Policy challenges for the management of HIV/AIDS in armed forces in southern Africa

Edited by Lauren Hutton

17 – 19 October 2007, Maseru, Lesotho

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Introduction

Dr Martin Rupiya
MilAIDS Project Manager, Institute for Security Studies

The Lesotho Defence Force Medical Corps in association with the MilAIDS project of the Institute for Security Studies (ISS), funded by the Rockefeller Brothers Fund (RBF), organised the conference on Policy Challenges for Management of HIV/AIDS in Armed Forces in Southern Africa. Makoanyane Military Hospital in Lesotho was the local host of the conference, which was held from 17 to 19 October 2007 at the Maseru Sun Hotel.

The conference focused on two themes: firstly, policy challenges in the management of HIV/AIDS (human immunodeficiency virus/ acquired immune deficiency syndrome) in the uniformed sector and secondly, male circumcision and the accompanying challenges in the armed forces. The conference follows the evidence presented by three randomised controlled trials (Orange Farm, South Africa; Rakai, Uganda; and Kisumu, Kenya) that have found that circumcised men have a reduced risk of about 60 per cent of contracting HIV infection from heterosexual intercourse. Consultations have been held to consider the policy and programming implications of this evidence. In addition, sub-Saharan Africa faces challenges such as linkages of national and regional efforts in the response to the AIDS epidemic. This conference addresses policy and programme challenges to strengthening armed forces in Africa.

The participants included senior military medical officers, doctors and nurses from southern African militaries; representatives of police and correctional services, United Nations partners and specialist nongovernmental organisations (NGOs) working in the HIV/AIDS field; and academics, researchers and other members of civil society. The participants represented countries from southern Africa, such as Lesotho, Swaziland, Zambia and Zimbabwe, and other regions of Africa, such as Ethiopia, Sudan, Uganda and the Democratic Republic of the Congo (DRC). There was a mix of expertise in areas such as policy and strategy for HIV/AIDS, military and civil security, logistics, and research and medical services.

The purpose of the conference was to

- Share the unique experiences of each context and represented country
- Identify and discuss challenges faced by medical services of security forces
- Make recommendations for addressing the challenges facing the security sector in fighting HIV/AIDS

The conference programme was covered in two days and consisted of plenary sessions followed by general discussions. It was an interactive process with different experts sharing knowledge. Medical officers and representatives from defence and police forces and correctional services made key presentations on their experiences and the challenges facing the security sector in responding to the HIV/AIDS crisis in Africa. The presentations were followed by discussions on policy options such as male circumcision for HIV prevention and general responses to the epidemic.

Session I

Opening remarks

Ms Mahall Lebesa
Principal Secretary, Ministry of Defence and National Security, Lesotho

The Principal Secretary for the Ministry of Defence and National Security of Lesotho, Ms Mahall Lebesa, officially opened the conference. She noted that during the last decade, the increasing global concern about HIV/AIDS had been accompanied by intensified efforts to fight the epidemic at international, regional and national levels. At the national level, governments and civil society have been forming partnerships with the aim of intensifying prevention to ensure that those still uninfected maintain their negative status while also strengthening the capacity for treatment, care and support to ensure that those infected live long and have quality lives. For example, in Lesotho, the Know Your Status campaign, the provision of antiretroviral treatment (ART) and the establishment of the National AIDS Commission have been the thrust of the national response to the HIV/AIDS crisis.

At the sub-regional level, South African Development Community (SADC) heads of state and governments have declared that AIDS is a national and regional disaster and a threat to human security in southern Africa. A strategic framework for the management of the HIV/AIDS epidemic has been developed and is currently being implemented in a resource-constrained environment. It builds on previous commitments by heads of state and international partners, for example the Maseru Declaration of 2003, the Abuja Declaration, the United Nations General Assembly Special Session and the Millennium Development Goals.

The conference focused on HIV/AIDS policy and management challenges in the defence and security sector. It addressed the challenges of rolling out male circumcision for HIV prevention in the armed forces following the positive findings of the trials in Kenya, South Africa and Uganda. In addition, it addressed existing challenges facing the military, such as the procurement and distribution of drugs and policies on HIV/AIDS guiding peacekeeping missions and operations and linkages between national policies and regional initiatives.

Ms Lebesa emphasised that HIV/AIDS was not confined to specific boundaries and that regional initiatives increased the chance of success in fighting the epidemic. She wished participants fruitful deliberations and expressed the hope that clear recommendations would be made to address the challenges faced by armed forces and police in regard to HIV.

