HIV/AIDS AND MmilitaRIES IN AFRICA

CENTRE FOR CONFLICT RESOLUTION
CAPE TOWN, SOUTH AFRICA

KOFI ANNAN INTERNATIONAL PEACEKEEPING TRAINING CENTRE
ACCRA, GHANA

A POLICY RESEARCH REPORT

HIV/AIDS AND MILITARIES IN AFRICA

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RAPPORTEURS
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Acknowledgements

The Centre for Conflict Resolution (CCR), Cape Town, South Africa, would like to thank TrustAfrica in Dakar, Senegal; the Rockefeller Brothers Foundation (RBF); and the governments of Denmark, the Netherlands, Sweden, Norway, and Finland, as well as the United Kingdom's (UK) Department for International Development (DFID) for their generous support that made possible the holding of the three policy seminars in Windhoek, Namibia, in February 2006; in Cairo, Egypt, in September 2007; and in Addis Ababa, Ethiopia, in November 2007.

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 Kofi Annan International Peacekeeping Training Centre

The Kofi Annan International Peacekeeping Training Centre (KAIPTC) in Accra, Ghana, is a Regional Centre of Excellence that provides education, training and research on all aspects of peace operations. The Centre offers Ghanaian, regional and international participants the opportunity to examine specific peace operations issues at the operational level and to update and share their knowledge of the latest practices through conferences, discussions, lectures and computer-assisted training exercises.

The Rapporteurs

Ms Angela Ndinga-Muvumba was a Senior Researcher at the Centre for Conflict Resolution, Cape Town, South Africa, between 2005 and 2008. Ms Robyn Pharoah is a former researcher at the Institute for Security Studies (ISS) in Tshwane (Pretoria), South Africa, and is a consultant based in Cape Town.

Executive Summary

Acquired immune-deficiency syndrome (AIDS) was first officially defined as a disease in 1982 and the human immunodeficiency virus (HIV) identified in 1984. It has been over 25 years since the start of the HIV/AIDS pandemic. Despite reductions in the national HIV rates of Côte d'Ivoire, Kenya, Tanzania, Uganda and Zimbabwe, sub-Saharan Africa accounted for 76 per cent of global AIDS-related deaths in 2007.

An estimated 22 million Africans are infected with HIV, 61 per cent of whom are women, and the continent's average prevalence rate is five per cent. The scale of Africa's epidemic means that large percentages of military populations are, or will be, infected by HIV. The litany of potential consequences ensuing from HIV/AIDS illnesses and deaths have included: a heavy toll on decision-making command structures; rising costs in re-training highly-skilled personnel; and delayed deployment to international peace operations. An additional concern has included the vulnerability of peacekeepers to HIV within conflict zones and the risk of these troops spreading the virus among civilian populations at home and abroad.

The last decade of the pandemic has also coincided with the emergence of African security institutions in the form of regional economic communities (RECs) as well as the new African Union (AU). Furthermore, there is a new and urgent role for Africa's militaries beyond their national borders. A simple assessment of United Nation (UN) peacekeeping missions demonstrates that the continent is still very dependent on such operations to maintain and build peace. About 80 per cent of the UN's peacekeepers were deployed in seven African conflict zones (Western Sahara, southern Sudan, Sudan's Darfur region, the Democratic Republic of the Congo, Côte d'Ivoire, Ethiopia/Eritrea, Liberia, and Central African Republic/Chad) in 2008. Indeed, article 13 of the AU Peace and Security Council's Protocol calls for the establishment of an African Standby Force (ASF) by 2010.

If unaddressed, there is the strong possibility that the HIV/AIDS pandemic will slow the process of institutionalising peacekeeping in Africa. Troops for the African Standby Force will be drawn from various countries, each with its own HIV epidemic and strategy for containing the disease. But these diverse strategies have yet to be properly documented and co-ordinated at the sub-regional and continental levels.

In a bid to address these issues, the Cape Town-based Centre for Conflict Resolution (CCR) project, *HIV/AIDS and African Militaries: Addressing the Pandemic, Strengthening Peacekeeping*, has sought to strengthen the capacity of African peace and security institutions to respond to the challenge of HIV/AIDS. Between 2004 and 2007, the initiative examined the HIV/AIDS policies of African military institutions across all five of its sub-regions and sought to align knowledge and practice in this area with Africa's sub-regional and continental conflict management architecture.

This report is based on three regional advisory group seminars that took place in Windhoek, Namibia (February 2006); Cairo, Egypt (September 2007); and Addis Ababa, Ethiopia (November 2007). The policy meetings covered HIV/AIDS, African militaries and peacekeeping issues in Southern, North, West, Central and Eastern Africa. Each meeting sought critically to assess the response to the epidemic within defence forces in each sub-region. In this context, the seminars also considered the HIV/AIDS and security commitments of the African Union and the related policies of five sub-regional organisations: 1) the Southern African Development

Community (SADC); 2) the Economic Community of West African States (ECOWAS); 3) the Economic Community of Central African States (ECCAS); 4) the Intergovernmental Authority on Development (IGAD); and 5) the Arab Maghreb Union (AMU). Each of the three meetings provided a platform for the exchange of views between experts engaged in African peacekeeping and their counterparts in military health medicine.

