership on Mobile Populations and HIV/AIDS in Southern Africa. The pilot project is currently finalising HIV and AIDS guidelines for the uniformed services sectors.

Just two weeks ago we organised a meeting with the UNAIDS Regional Office for Southern and Eastern Africa where a Monitoring and Evaluation Framework for HIV and AIDS in the region was reviewed. The framework defines, among others, a set of indicators for monitoring the HIV and AIDS response of the uniformed forces both in countries and in the region.

Data will be collected on these indicators and a regional analysis will be made. Funds are available for operationalising the Framework, as well as for implementing specific military services sector interventions.

HIV and AIDS are not only health issues but are a security concern too. The Strategic Indicative Plan for the Organ (SIPO) takes this pandemic seriously. The defence and security forces and services have incorporated HIV and AIDS in their plans and activities as a way to mainstream prevention and administration of ARVs.

The framework of the SADC Standby Force must incorporate HIV and AIDS, including in the Doctrine and Standing Operation Procedures (SOPs) which are instruments governing peace support missions. Indeed, we still have to do more as our men and women in uniform are deployed on missions and interact with the public at large.

We all are aware that the interaction between uniformed services, vulnerable populations and humanitarian workers creates an environment that can fuel the rapid transmission of STIs, including HIV. Because young military recruits and soldiers generally fall within the age of the most vulnerable group for HIV (15 - 49) the pandemic in the military has long-range and nuanced impacts.

Young recruits have a strong influence among their peers, within and outside the services. If properly educated, they can transmit clear messages to the surrounding society, especially youth.

Let us use the organised and disciplinary capacity of uniformed services to integrate information on HIV prevention into all operations of uniformed services, and turn them into champions of HIV awareness, to spread information wherever they go.

From the SADC Secretariat side, we remain committed to facilitate the implementation of the business plan on HIV and AIDS. This will be achieved through the agreed five priority areas:

- First, we will continue to facilitate policy development and harmonisation in the region;
- Second, we will strive to enhance capacity-building for mainstreaming HIV and AIDS into all policies and programmes;
- Third, we will use our regional position to facilitate sharing of technical experts and resource networks among member states;
- Fourth, we will continue to mobilise resources that are commensurate to the challenge. This includes making the Regional HIV and AIDS Trust Fund a reality; and
- Fifth, we will strive to strengthen the systems for monitoring and evaluation of the epidemic to enable our leaders to have regularly updated information.

Our efforts are intended to complement and support the activities of the member states and other development partners. We are therefore mindful that the real action remains with the member states and that the vision of the Maseru Declaration can only be achieved if we all play our roles effectively. This includes the state and non-state players at national level, the international co-operating partners and, of course, ourselves at the SADC Secretariat.

It is our hope that a regional southern African HIV/AIDS management and mitigation strategy in the context of defence and security will be agreed upon by this meeting. We look forward to positive outcomes which will translate into concrete changes on the ground, in terms of an increased number of member states having HIV and AIDS programmes for uniformed services in place, regional guidelines and toolkits adopted for us to reach the region's ultimate goal.

Annex III

Agenda

Day One: 9 February 2006

9h00 – 9h15 Welcoming Remarks

Dr Adekeye Adebajo, Executive Director, Centre for Conflict Resolution, Cape Town
Major-General (Ret) Charles Namoloh, Minister of Defence, Windhoek

9h15 – 11h15 Session I: Shaping the Future: SADC's Response to the HIV/AIDS Pandemic

Chair: Major-General (Ret) Charles Namoloh, Minister of Defence, Windhoek

Mr Tomaz Augusto Salomão, Executive Secretary, Southern African Development Community (SADC), Gaborone

11h15 – 11h30 Coffee Break

11h30 – 13h30 Session II: Africa's New Security Agenda: HIV/AIDS, the AU and SADC

Chair: Major-General (Ret) Charles Namoloh, Minister of Defence, Windhoek

Professor Andre du Pisani, University of Namibia, Windhoek

Dr Grace Kalimugogo, Commission of the African Union, Addis Ababa

Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town

13h30 – 14h45 Lunch

14h45 – 17h00 Session III: HIV/AIDS and the Military: What Works? Lessons in Prevention, Management and Treatment

Chair: Brigadier-General Paulino Macaringue, University of the Witwatersrand, Johannesburg

Brigadier-General G Gwinji, Zimbabwe Defence Forces (ZDF) and Ministry of Defence, Harare

Colonel Gertrude PS Mutasa, Epidemiology and Research, Zimbabwe Defence Forces (ZDF), Harare