Session II

Male circumcision and HIV prevention

Evidence and recommendations

Dr Kim Eva Dickson
Regional Development Director Reproductive Health, World Health Organisation

This presentation gave an overview of the determinants of male circumcision worldwide, the evidence of the HIV protective effect of male circumcision and the actions of the UN in response to the evidence. Dr Dickson explained that mainly for religious, cultural and social reasons, about one third of males around the world are circumcised. Ecological and epidemiological evidence dating back to the late 1980s has shown a link between lower HIV prevalence and higher male circumcision incidence. Three randomised controlled trials were conducted in Kenya, South Africa and Uganda; they were completed by December 2006 and showed the protective effect of male circumcision on HIV incidence. According to the speaker, the trails revealed that male circumcision reduced the possibility of infection by up to 60 per cent.

As a result of the evidence presented by the trials, the World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) convened an international consultation meeting in March 2007 and released policy and programming recommendations on male HIV prevention. The presenter explained that the conclusions and recommendations of the March conference covered various aspects relating to the combating of the epidemic, including partial protection, health systems, human rights issues, resource mobilisation and further research issues.

WHO and UNAIDS furthermore recommended that male circumcision be recognised as an additional important strategy for HIV prevention. Dr Dickson noted that the proposal of WHO and UNAIDS was not that male circumcision should replace other interventions but rather that it should be part of a comprehensive HIV prevention package. The speaker stressed that while male circumcision could be useful as part of a preventative strategy, health services needed to be strengthened to increase access to safe male circumcision services and to accord male circumcision full adherence to medical ethics and human rights. According to the speaker, the March conference recommended that countries with a high prevalence (that is more than 15 per cent) should consider urgently scaling up access to male circumcision services.

Dr Dickson further said that under the leadership of WHO, UN agencies had developed a work plan whose objectives were to

- Set global standards and norms for male circumcision
- Provide technical support to countries in regard to the implementation or potential implementation of male circumcision as part of prevention strategies
- Develop communication and advocacy strategies and messages
- Coordinate research, monitoring and evaluation of male circumcision services

The speaker concluded that the evidence for male circumcision was much more conclusive than that for many other interventions that were being implemented. Dr Dickson noted, however, that there were many challenges and that all actors needed to work together to overcome the implementation ones.

DISCUSSION

During the ensuing discussion participants emphasised that male circumcision was only partially protective and that males could still be infected. One participant living with HIV noted that although he had been circumcised as a child, he was still infected. Questions were raised as to whether or not any proof existed that female circumcision had similar potential partial protective value. Dr Dickson

replied that research conducted by WHO had shown that female circumcision manifested most often as female genital mutilation and was associated with complications rather than with benefits.

The participants discussed the age at which circumcision should take place. Although it is an easy procedure that can be performed at any age, the model of neonatal circumcision was recommended. Circumcision in infants has the additional benefit of reduced risk of urinary tract infection; furthermore, at such a young age it is disassociated with sexual activity. However, the effect of male circumcision on HIV prevention will only be seen in later years. Concerns were also raised about the trials, and it was explained that the trials had been conducted in Africa because the continent was facing some of the highest HIV prevalence rates and it was confirmed that the participants had participated voluntarily and with full consent.

The conference participants raised concerns about male circumcision being viewed as a preventative measure in itself and the risk that people who underwent circumcision would abandon other prevention measures. Participants believed that this matter posed a challenge for clear, effective communication and messaging for everyone.

Session III

Country presentations

Country presentations focused on the two themes of the conference: first, challenges of integrating male circumcision in HIV prevention interventions and second, challenges facing HIV/AIDS programmes in the armed forces.

Zambia

(Col) Dr Lawson Simapuka
Senior Consultant Physician, Zambia Defence Force

According to Dr Simapuka, in Zambia, male circumcision had been traditionally practised in North Western Province, which also had had the lowest HIV prevalence rates (7 per cent) in the country. However, there had been increased mining activity in the province and the prevalence had increased. He pointed out that nationally, the prevalence rates were higher in the military than in the general population. The speaker provided details of the HIV prevalence rate and treatment tendencies in Zambia, informing the conference that approximately one million people were living with HIV in Zambia and that 120 000 people were on ART. Highly active antiretroviral therapy (HAART) was introduced in 1998. However, certain challenges still faced the country in combating the epidemic, such as difficulties with drug procurement, a lack of laboratory facilities and weaknesses in the health care system.