The three regional advisory seminars were:

- **HIV/AIDS and Militaries in Southern Africa**: This meeting was convened in partnership with the University of Namibia (UNAM) in February 2006 in Windhoek, Namibia, and was organised in response to a request by Namibia's Minister of Defence, General Charles Namoloh, the Chair of the Southern African Development Community Organ on Politics, Defence and Security Co-operation (OPDSC) between 2006 and 2007. The advisory group examined HIV/AIDS management and mitigation programmes undertaken by defence forces in Namibia, Lesotho, Tanzania and Zimbabwe. The meeting's major output was a proposal for developing a Southern African HIV/AIDS and security policy through the SADC Organ on Politics, Defence and Security Co-operation.

- **HIV/AIDS, Militaries and Peacekeeping in North and West Africa**: This advisory group meeting was the first of two seminars organised in partnership with the Kofi Annan International Peacekeeping Training Centre (KAIPTC), based in Accra, Ghana. The seminar took place in Cairo, Egypt, in September 2007 and brought together HIV/AIDS military health practitioners and "traditional" peace and security policymakers from North and West Africa. Practitioners from military HIV/AIDS programmes in Ghana, Sierra Leone, Algeria and Tunisia delivered presentations on the challenges of HIV/AIDS prevention, treatment, care and support in their respective defence forces.

- **HIV/AIDS, Militaries and Peacekeeping in Central and Eastern Africa**: The third advisory group met in Addis Ababa, Ethiopia, in November 2007 and this policy seminar was also organised in partnership with KAIPTC. Both the Cairo and Addis Ababa meetings were convened in association with officials of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The Addis Ababa seminar assessed the strategic implications of HIV/AIDS for Central and Eastern Africa's peace and security architecture. Presentations were made on military HIV/AIDS programmes in Rwanda, Sudan and Uganda. This meeting also provided an opportunity to draw on regional perspectives from each of Africa's sub-regions, and provided a platform for dialogue with policymakers at the African Union Commission. The Addis Ababa seminar aimed to consolidate the recommendations of all three meetings on HIV/AIDS and militaries.

Through assessments of the limitations and constraints of existing efforts to address HIV/AIDS in African militaries, participants generated views on the "best practices" of military programmes among a range of actors and institutions. These seminars filled a policy gap between national, sub-regional and continental approaches to controlling HIV/AIDS in the context of African-led peacekeeping operations. This report, based on the three seminars and commissioned research from these meetings, brings together views on the policies and practice of HIV/AIDS and militaries across five African sub-regions. The report also addresses prospects for a response to the HIV/AIDS epidemic within the context of African peacekeeping and regional security.

HIV/AIDS and Africa's Militaries

While HIV prevalence rates among African militaries vary considerably, and are not uniformly higher than among civilian populations, the constraint of preventing and treating an incurable disease such as HIV/AIDS presents new challenges for Africa's militaries. HIV/AIDS treatment, care and support, require a lifetime provision of anti-retroviral (ARV) therapy, nutrition and psychosocial support. The burden of the disease poses questions for the management of human and financial resources in all sectors of society.

The Windhoek, Cairo and Addis Ababa seminars revealed a number of common challenges shared by African militaries in their efforts to respond effectively to HIV/AIDS. The meetings highlighted the gap between national, sub-regional and continental knowledge, perceptions and actions on a number of issues. There is insufficient evidence about the impact of HIV/AIDS on the long-term operability of African militaries. However, the majority of African militaries are implementing comprehensive HIV/AIDS prevention, treatment and care programmes. While these initiatives are under-resourced and limited in scale, they hold promise for mitigating the pandemic's long-term impact on Africa's evolving security architecture.

There is an emerging consensus on existing best practices for HIV/AIDS prevention, treatment, care and support. Common HIV prevention and treatment practices include:

- Education and awareness-raising;
- Promotion of voluntary counselling and testing;
- Condom distribution;
- Systematic HIV testing at recruitment, pre-deployment and post-deployment stages;
- Peer-to-peer support;
- Community care and support initiatives including home-based care and referral systems;
- Access to ARV therapy through military and national hospitals; and
- The use of media tools such as videos, plays, film and radio.

While the UN promotes voluntary counselling and testing before deployment of troops to peace operations, routine HIV screening as part of health assessments is an established policy among militaries across all of Africa's five sub-regions. In most militaries, a sero-positive individual will not be deployed to a peacekeeping mission, but can continue to serve in other functions. However, routine HIV screening in defence forces presents a number of challenges relating to the human rights of people living with HIV/AIDS. African militaries must pay careful attention to the human rights of their members who are diagnosed as HIV-positive and make special efforts to explain the rationale of mandatory testing to the general public.

African armies are also increasingly confronted with deploying troops to peacekeeping missions, managing humanitarian crises, and serving police functions in newly democratic and post-conflict societies. The African Standby Force's mandate is to support peacekeeping processes on the continent. The Force is envisaged as an African integrated blue helmet unit with robust, rapidly deployable capability to execute a wide range of missions, from disaster relief to conflict intervention. This force is to be composed of standby multi-disciplinary components with civilian, police and military components. These are to be based in their countries of origin, ready for rapid deployment at between 14 to 90 days notice. The African Standby Force will be comprised of

standby brigades in Central, North, Southern, Eastern, and West Africa, and will undertake traditional peacekeeping functions, as well as observer missions and post-conflict peace support activities. In some sub-regions, the brigades are being organised according to the building blocks of the AU – the regional economic communities. These include:

1. The Southern African Development Community;
2. The Economic Community of West African States;
3. The Intergovernmental Authority on Development;
4. The Economic Community of Central African States; and
5. The Arab Maghreb Union.