Major Mariane Muvangua, Namibian Defence Force and Ministry of Defence, Windhoek

Lieutenant-Colonel Paul Kuenane, Lesotho Defence Forces, Maseru

- 17h00 – 17h15 Coffee Break
- 17h15 – 18h00 Video: “Remember Eliphas”, produced by the Social Marketing Association (Namibia) and the Namibian Ministry of Defence; introduced by Major Mariane Muvangua, Namibian Defence Force/Ministry of Defence, Windhoek
- 18h30 – 20h00 Session IV: Roundtable Discussion: Building A New African Union For The 21st Century: Relations With The RECs, NEPAD And Civil Society**
- (A special roundtable discussion in advance of dinner to launch the CCR policy report “Building An African Union for the 21st Century: Relations with the RECs, NEPAD, and Civil Society”, based on a seminar which took place in Cape Town, South Africa, in August 2005.)
- Chair: **The Honorable TB Gurirab**, Speaker, National Assembly of Namibia, Windhoek
- Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town
- Dr Adekeye Adebajo, Centre for Conflict Resolution, Cape Town
- Day Two: 10 February 2006
- 9h00 – 10h30 Session V: Southern Africa’s Framework for Security: Constraints and Limitations for Including HIV/AIDS?**
- Chair: Major-General Solly Mollo, Department of Defence, Tshwane
- Dr Kaire Mbuende, former Executive Secretary of the Southern African Development Community (SADC), Windhoek
- Ms Victoria Lonje, Alliance of Mayors’ Initiative for Community Action Against HIV/AIDS at Local Level (UN AMICAALL Programme), Windhoek
- 10h30 – 10h45 Coffee Break
- 10h45 – 12h30 Session VI: Halting the HIV/AIDS Pandemic: National and Sub- Regional Approaches**
- Chair: Dr Kaire Mbuende, former Executive Secretary of the Southern African Development Community (SADC), Windhoek
- Mr Salvator Niyonzima, Joint United Nations Programme on HIV/AIDS (UNAIDS), Windhoek
Mr Benjamin Ofosu-Koranteng, United Nations Development Programme (UNDP), Windhoek
- 12h30 – 13h30 Lunch

- 13h30 – 15h00** **Session VII: Accelerating the Response to HIV/AIDS: The Role of the UN**
- Chair: Dr Grace Kalimugogo, Commission of the African Union, Addis Ababa
- Dr Antonica Hembe, Southern African Development Community (SADC), Gaborone
- Colonel (Dr) Grayson Idinga, Tanzanian People's Defence Force, Dar es Salaam
- 15h00 – 15h30** Coffee Break
- 15h30 – 16h20** **Session VIII: The Way Forward and Closing**
- The Honourable Victor Simunje, Namibian Deputy Minister of Defence, Windhoek
- Rapporteurs Report**
- Ms Noria Mashumba and Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town
- 16h20 – 16h30** Closing
- The Honourable Victor Simunje, Namibian Deputy Minister of Defence, Windhoek
Dr Adekeye Adebajo, Executive Director, Centre for Conflict Resolution, Cape Town

Annex IV

List of Participants

1. Dr Adekeye Adebajo
Centre for Conflict Resolution
South Africa
2. Ms Anne Anamela
Development Co-operation Ireland
South Africa
3. Ms Valerie Andriantsiresy
University of Namibia
Namibia
4. Dr Sheila Bunwaree
University of Mauritius
Mauritius
5. Dr Tapera Chirawu
University of Mauritius
Mauritius
6. Professor Andre du Pisani
University of Namibia
Namibia
7. Mr Theo-Ben Gurirab
National Assembly of Namibia
Namibia
8. Brigadier-General G Gwinji
Zimbabwean Defence Force
Zimbabwe
9. Dr Antonica Hembe
Southern African Development Community
Botswana
10. Colonel (Dr) Grayson E Idinga
Tanzanian Defence Force
Tanzania
11. Mr Andrew Intamba
Office of the President
Namibia
12. Mr Phaniel Kaapama
University of Namibia
Namibia
13. Dr Grace Kalimugogo
African Union Commission
Ethiopia
14. Mr Ulf Källstig
Regional Swedish-Norwegian
HIV/Aids Team for Africa
Zambia
15. Lieutenant-Colonel Micheal J Kelley
Embassy of the United States
Namibia
16. Lieutenant-Colonel Paul Kuenane
Lesotho Defence Force
Lesotho

17. Professor William Lindeke
University of Namibia
Namibia
18. Ms Victoria Lonje
UN AMICAALL Programme
Namibia
19. Brigadier-General Paulino Macaringue
University of the Witwatersrand
South Africa
20. Ms Noria Mashumba
Centre for Conflict Resolution
South Africa
21. Dr Kaire Mbuende
Former Executive Secretary
Southern African Development Community
Namibia
22. Major-General Solly Mollo
South African Ministry of Defence
South Africa
23. Colonel Gertrude PS Mutasa
Zimbabwean Defence Force
Zimbabwe
24. Major Mariane Muvangua
Namibian Defence Force
Namibia
25. Mr Peter Mwatile
Ministry of Safety and Security
Namibia
26. Major-General (Ret) Charles Namoloh
Namibian Defence Force
Namibia
27. Lieutenant-Colonel Petrus Nathinge
Namibian Defence Force
Namibia
28. Ms Angela Ndinga-Muvumba
Centre for Conflict Resolution
South Africa
29. Ms Cecilia Lwiindi Nedziwe
Centre for Peace Initiatives in Africa
Zimbabwe
30. Mr Veiccoh Nghiwete
Ministry of Foreign Affairs
Namibia
31. Mr Salvator Niyonzima
Joint United Nations Programme on HIV/AIDS
Namibia
32. Mr Benjamin Ofosu-Koranteng
United Nations Development Programme
Namibia
33. Ms Nadira Omarjee
People Opposing Women Abuse
South Africa
34. Mr Hoze Riruako
University of Namibia
Namibia