The presenter then discussed issues relating to the development of coherent and comprehensive policies to guide state responses to HIV/AIDS. HIV/AIDS policy development in Zambia dated back to 1985 and was largely influenced by advocacy activities. Currently, there was a national master plan for the prevention, treatment and management of HIV/AIDS in Zambia. In 2006, the military developed their own AIDS policy based on the national approach, with the inclusion of some additional issues that were specific to the security sector. For example, according to the military policy, there was no routine HIV testing for those on active duty, except for those engaged in peacekeeping missions. Dr Simapuka pointed out that those who test positive were deployed with ART packages. Furthermore, as the virus advanced, those who were too sickly to continue active duty retired on medical grounds and continued to be supported by the military. Care International supported children orphaned by the epidemic in Zambia.

LESOTHO

Nursing Officer Cecilia Brown
Lesotho Defence Force

Officer Brown began her presentation by outlining the factors that made the military a vulnerable population for HIV infection. These factors included long periods away from home during deployment and the availability of commercial sex. According to the speaker, male circumcision was a welcome HIV preventative measure for the armed forces.

The presentation then focused on challenges in integrating male circumcision to combat the spread of HIV/AIDS among the armed forces. Officer Brown pointed out that there was a lack of human resources in the health service sector in the SADC region, which was aggravated by the migration of health workers to developed countries. The lack of capacity in the health services was further complicated by other interventions being loaded on the health system, such as ART and preventing mother-to-child transmission (PMTCT) treatment.

The speaker explained that there would be challenges in implementing male circumcision because the measure might not be acceptable among military personnel,

traditionalists and religious leaders. Agreeing with a statement made previously in the conference, Officer Brown emphasised the importance of clear communication and messaging to stress that circumcision offered only partial protection.

The presenter concluded by saying that based on the strength of evidence that male circumcision could reduce the transmission of HIV, the measure should be promoted in the Lesotho Defence Force. She noted, however, that in order for male circumcision to be implemented, high-level advocacy with senior commanders was needed. She also commented that similar to ART and condoms, male circumcision should be provided free of charge.

DEMOCRATIC REPUBLIC OF CONGO

Prof Grevisse Yav-Ditend

Prof Grevisse began his presentation by revealing that HIV prevalence in the military in the DRC was higher than in the general population and that the majority of deaths in the military were caused by AIDS. He indicated several reasons for the high prevalence rate in the military, which included the high mobility of soldiers, easy access to non-regular partners, and the fact that soldiers were usually young and in a sexually active age group. He emphasised that HIV prevention efforts needed to be intensified in the armed forces. In conclusion, he highlighted the need to conduct a situation analysis of HIV/AIDS in the military in the DRC as there was no systematic data collection owing to security sensitivity. It was recommended that data collection in the military be improved.

UGANDA

Lt Col Charles Bakuhumura

Commanding Officer, Uganda People's Defence Force (UPDF)

Lt Col Bakuhumura's presentation focused on east Africa with Uganda as a case study. He noted that although HIV rates were lower in east Africa than in southern Africa, HIV/AIDS remained a serious challenge. The speaker also pointed out that while many argued that HIV prevalence rates were higher in the military than in the general population, statistics proving this fact were scarce and were kept secret, mostly for security reasons. He commented that countries involved in conflict were more vulnerable to the spread of the disease.

Lt Col Bakuhumura emphasised that armed forces in Africa had the same vision: to have strong and healthy forces. To accomplish this aim, the WHO recommendations on male circumcision needed to be contextualised for the military sector. In conclusion, the speaker highlighted that in formulating HIV/AIDS policy, principles for policy formulation need to be adhered to. This step included openness in talking about HIV/AIDS at every level of command and involving people living with HIV to a greater extent in the process. Furthermore, he emphasised that there should be no discrimination against people living with the virus; they should not be denied opportunities and their human rights should be respected in all aspects.

SUDAN

Ms Afaf Yahya

Senior Researcher, Futures Foundation

Ms Yahya began her presentation by explaining the context in which Sudan was facing the AIDS pandemic. Sudan belongs to a region with long-standing civil conflict, and foreign peacekeeping forces are present in the eastern region. Even with the high levels of conflict the state has experienced, Sudan has one of the lowest HIV rates in sub-Saharan Africa; however, it is amongst the highest prevalence rates in the Arab world. She explained that the national policy was grounded on human rights and that laws protected people living with HIV against discrimination.