While African governments have made commitments such as the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases; and the SADC HIV/AIDS Strategic Framework and Plan of Action: 2003 - 2007, adopted in Maseru, Lesotho, in July 2003, their defence and security practices and policies have often failed to acknowledge the national security and human security aspects of the pandemic. Regional economic communities have not yet implemented strategies for their own co-ordinated sub-regional responses to HIV/AIDS. SADC's peace and security plan – encapsulated in the Strategic Indicative Plan for the Organ on Politics, Security and Defence Co-operation (SIPO) of 2004 – acknowledged the impact of HIV/AIDS in southern Africa, but the policy document provided no guidance to policymakers for developing a regional approach to HIV/AIDS and militaries. ECOWAS has a Plan of Action for 2004 – 2006 for the control of sexually-transmitted infections (STIs) and HIV/AIDS within armed forces, through its West African Health Organisation (WAHO). However, ECOWAS is yet to incorporate the WAHO plan into its conflict management strategic planning or operations. Indeed, the plan is not widely known in ECOWAS' defence, politics or security departments. HIV/AIDS and military preparedness has not yet fallen under the purview of regional groupings of the ASF in Central, Eastern and North Africa. These gaps in knowledge, perception and action could therefore result in significant problems in operationalising the African Standby Force by 2010.

Policy Recommendations

The discussions and research from the CCR project on "HIV/AIDS and African Militaries: Addressing the Pandemic, Strengthening Peacekeeping" resulted in the following four key policy recommendations:

1. **Address the challenges of scaling-up HIV/AIDS treatment within the context of failing health systems in Africa**: Key gaps in the response to HIV/AIDS are linked to poor primary healthcare, poorly-resourced hospitals and local clinics, and a deficit in capable healthcare workers. These facilities at the local and national level require predictable and sustained human and financial resources. African militaries face similar human and financial constraints that impact the quality of care in hospitals and the ability to secure medical equipment and supplies. This often results in a reliance on national health systems, which are also severely under-resourced. Governments, donor partners and civil society organisations should thus revisit the fragile state of health systems in Africa.

2. Leverage new avenues for facilitating wider behaviour change among military personnel: Soldiers represent a unique demographic group because they are a captive audience for instruction and education. The hierarchical nature of military institutions also provides a unique environment for transferring values and standards of behaviour from senior officers to younger serving members. Soldiers are part of broader communities and their behaviour directly impacts values within society. Collaboration across all sectors, and most pertinently, co-operation and information-sharing between militaries on the continent and across the civil-military divide, could prove critical to providing training, support and knowledge on broader societal issues such as gender and tradition, which often influence behaviour-change and HIV prevention.

3. Convene fora for monitoring military HIV/AIDS approaches at the regional level: Initiatives undertaken to develop HIV/AIDS policies at the national and sub-regional levels and the efforts to establish regional brigades of the African Standby Force have not been effectively integrated. Steps should therefore be taken by the African Union and the RECs to co-ordinate national HIV/AIDS policies; rationalise regional approaches such as the West Africa Health Organisation's policy; and develop measurable indicators across Africa. The African Union should bring together brigade-level planners and military health officers as part of the process of establishing the ASF. ECOWAS's policies should be widely examined in regional fora in Southern, Central, Eastern, and North Africa as it could provide a model for developing a continental approach. The lessons learned by the UN in managing its HIV/AIDS and peacekeeping policies should also be examined and integrated into the policies of the RECs and the AU.

4. Accelerate the implementation of HIV/AIDS plans through sub-regional, continental and international co-operation: Africa has already developed a roadmap for an exceptional response to HIV/AIDS. The African Union Commission's HIV/AIDS Strategic Plan and the African Common Position all embody the objectives and policies for an effective response to the pandemic. There is, however, a need to integrate and harmonise the implementation of both of these policies at the national and sub-regional levels. Efforts to domesticate legal and policy implications of these commitments should be made through African parliamentary fora and with national executives and ministerial institutions. Civil society organisations engaged in peace and security issues should be exposed to, and mobilised around, the AU Commission Plan and the Common Position.



From left: Mr Ivo Correia, Joint United Nations Programme on HIV/AIDS, Maputo, Mozambique; Ms Noria Mashumba, Centre for Conflict Resolution, Cape Town, South Africa; Major-General (Dr) Safi Eldin Elnur Ali, Omdurman Military Hospital, Khartoum, Sudan

1. Introduction

The Cape Town-based Centre for Conflict Resolution's (CCR) project, *HIV/AIDS and African Militaries: Addressing the Pandemic, Strengthening Peacekeeping*, has sought to bolster the capacity of African peace and security institutions to respond to the challenge of HIV/AIDS.

Between 2004 and 2007, the initiative examined the HIV/AIDS policies of African military institutions across all five of its sub-regions and sought to align knowledge and practice in this area with the continent's sub-regional and continental conflict management architecture.