35. Dr Martin Rupiya
Institute for Security Studies
South Africa
36. Mr Tomaz Augusto Salomão
Southern African Development Community
Botswana
37. Major-General Charles A Shalumbu
Namibian Defence Force
Namibia
38. Mr Petrus Shivute
Namibian Defence Force
Namibia
39. The Honourable Victor Simunje
Ministry of Defence
Namibia
40. Professor Earle Taylor
University of Namibia
Namibia
41. Captain Matsotetsi Tlelai
Lesotho Defence Force
Lesotho
42. Mr Benjamin Schernick
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Namibia
43. Mr Hans Poley
Royal Netherlands Embassy
Namibia
44. Lieutenant-Colonel FS Siluzungila
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Namibia
45. Brigadier-General NRK Hamata
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46. Ms Eunice Ipinge
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Namibia
- Conference Team**
47. Ms Selma Walters
Centre for Conflict Resolution
South Africa
48. Ms Elizabeth Myburgh
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South Africa

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THE NEW PARTNERSHIP FOR AFRICA'S SECURITY

THE UNITED NATIONS, REGIONAL ORGANISATIONS AND FUTURE SECURITY THREATS IN AFRICA

The inter-related and vexing issues of political instability in Africa and international security were specifically focused on at this policy seminar, held from 21 - 23 May 2004 in Claremont, Cape Town.



SOUTH AFRICA IN AFRICA

THE POST-APARTHEID DECADE

The role that South Africa has played on the African continent and the challenges that persist in South Africa's domestic transformation 10 years into democracy were assessed at this meeting in Stellenbosch, Cape Town, from 29 July - 1 August 2004.



THE AU/NEPAD AND AFRICA'S EVOLVING GOVERNANCE AND SECURITY ARCHITECTURE

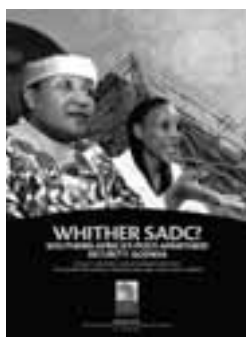
The state of governance and security in Africa under the AU and NEPAD were analysed and assessed at this policy advisory group meeting in Misty Hills, Johannesburg, on 11 and 12 December 2004.



A MORE SECURE CONTINENT

AFRICAN PERSPECTIVES ON THE UN HIGH-LEVEL PANEL REPORT, A MORE SECURE WORLD: OUR SHARED RESPONSIBILITY

African perspectives on the United Nations' (UN) High-Level Panel report on Threats, Challenges and Change were considered at this policy advisory group meeting in Somerset West, Cape Town, on 23 and 24 April 2005.



WHITHER SADC?

SOUTHERN AFRICA'S POST-APARTHEID SECURITY AGENDA

The role and capacity of South Africa as Chair of the Southern African Development Community's (SADC) Organ on Politics, Defence and Security (OPDS) were focused on at this meeting in Oudekraal, Cape Town, on 18 and 19 June 2005.



BUILDING AN AFRICAN UNION FOR THE 21ST CENTURY

RELATIONS WITH REGIONAL ECONOMIC COMMUNITIES (RECS), NEPAD AND CIVIL SOCIETY

This seminar in Cape Town from 20 - 22 August 2005 made policy recommendations on how the AU's institutions, including NEPAD, could achieve their aims and objectives.

Other publications in this series

(available at <http://ccrweb.ccr.uct.ac.za>)



HIV/AIDS AND HUMAN SECURITY:

AN AGENDA FOR AFRICA

The links between human security and the HIV/AIDS pandemic in Africa, and the potential role of African leadership in addressing this crisis were analysed at this policy advisory group meeting in Addis Ababa, Ethiopia, on 9 and 10 September 2005.



THE PEACE-BUILDING ROLE OF CIVIL SOCIETY IN SOUTHERN AFRICA

This meeting, held at the Maseru Sun, Lesotho, on 14 and 15 October 2005, explores civil society in relation to southern Africa, democratic governance, its nexus with government, and draws on comparative experiences in peacebuilding.



WOMEN AND PEACEBUILDING IN AFRICA

This meeting, held in Cape Town on 27 and 28 October 2005, reviewed the progress of the implementation of UN Security Council Resolution 1325 in Africa in the five years since its adoption by the United Nations in 2000.

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