The presenter discussed the challenges being faced by Sudan in combating HIV/AIDS. HIV/AIDS was still a stigmatised issue at both the political and the community level and across cultures and religions. Other challenges included the low media coverage of HIV/AIDS issues, the lack of commitment by decision-makers to address the problem, uncoordinated policy, the absence of mechanisms to monitor and evaluate the impact of the national HIV/AIDS policy and low levels of involvement by people living with HIV/AIDS in the policy process.

In regard to the military sector, Ms Yahya explained that many challenges were being faced in addressing the impact of the epidemic on the armed forces. She pointed out that military personnel often lived in isolated areas and that collecting data from them was difficult for security reasons. Furthermore, she informed the conference that there was only one voluntary counselling and testing (VCT) centre and that it was based in the capital of North Sudan, Khartoum. Echoing the national environment in dealing with the disease, there was low HIV awareness in the military and the primary tool of the defence policy, the White Paper on Defence, was silent on issues of HIV/AIDS. According to the speaker, there was also a lack of adherence to UN Security Council resolutions on HIV/AIDS in the defence sector.

In conclusion, the speaker emphasised that Sudan needed to address social and security needs simultaneously. This is evident, for example, in the need to protect soldiers and communities during demobilisation and reintegration.

MALAWI

Lt Col Victor Phiri
Coordinator HIV Programme, Malawi Defence Force

Lt Col Phiri began his presentation by explaining that in Malawi, HIV prevalence was 14 per cent and that the infection trends in the armed forces were very similar to those reflected by national statistics. However, in the recent past, the Malawi Defence Force had been experiencing a decline in the number of deaths due to AIDS.

He described how HIV interventions in the armed forces started in 1996 as part of workplace programmes that were introduced after a presidential directive. In the Malawi Defence Force, HIV was recognised as a command problem and a committee represented by head of departments in the army addressed various issues relating to treatment and prevention and HIV/AIDS-related policy. Furthermore, a national consultation had been held to consider integrating male circumcision as part of a national HIV prevention strategy. Male circumcision was not widely practised in Malawi except among two ethnic groups and among members of the Muslim community. There was a need to promote the health benefits of male circumcision.

In detailing other issues and challenges, the presenter mentioned a 2003 study that had been conducted in the defence force. This study showed that 10 per cent of defence force members and their families did not have full knowledge of HIV transmission. Communication strategies were developed in response to this, and a behaviour change survey was currently taking place.

ZIMBABWE

Brig Gen Gerald Gwinji
Director Medical Services Corps, Zimbabwe Defence Force

The presenter began by explaining that the national HIV prevalence rate in Zimbabwe had declined from 25 per cent in 2000 to only 18 per cent currently. However, he pointed out that in the defence force, the prevalence rate was still 25 per cent. He also commented that in Zimbabwe, less than 20 per cent of males were circumcised.

Brig Gen Gwinji explained that AIDS programmes in the military were resourced by direct military budgets but that efforts were increasingly made to draw from the national health budget. He explained that there had been a national consultation on circumcision in Zimbabwe and that the military had been part of the process. According to the speaker, studies have shown that male circumcision was acceptable in Zimbabwe.

In conclusion, the speaker described some of the policy challenges in implementing male circumcision in the military in Zimbabwe. First, one had to decide who was to be targeted: new recruits or all members of active service. Second, issues of human rights had to be considered, as well as concerns about coercing personnel to participate in circumcision programmes. He noted with concern the need for the Zimbabwe Defence Force to mobilise resources from outside the military to implement such programmes.

DISCUSSION

Many important issues were raised during the rich discussions that followed the presentations. The following serves as a brief summary of some of the points raised. The participants discussed HIV testing for recruits and the practice of mandatory testing. It was explained that in many countries, it was standard procedure to test potential recruits for HIV and to enlist only those who were HIV-negative. HIV was considered according to exclusion criteria similar to those of other chronic diseases such as diabetes or asthma. It was noted with concern, however, that those found positive were not referred to any care, treatment or support services. Interestingly, the discussants noted that in post-conflict countries, such as the DRC, and in countries where the integration of various armed factions had occurred, integrating forces were not tested although pre-recruitment testing was done.

In regard to peacekeeping deployments, it was noted that soldiers were tested pre-deployment but not when they return from active service. The issue of the deployment or non-deployment of HIV-positive personnel in peacekeeping forces is a complex one, and the audience felt that neither literature nor practice clearly indicated whether or not HIV-positive personnel should be deployed. It was believed that the testing of members of peacekeeping forces depended on the requirements of host countries. During the discussion it was suggested that these members should be tested when returning from deployment in order to gather data on the levels of infection during conflict.