This report is based on three regional advisory group seminars that took place in Windhoek, Namibia (February 2006); Cairo, Egypt (September 2007); and Addis Ababa, Ethiopia (November 2007). The policy meetings covered HIV/AIDS, African militaries and peacekeeping issues in Southern, North, West, Central and Eastern Africa. Each meeting sought critically to assess the response to the epidemic within defence forces in each sub-region. In this context, the seminars also considered the HIV/AIDS and security commitments of the African Union (AU) and the related policies of five Regional Economic Communities (RECs): 1) the Southern African Development Community (SADC); 2) the Economic Community of West African States (ECOWAS); 3) the Economic Community of Central African States (ECCAS); 4) the Intergovernmental Authority on Development (IGAD); and 5) the Arab Maghreb Union (AMU). Each of these meetings provided a platform for the exchange of views between experts engaged in African peacekeeping and their counterparts in military health medicine.

The three regional advisory seminars were:

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Seminar Themes

The following three themes formed the basis of the three advisory group seminars:

1. HIV/AIDS and the Military: Policies and Practice
   - Policy development of HIV/AIDS management and mitigation in African militaries;
   - Case studies in HIV/AIDS prevention, care, support and treatment challenges within the context of regional defence structures; and
   - Best practices for HIV/AIDS management and mitigation from a military perspective.

2. Sub-regional, Continental and International Co-operation: RECs, the AU and the United Nations
   - The AU's HIV/AIDS Strategic Plan: 2005 - 2008;
   - The African Standby Force (ASF) – to be established under the AU's co-ordination by 2010 – and regional arrangements for establishing the North, West, Central and Eastern African standby brigades; and
   - HIV/AIDS mitigation lessons from UNAIDS and the UN Department of Peacekeeping Operations (DPKO).

3. Tackling Constraints and Limitations
   - Translating policy recommendations into workable frameworks;
   - Mobilising political will and financial support for a durable and predictable response to the HIV/AIDS pandemic; and
   - Strengthening human resources in national militaries and bolstering the capacity of Africa's RECs and the AU to combat the pandemic effectively.

This project brought together a diverse group of African actors and individuals. The three seminars involved participants from the following 28 African countries from five sub-regions: Algeria, Angola, Botswana, Burundi, Burkina Faso, Cameroon, Côte d'Ivoire, Egypt, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Libya, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, Somaliland, South Africa, Sudan, Tunisia, Uganda, Zambia and Zimbabwe. Each sub-regional seminar involved an average of 31 participants. While several of the advisory group members took part in more than one seminar, a total of 90 individuals contributed to the project through these regional meetings. Specifically, the project brought together a range of military experts, civil society representatives, academics and policymakers from African governments, RECs, the AU and the UN. Key policymakers included:

- General Charles Namoloh, the Minister of Defence of Namibia;
- Dr Tomaz Augusto Salomão, SADC's Executive Secretary;

- Dr Kaire Mbuende, former SADC Executive Secretary;
- Dr Grace Kalimugogo, Acting Director of the Department of Social Affairs, African Union Commission;
- Mr Bereng Mtimkulu, Head of Peace Support Operations, African Union Commission;
- Dr Antonica Hembe, Head of the SADC HIV/AIDS Unit;
- Colonel Ahmadu Bello, Principal Programme Officer for Mission Planning and Management in ECOWAS;
- Colonel Alefati Zrass, the African Union's designated focal point for the African Standby Force's North African Brigade (NASBRIG);
- Ambassador Abdelrahim Khalil, Director of the Conflict Early Warning Response Mechanism (CEWARN) of IGAD;
- Mr Simon Mulongo, Director of the Eastern Africa Standby Co-ordination Mechanism (EASBRIG) of the African Standby Force;
- Dr Oussama Tawil, Regional Director, Middle East and North Africa, UNAIDS;
- Mr Abdul Dieng, Regional Adviser, African Organisations, UNAIDS;
- Ms Brigitte Quenem, Adviser, HIV and Humanitarian Affairs, UNAIDS Regional Support Team for West and Central Africa;
- General Henry Anyidoho, Deputy Force Commander of the United Nations/African Union Hybrid Mission in Darfur (UNAMID);
- Professor Margaret Vogt, Deputy Director, Department of Political Affairs, UN; and
- Dr Abdel-Kader Haireche, Team Leader, AU Peace Support Team, UN Department of Peacekeeping.

Through assessments of the limitations and constraints of existing efforts to address HIV/AIDS within African militaries across five sub-regions, participants generated views on common HIV/AIDS interventions. The three seminars identified a policy gap between national, sub-regional and continental HIV/AIDS management and mitigation, in the context of African-led peacekeeping operations. This report, based on the three policy seminars and commissioned research, brings together views on the policies and practice of HIV/AIDS and militaries. The report also addresses prospects for a response to the HIV/AIDS epidemic within the context of African peacekeeping and regional peace and security.

Anatomy of a Pandemic

Acquired immune-deficiency syndrome (AIDS) was first officially defined as a disease in 1982, while the human immunodeficiency virus was first identified in 1984.[1] Despite reductions in the national HIV rates of Côte d'Ivoire, Kenya, Tanzania, Uganda and Zimbabwe, sub-Saharan Africa accounted for 76 per cent of global AIDS-related deaths in 2007.[2] An estimated 22 million Africans are infected with HIV, 61 per cent of whom are women, and the average prevalence rate of the disease is five per cent.[3] Southern Africa remains the epicentre of the global pandemic. In 2007, 32 per cent of the world's new HIV infections and AIDS deaths took place in this sub-region. Even though most of Southern Africa's national epidemics have reached their estimated peak, adult HIV prevalence is more than 15 per cent in Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.[4]

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1 The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), "25 years of AIDS", UNAIDS/06.20E, May 2006.
2 *AIDS Epidemic Update*, Report published by the Joint United Nations Programme on HIV/AIDS and the World Health Organisation, UNAIDS/07.27E / JC1322E, December 2007, p.6.
3 Ibid., p.7.
4 Ibid., p.15.