The participants revealed that in general, no routine testing was done of those in service, although some militaries were planning to introduce the measure. Regular CD4 count testing was done for those who tested positive to determine what treatment, care and support was required and which level of physical activity they could withstand. It was noted that members of the armed forces in some countries had formed support groups, although this seemed more common among the wives of soldiers. Some preferred to access care and support services outside the barracks because of confidentiality and the fear of stigmatisation within the armed forces.

It was learnt the Zambian army had decided not to include male circumcision as an HIV prevention strategy because it was provided at primary health care level. Participants said that one needed to look at the extent of the HIV epidemic and the use of other interventions in one's own country and decide whether or not to include male circumcision in the prevention package. Participants highly recommended male circumcision for countries with high prevalence of HIV and low use of condoms. Several participants emphasised that male circumcision should be offered to soldiers as a method of HIV prevention. It was noted that although male members of armed forces could be ordered to undergo circumcision, it should not be compulsory.

Session IV

HIV/AIDS in police and correctional services in southern Africa

Management of AIDS in the police services

Themba Masuku
Senior Researcher, Centre for the Study of Violence and Reconciliation

Mr Masuku noted that the rate of HIV infection in police services in southern Africa equalled national averages. He pointed out that screening at recruitment applied only to police who were army reserves. Police officers living with HIV/AIDS received varying degrees of support; for example, in Johannesburg, only one social worker was assigned to deal with HIV at 21 stations with 6 500 officers.

Mr Masuku commented that not much was known about HIV/AIDS among the police. He noted several challenges influencing research on this sensitive issue, for instance a lack of trust between police and researchers and the challenges of collecting accurate data because the rate of AIDS is inferred on the basis of attrition figures.

The presenter explained that similar to the armed forces, the police services are classified as a high-risk group for HIV infection. However, he noted that behavioural factors rather than the nature of their work put them at a higher risk. Such behavioural factors included youthfulness, a culture of male dominance and a sense of power; working away from home; and indulging in commercial sex. He concluded his presentation by emphasising that more research was needed for a better understanding of the determinants of HIV/AIDS and their impact on the police services in southern Africa.

HIV/AIDS IN PRISONS

Dr Martin Rupiya
MilAIDS Project Manager, Institute of Security Studies

In this brief interpolation, Dr Rupiya explained that many factors contributed to the high risk of HIV infection in correctional facilities. These factors included a lack of 24-hour security, overcrowding, staff shortages and high-risk behaviour. He concluded by noting that one needed to question what was happening in prisons in the region in regard to HIV infection.

AIDS IN LESOTHO PRISONS

Chief Officer P Scout
Correctional Services, Lesotho

According to the speaker, Lesotho was in the process of drafting a policy for the correctional services that included addressing HIV for inmates and officers. Furthermore, the national Know Your Status campaign involved inmates and officers. He pointed out that as an HIV prevention measure, condoms were made available in prisons; in addition, sodomy was a criminal office in Lesotho.

Chief Officer Scout explained that no accurate statistics were available on HIV prevalence among inmates. However, he informed the audience that of 2 800 inmates in Lesotho, about 270 were known positives and 60 were on ARTs. Heads of correctional services in the region had agreed to conduct more research on AIDS in prisons.

DISCUSSION

The discussion which followed the above presentations focused on many issues, but resource constraints seemed to be the primary obstacle to overcoming or addressing the challenges of HIV infection in police and prison services. One of the problems of implementing HIV prevention and treatment programmes in the police sector was that unlike the military who usually reside in barracks, the police are usually spread throughout the population and are therefore not easily targeted as a single entity for interventions. Participants argued that prisons in the region were not adequately funded, which affected

security and HIV prevention services. Similarly, prison populations were often stigmatised and this affected the mobilisation of extra resources for correctional facilities.

The issue of unequal power relations was also highlighted in both sectors. In the police service, male police officers were often a high-risk group because they sexually exploited vulnerable groups, for example sex workers and undocumented immigrants. In regard to the penal system, it was remarked that policy makers may deny that homosexuality existed in prisons but this was a real security issue and was often linked to the exploitation of weaker inmates. Some participants believed that simply providing inmates with condoms without strengthening security was dealing with symptoms of the problem and was a form of denial. It was highlighted that according to national AIDS policies, the prisoner population was classified as vulnerable and that those who were sexually active needed to be provided with condoms for HIV prevention, just like the rest of the population.

Session V

Policy challenges in the management of HIV/AIDS

POLICY CHALLENGES IN THE MANAGEMENT OF AIDS

Dr Martin Rupiya

Dr Rupiya began his presentation by outlining the evolution of international HIV/AIDS policy. He explained that in the early 1980s, WHO and the World Bank offered guidelines and UNAIDS was formed in the mid 1990s to guide policy. However, it included a number of agencies, WHO, the United Nations Fund for Children (UNICEF) and the United Nations Population Fund (UNFPA), looking at aspects of HIV/AIDS and mainly relied on seconded staff from these bodies, which created certain resourcing problems. An approach of division of labour among UN agencies was adopted two years ago to make sponsoring agencies accountable and to obtain policy support from them.

The speaker explained that AIDS had affected the regions of the world differently, with sub-Saharan Africa being the worst hit, and that pressure had been applied to develop international policy at the regional level. He noted that at the national level, AIDS was generally viewed as a health issue and it fell under the ministry of health. In many countries, it was later prioritised as a cell within the presidency. Subsequently, national AIDS commissions (NACs) were formed to draft national policies. NACs generally asked stakeholders to draft sectoral policies (for instance on security and labour) to be part of national policy.

The speaker continued by discussing issues that had been confronted in terms of drug research, pricing and distribution. According to Dr Rupiya, pharmaceutical companies in developing countries invested largely in drug research and development and patented their products. The World Trade Organisation (WTO) supported them by prohibiting countries to order generic versions of the drugs.

The presentation then focused more specifically on the issue of HIV/AIDS in the military sector. Of note are problems with obtaining verifiable and accurate prevalence rates in the armed forces.

The ISS MilAIDS project has deliberately not focused on prevalence but on the development of policy options from which authorities can choose. Some of these policy challenges, according to the speaker, included the screening of recruits, the re-mastering of in-service staff (moving to less physically demanding tasks), post-test care, budget constraints and improved treatment options.

NATIONAL AIDS POLICY FOR LESOTHO (2006)

Thabang Ts'ehlo

The presenter began by detailing the goals of the national AIDS policy for Lesotho, which is to prevent the further spread of the epidemic; to provide treatment, care and support services; and to mitigate the impact of HIV and AIDS on individuals, families, communities and the nation as a whole. The policy has been designed to address four key areas of focus: multi-sectoral coordination; prevention; treatment, care and support; and impact mitigation. The speaker noted that policy statements were outlined for each of these focus areas.

Mr Ts'ehlo pointed out that male circumcision had not yet been included in the national policy. It would be advocated and included with other emerging prevention technologies.

DEMOBILISATION, DISARMAMENT AND REINSTATEMENT IN THE DEMOCRATIC REPUBLIC OF THE CONGO

Dr Daniel Kawata
Former Director of the National Commission for Disarmament, Demobilisation and Reintegration (DDR) (CONADER) in the DRC

Dr Kawata described the complex process in the DRC of demobilising and integrating more than ten individual armies into one regular army or turning them into civilians. Soldiers were moved from main centres to orientation centres and provincial offices and finally to the community level. HIV tests were offered at orientation centres, but many people did not want to have the test. Condoms were distributed, but they were thought to promote promiscuity.

The speaker then highlighted some of the challenges being faced in the DRC. These included the absence of HIV testing for those who joined the army through reintegration. Furthermore, some soldiers lived in the community because of a lack of accommodation in the barracks, which could make access to health services difficult. Dr Kawata pointed out that the army was not included in the national AIDS policy, but he quoted startling statistics to highlight the impact of HIV on the armed forces in the DRC. According to the speaker, there was a variation in HIV prevalence (2,9 to 10 per cent) among relocating soldiers and a prevalence of 30 per cent among regular soldiers. He commented that this situation was unacceptable to the High Commissioner of the Ministry of Defence.

DISCUSSION

During the discussion session, the issue of testing came up again and some participants believed that an incentive existed to test at recruitment; however, once personnel were employed, there was no incentive to test them. The audience also highlighted the issue of policy and emphasised that there should be a harmonisation of national and sectoral AIDS policies. It was noted that policy development in Lesotho was a consultative process whereby sectors submitted their policies and sectoral plans to be part of the national AIDS policy. Furthermore, the NAC checked sectoral policies to ensure that they were in harmony with the national policy.