Eastern Africa's HIV/AIDS epidemic reflects various trajectories of the disease. In many countries in this sub-region, HIV prevalence levels have either stabilised or declined. Between 1996 and 2000, Ethiopia's epidemic stabilised in urban areas and there has since been a noticeable decline. Behaviour change in Kenya has accounted for a decline in levels of infection from 14 per cent in the 1990s to five per cent in 2006. However, as in other parts of Africa, the virus is still predominantly affecting women. In Uganda, where HIV infection rates fell in the late 1990s, 7.5 per cent of women were living with HIV in 2007, while the rate among men was five per cent in the same year.[5]

As is typical of the epidemiology of the virus, HIV rates in many Central African countries vary considerably according to location. In 2005, Rwanda's HIV prevalence rate was highest in the capital of Kigali (13 percent), compared to other urban areas (five per cent) and rural areas (two per cent). In the Democratic Republic of the Congo (DRC), HIV rates vary considerably: from about 3.8 to 4.2 per cent in the capital of Kinshasa between 1995 and 2005, to higher levels in other large cities such as Kisangani, where HIV prevalence was six per cent among pregnant women in 2005.[6] Furthermore, despite progress made in controlling or decreasing the disease, it is important to understand that HIV/AIDS can fall and rise again. Burundi's epidemic, for example, seemed to be on the decline in the late 1990s, but after 2005, infection rates began to increase again.[7]

From left: At the launch of the CCR volume, "South Africa in Africa: The Post-Apartheid Era": Professor Gilbert Khadiagala, University of the Witwatersrand, Johannesburg, South Africa; Dr Adekeye Adebajo, Centre for Conflict Resolution, Cape Town, South Africa; H.E. Ambassador L.C. Pepani, Ambassador Extraordinary and Plenipotentiary of South Africa, Addis Ababa, Ethiopia; Mr Ben Kioko, Legal Counsel of the African Union Commission, Addis Ababa, Ethiopia; Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town, South Africa; Major-General Solly Mollo, South African Ministry of Defence, Tshwane, South Africa

5 Ibid., p.18.
6 Ibid., p.20.
7 Ibid., p.18.

It is widely acknowledged that North and West Africa have less virulent HIV epidemics since national adult prevalence levels have either remained stable or the epidemic has never reached the same proportions as in Southern and Eastern Africa. This presents both a great opportunity to control the disease and a risk that these states and societies will be apathetic in their responses to HIV/AIDS. Benin's HIV rate, for example, has remained at two per cent since 2004.[8] Togo has one of the highest rates in West Africa, at about 4.2 per cent among pregnant women in 2006,[9] while a demographic and health survey in Côte d'Ivoire found that the country's national prevalence rate was nearly 4.7 per cent.[10] Even in post-conflict states such as Sierra Leone and Liberia, early estimates of HIV trends suggest that there is hope for containing the epidemic. UNAIDS reports based on a national demographic and health survey in 2007 found that the average HIV prevalence rate among 15 to 49-year-old Liberians was 1.5 per cent. The highest levels of prevalence were in the capital of Monrovia at 2.6 per cent.[11] Although the epidemic might be increasing in Sierra Leone, HIV prevalence among pregnant women in mostly urban areas was 4.1 per cent in 2006.[12] Africa's most populous state, Nigeria, has higher rates and more variability: "...from as low as 1.6 per cent in the western state of Ekiti to 8 percent in Akwa Ibom in the south and 10 percent in Benue in the south-east".[13]

The differences between North Africa and the rest of Africa are multiple. A significant cause of the spread of HIV/AIDS in sub-Saharan Africa is unprotected heterosexual intercourse related to sexual mixing through multiple partners.[14] In North Africa, HIV transmission has been generally attributed to exposure to the virus through contaminated drug injection equipment such as needles or syringes. For example, UNAIDS reports that nearly four out of ten drug-users in Algeria, and five out of ten users in Egypt and Morocco have used non-sterile syringes.[15] Yet, increasingly, sex work and unprotected paid sex is a cause of HIV infections in Libya, Tunisia, Algeria and Morocco. [16]

The global HIV/AIDS pandemic has been compared to the 1918 flu epidemic and Europe's "Black Death" in the 14th Century. The comparisons have been rooted in the perception that HIV/AIDS is similar to these other epidemics in its scale – killing millions of people – and capacity radically to transform social, political and economic life. However, the flu epidemic and the "Black Death" unleashed directly observable ramifications in societies because their symptoms were immediately visible, and death imminent. HIV/AIDS, on the other hand, has a lengthy progression between HIV-infection, deterioration of the immune system, the onset of AIDS-related opportunistic infections (OIs) and death. Indeed, unless it is specifically tested, the disease does not become apparent for approximately ten years. Meanwhile, the disease's viral load, and therefore the likelihood of infection if the virus gains access to a new human host, is believed to be higher during the initial months after infection.[17] This means that HIV must be prevented most when its human host may not know that she or he is carrying the virus. Because it is most commonly transmitted through unprotected sex, HIV poses unbounded challenges for societies that place taboos on exploring and adapting sexual behaviour and practices. Thus,