Session VI

Country presentations on policy challenges in the management of AIDS

UGANDA

Lt Col Charles Bakahuma

Lt Col Bakahuma pointed out some of the policy challenges being faced by Uganda in the management of the AIDS epidemic and especially mentioned the challenges faced by the armed forces. At the national level, there was a coordinated multi-sectoral national response to AIDS with the NAC primarily responsible for coordination; however, there were still obstacles to coordinating civil society and government partners.

The speaker addressed challenges relating to mandatory testing and potential infringements on human rights. He noted that the testing and non-recruitment of HIV-positives might be viewed as a violation of human rights. Furthermore, ex-rebels who were integrated into the regular army had not been tested for the sake of peace. The final challenge highlighted by the speaker with reference to the Uganda case study was budget constraints. The military budget had been downsized, and this step has had a negative effect on the capacity of the military to address the HIV/AIDS crisis. Consequently, NGOs support the army in AIDS programmes.

SUDAN

Ms Afaf Yahya

In outlining the challenges faced by Sudan in regard to the management of the HIV/AIDS epidemic, Ms Yahya highlighted the high levels of stigma that were still associated with the disease in Sudan. This phenomenon complicated efforts to address the epidemic. Furthermore, the geopolitical context in which the North African state existed had an impact on the management of the disease. The policy challenges related to challenges of coordination in a geographically large state with current and potential conflict situations and weak institutional frameworks.

The speaker noted that a general lack of respect for human rights had negatively affected HIV/AIDS work and that there was a low resource allocation for the management of the pandemic in the midst of the peace process and the transitional arrangements. The effective management of the disease was prevented by low political commitment.

Ms Yahya concluded by highlighting that the military needed to develop a policy in relation to the national framework, focusing specifically on the protection of civilians in war-torn zones and providing guidelines on how to deal with peacekeeping forces.

ZAMBIA

Dr Lawson Simapuka

Dr Simapuka emphasised the way in which the human resources challenges facing the armed forces in Zambia impacted on the management of HIV/AIDS. It was difficult to attract and retain medical staff in a military setting given the inequalities in remuneration for medical professionals in state service and private sector employment. He also noted that in Zambia, the continuity of providing HIV management depended on ensuring continuous donor support for various AIDS programmes, especially for the provision of ART, which was currently funded by the United States government. One of the greatest challenges was to strengthen prevention strategies. Dr Simapuka reported that condom use was low and concern had been expressed that it might become even lower as a consequence of the implementation of male circumcision as part of the prevention plan.

ETHIOPIA

Mr Bizusew Mersha

The speaker began by saying that although HIV prevalence in Ethiopia was only 3 per cent, it was two to three times higher in the military. VCT centres now existed in military hospitals and there were peer education programmes at all ranks. According to Mr Mersha, the primary challenge facing Ethiopia was how to combat HIV/AIDS in a region filled with conflict, with active deployments and demobilised groups.

DEMOCRATIC REPUBLIC OF THE CONGO

Prof Yav-Ditend Grevisse

Prof Grevisse highlighted that for the DRC, one of the main challenges was the lack of availability of reliable data on HIV/AIDS. The implementation of prevention programmes and the low use of condoms among active members presented further challenges. It was important to link national policies to regional policies for synergy in combating the pandemic.

SWAZILAND

Major T Magongo

According to Major Magongo, HIV prevalence was still very high in Swaziland with estimates ranging from 25 to 39 per cent. He pointed out that the military had, however, not performed studies or surveys of its own on HIV prevalence. Prevention remained a challenge, and research studies revealed that condom use was low. He noted that one of the main challenges facing the military was the lack of a fully-fledged military hospital and military personnel were sent to government facilities for treatment. The government hospitals have certain resource constraints and the amount of diagnostic equipment is limited. Although the US has offered to assist, the hospitals still do not have equipment to determine CD4 counts.

LESOTHO

Lt Irene Selialia

The presentation on policy challenges on the management of HIV/AIDS in Lesotho proved that the mandatory testing of potential recruits was a controversial practice. The speaker noted that the public did not approve of testing at recruitment. Furthermore, the AIDS policy of the Lesotho Defence Force (LDF) required testing for all soldiers travelling outside their home country for any official reason. Plans were being formulated for routine annual testing in the LDF.

Lt Selialia furthermore revealed that HIV/AIDS was still a stigmatised sickness in Lesotho and that some soldiers preferred to be tested at facilities outside the military to avoid having their status known to others. She commented that in some cases, infected soldiers only became known when they were terminally ill.