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8 Ibid.
9 Ibid., p.19.
10 Ibid. p.20.
11 Ibid.
12 Ibid.
13 Ibid. p.18.
14 Daniel T Halperin and Helen Epstein, "Sexual Partnerships Help to Explain Africa's High HIV Prevalence: Implications for Prevention", *The Lancet*, 364 (2004) (9 428): 4–6.
15 *AIDS Epidemic Update: Special Report on HIV/AIDS*, Report published by UNAIDS and WHO, UNAIDS/06.29OE, December 2006, p.60.
16 Ibid. p.60.
17 Halperin and Epstein, op.cit., p.5.

beyond the distressing toll of the disease on the human immune system, resulting in an abundance of painful progressive illnesses, HIV/AIDS has been mired in social stigma and shame. In the gallery of sexually transmitted infections (STIs) and other infectious diseases, HIV/AIDS remains unique in this regard.

With the arrival of highly active anti-retroviral therapy (HAART) – more often referred to as anti-retroviral (ARV) therapy – the HIV/AIDS pandemic has become even more exceptional in its disposition. Affordable access to ARVs means that people living with the disease need not die early as a result of the disease, but can live longer, good quality lives. But this, in turn, presents additional challenges. First, even with affordable drugs made available, overcoming the stigma of HIV/AIDS will be very difficult, and many people are unlikely to be able to access these drugs. Second, drug therapy requires systematic attention to the substance, longevity and side effects of the drug. This means that patients must have proper counseling and guidance, strong social support to maintain their drug regimens every day, and access to regular drug supplies. These factors are possible when local and national health systems are equipped with effective and well-trained healthcare workers.

Lifetime provision of universal HIV medication requires human and financial resources; health, education and social infrastructure development; and political leadership. The features of AIDS – its invisibility, its duration, and its capacity to be prevented and treated – make the disease altogether unlike any of the world's previous epidemics. Nevertheless, HIV/AIDS does have important long-term impacts on states and societies. The principle reason is that, in its manifestation in most parts of the world today, the disease is a generalised epidemic rooted in unprotected sexual intercourse. People are most likely to be infected with HIV during their most sexually active years: between the ages of 15 and 49. Thus, working-age adults in this demographic group bear the greatest burden of HIV infections. Because working adults are thus removed from productive life in order to cope with illness or to care for the sick, some believe that the pandemic poses long-term, cyclical problems for Africa's development and democratisation. Indeed, HIV/AIDS is widely referred to as a "long wave" event that will influence how African societies develop and how their communities survive for many decades to come.[18] The scale of Africa's AIDS epidemic means that large percentages of military populations are, or will be infected by, HIV. Thus, in some southern African countries, 20 to 40 per cent of members of defence forces are estimated to be infected with HIV/AIDS.[19] Illness and death of security personnel such as soldiers could result in operational inefficiency in national security structures, leading to a negative impact on troop strength and the maintenance of a deployable number of soldiers. The litany of potential consequences ensuing from HIV/AIDS illnesses and deaths in militaries have included: a heavy toll on decision-making command structures; rising costs in retraining highly-skilled personnel; and delayed deployment to international peace operations. An additional concern has included: the vulnerability of peacekeepers to HIV within conflict zones, and the risk of these troops spreading the virus among civilian populations at home and abroad.[20] Although many of these fears have been difficult to prove or disprove definitely through comparable and reliable data, national governments, regional bodies, and the UN have put in place policies for managing the epidemic's impact on peacekeeping and military life.

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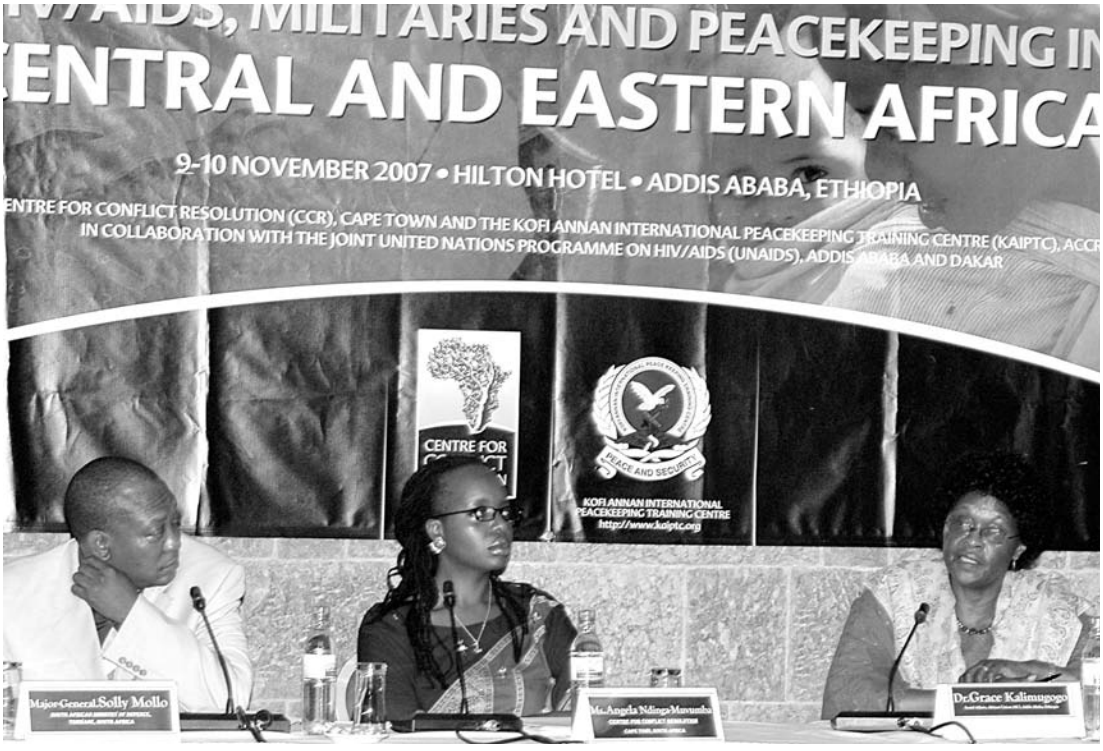
18 See *HIV/AIDS and Society in South Africa: Building a Community of Practice*, Cape Town, South Africa, 27 and 28 March 2006, and *HIV/AIDS and Human Security in South Africa*, Cape Town, South Africa, 26 and 27 June 2006, Reports published by the Centre for Conflict Resolution (available at http://ccrweb.ccr.uct.ac.za). See also Angela Ndinga-Muvumba and Robyn Pharoah (eds), *HIV/AIDS and Society in South Africa* (Scottsville: UKZN Press, 2008).

19 See Armed Forces Medical Intelligence Centre, *Impact of HIV/AIDS on Military Forces: Sub-Saharan Africa*, DI-1817-2-00 (Washington, D.C.: Defence Intelligence Agency, 2000), cited in Laurie Garrett, *HIV and National Security: Where are the Links?* (New York: Council on Foreign Relations, 2005), p.28.

20 See CCR reports, *HIV/AIDS and Militaries in Southern Africa*, Windhoek, Namibia, 9 and 10 February 2006; and *HIV/AIDS and Human Security: An Agenda for Africa*, Addis Ababa, Ethiopia, 9 and 10 September 2005 (available at http://ccrweb.ccr.uct.ac.za).

At the level of African governments, militaries have taken on commitments to provide basic prevention services; to increase access to condoms; to encourage voluntary testing as a supplement to routine mandatory HIV surveillance; and to plan for increasing access to ARV therapy, care and support. Africa's regional organisations are increasingly co-ordinating their efforts and learning lessons from national experiences. At the international level, UNAIDS' Office on AIDS, Security, and Humanitarian Response and the UN's Department of Peacekeeping Operations (DPKO) in New York have implemented an integrated approach to AIDS and security within the UN's peacekeeping missions. Each major UN peacekeeping operation now has a full-time AIDS adviser, supported by trainers and counsellors; while all smaller missions have an AIDS focal point. UNAIDS also supports Africa's continental, sub-regional, and national HIV/AIDS management and mitigation initiatives.[21]



ABOVE : *From left:* Major-General Solly Mollo, South African Ministry of Defence, Tshwane, South Africa; Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town, South Africa; Dr Grace Kalimugogo, African Union Commission, Addis Ababa, Ethiopia

RIGHT : *From left:* Dr Abdel-Kader Haireche, United Nations Department of Peacekeeping Operations, Addis Ababa, Ethiopia; Colonel George McGarr, Kofi Annan International Peacekeeping Training Centre, Accra, Ghana; Major-General Henry Anyidoho, United Nations/African Union Hybrid Mission in Darfur, Sudan

21 UNAIDS Office of AIDS, Security and Humanitarian Response, Progress Report, unpublished paper, 2005; and UNAIDS, *On the Front Line: A Review of Policies and Programmes to Address AIDS Among Peacekeepers and Uniformed Services*, New York: July 2003.

HIV/AIDS requires all segments of society to plan for its impact on available human resources; the increased demand for healthcare and psycho-social support; the toll on family life and its influence on productivity; and other unanticipated issues that will arise as morbidity, mortality and orphaning peak. For these reasons, mandatory testing has become a central policy in many defence sectors. Since militaries must accurately plan their operational capacity and rapid deployment, planners measure the fitness of their members and gauge the disease burden of the force. HIV can only be detected through specific screenings which are generally voluntary in the civilian world and not yet part of normal health assessments. However, most militaries in Africa and elsewhere screen all new recruits for HIV, and maintain continuous mandatory testing before and after deployment. Without these steps, defence planners argue that they would be unable to estimate operability and capability. Human rights groups, however, contend that mandatory screening compromises the rights of individuals when a positive result for HIV disqualifies admission into the military or deployment to certain missions. African defence forces, for their part, maintain that it would be irresponsible to deploy an HIV-infected person into a conflict environment, and that HIV is treated as any other condition – such as poor eyesight or flat feet – which preclude admission into the military. Similar practices may evolve in other segments of societies, and many of them would lead to an impasse between groups on sensitive human rights and legal issues.

The last decade of the HIV/AIDS pandemic has also coincided with the emergence of African security institutions in the form of regional economic communities as well as the African Union which succeeded the Organisation of African Unity (OAU) in 2002. These organisations are the key actors in the development and establishment of the continent's peacekeeping body, the African Standby Force, to be established by 2010 based on five sub-regional pillars.[22] Africa's militaries are increasingly viewed as central to developing a peacekeeping capacity on the continent. These armies are now confronted with deployment to multidimensional peacekeeping operations, managing humanitarian crises, and/or serving police functions in newly democratic and post-conflict societies. A simple assessment of UN peacekeeping missions demonstrates that Africa is still very dependent on such operations to maintain and build peace. Out of 90 000 peacekeepers in the world in 2006, nearly 58 346 of the UN's military and civilian police were deployed in Africa.[23] About 80 per cent of the UN's peacekeepers were deployed in seven African conflict zones (Western Sahara, South Sudan, Sudan's Darfur region, DRC, Côte d'Ivoire, Liberia, Central African Republic/Chad) in 2008.