She outlined macro challenges that were affecting the ability of the military to combat the HIV/AIDS epidemic, such as the limited resource basket of the small southern African state, the brain drain of experienced health care professionals to neighbouring countries and the developed world and a general lack of infrastructure in state hospitals.

ZIMBABWE

Brig Gen Gerald Gwinji

Brig Gen Gwinji highlighted policy challenges that Zimbabwe faced with reference to the management of the HIV/AIDS pandemic and the impact of the sickness on the armed forces in particular. He outlined challenges in regard to training and communication, specifically noting that they were challenged to develop and impart messages within a specific time frame and with limited resources.

The speaker referred to problems of resourcing as health funding competed with core military expenditure. In an attempt to overcome resource gaps, the defence force was forming partnerships with other militaries and civilians to address HIV/AIDS with security concerns in mind. He noted that the Zimbabwe Defence Force was attempting to reduce HIV risk factors in the armed forces, such as policies to limit the separation of families through long-distance postings and to discourage long-distance night driving to avoid stops at entertainment places.

LESOTHO CORRECTIONAL SERVICES

Chief Officer P Scout

Chief Officer Scout emphasised that the primary challenge the Lesotho Correctional Services faced in regard to the management of HIV/AIDS was the limited resources available to the penal system. He noted that this problem was common to all correctional services in the region and that the limited budget appropriations for the penal sector meant that the amount of care for staff and inmates was limited. One of the problems related to increasing the budget for prisons, according to the speaker, was the negative public perception of prisons. Prison was viewed by many as punishment, and any effort to improve prison conditions was resisted. For example, if people contracted a disease in prison, the public would say, 'They deserve it,' yet the inmates returned to the community and could infect others.

DISCUSSION

After the highly informative presentations, the conference participants energetically interacted on the range of issues that had been presented. Of the key matters that had repeatedly been raised were the challenges associated with operating in a resource-constrained setting. Participants were called upon to be resourceful and innovative. The example set by Zimbabwe of banning night driving to reduce exposure to risk was cited as an illustration.

The issue of testing at recruitment was once again raised, and it was emphasised that HIV testing should not be stigmatised as it is done as part of a screening process for chronic diseases. Participants believed that other security services also needed to test given the physically demanding nature of the work; testing would enable them to refer the infected to support services and help patients to manage their health condition better. Participants also noted that efforts should be increased to raise public awareness of the prison services and to overcome the stigma attached to the penal system in general.

Participants also raised the issue of culture and the impact of culture on sexual behaviour. They noted that certain risky cultural practices needed to be addressed in HIV/AIDS programming, for example polygamy, widow inheritance and female genital mutilation.

Session VII

Closing remarks and way forward

KEY POLICY CHALLENGES

Dr Martin Rupiya outlined the following key policy challenges facing the management of HIV/AIDS in the armed forces:

- Review of HIV testing policies – Potential recruits needed to be tested. Testing was also necessary during employment and before deployment. Post-deployment testing should be encouraged, as well as testing during integration in post-conflict settings.
- Policy formulation – AIDS workplace policies in the security sector needed to be guided by policy instruments at the national level.
- Reduction of the impact of risk factors – Treatment and care focused on the family unit, but little was done to understand the risk factors of HIV infection. For example, men were sexually active during deployment and they needed to be protected.
- Weaknesses in regional linkages – Beyond the national policy, there is not much linkage with regional policies. It was noted that the SADC was making efforts to create linkages in national policies.
- Drug procurement

KEY ISSUES FOR THE IMPLEMENTATION OF POLICY

Prof Daniel Kawata outlined the following prerequisites for the effective implementation of HIV/AIDS policies:

- Policy and technical leadership–For policy to be implemented, it needs to have ownership and collaboration from all stakeholders: leaders, policymakers and technical teams. Leadership is the key to the endorsement of policy.
- Capacity of the implementation team–Members of the team need to be trained and empowered. One needs to have a clear division of labour and to use people in their best areas, some as policy developers and others as implementers.
- Cultural issues–Culture is dynamic, and it can be enriched. For example, in some countries male circumcision is widely practised while in others it is not. Male circumcision can be viewed as a way of enriching culture with new interventions that can help in curbing AIDS in society.

CONCLUSION

It was agreed that the objectives of the conference, to discuss AIDS management challenges, to share experiences and to build networks in fighting AIDS, had been achieved. It was emphasised that the armed forces in Africa operated in resource-limited settings and that the challenge was to implement programmes within the environment.

Lt Col Paul Kuanene closed the conference on behalf of the Principal Secretary, who had sent his apologies.

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