If unaddressed, there is the probability that HIV/AIDS will slow the process of institutionalising peacekeeping in Africa. The troops for continental peacekeeping will be drawn from various countries, each with its own HIV epidemic and strategy for containing the disease. However, the diverse strategies to tackle this problem have not yet been properly documented and co-ordinated at the sub-regional and continental levels.

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22 African Union, *Protocol Relating to the Establishment of the Peace and Security Council of the African Union*, Ist Ordinary Session of the Assembly of the Heads of State, Durban, South Africa, 9 July 2002 (available at http://www.africaunion.org/root/au/Documents/Treaties/Text/Protocol_peace%20and%20security.pdf).

23 UN Department of Peacekeeping Operations Factsheet (available at http://www.un.org/Depts/dpko/factsheet.pdf ; accessed 24 September 2006) and descriptions of current peacekeeping operations (available at http://www.un.org/Depts/dpko/dpko/).

2. HIV/AIDS and Africa's New Security Architecture

As noted earlier, the African Union is aiming to establish an African Standby Force by 2010. The ASF's mandate is to support peacekeeping processes on Africa. The Force is envisaged as an African integrated unit with robust, rapidly deployable capability to execute a wide range of missions, from disaster relief to conflict intervention.

This force is to be composed of standby multi-disciplinary components with civilian, police and military components. These are to be based in their countries of origin, ready for rapid deployment at between 14 to 90 days notice.[24] The ASF will be comprised of standby brigades in Central, North, Southern, Eastern, and West Africa, and will undertake traditional peacekeeping functions, as well as observer missions and post-conflict peace support activities (Figure 1).[25] In some African sub-regions, the brigades are being organised according to the building blocks of the AU – the regional economic communities. These include:

- The Southern African Development Community;
- The Economic Community of West African States;
- The Intergovernmental Authority on Development;
- The Economic Community of Central African States; and
- The Arab Maghreb Union.

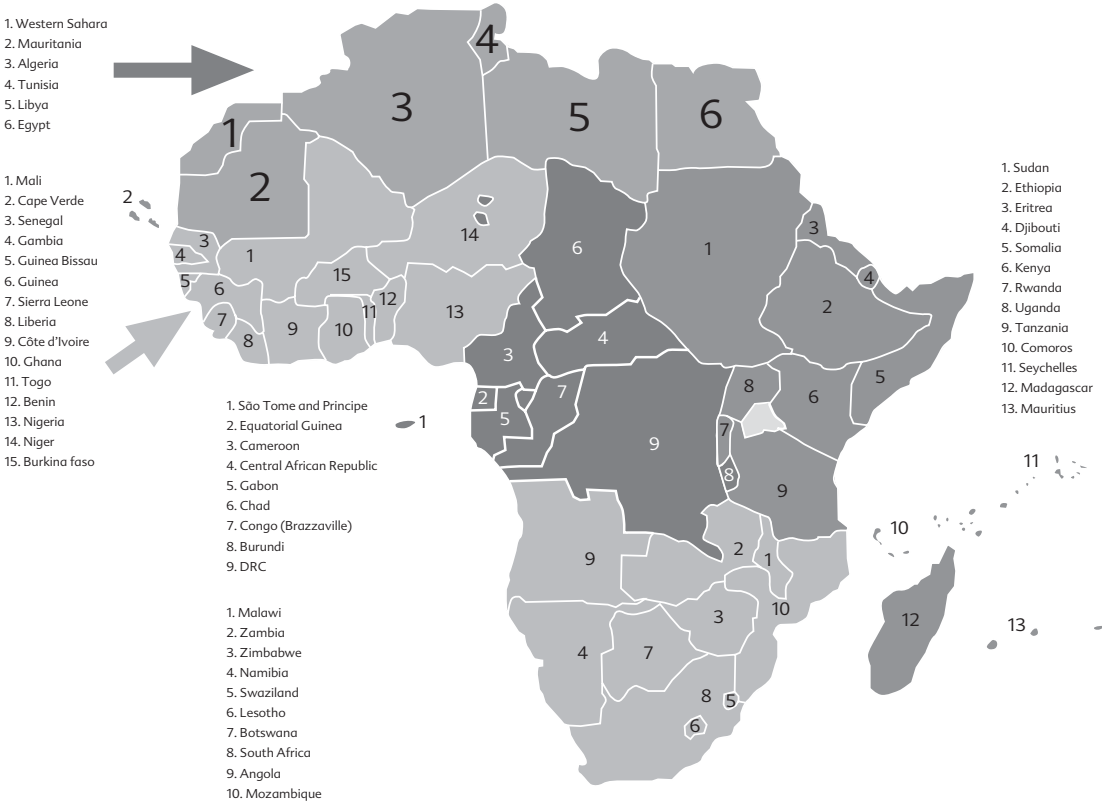
ABOVE: *From left* : Major-General Dr Safi Eldin Elnur Ali, Omdurman Military Hospital, Khartoum, Sudan; Mr Fai Fominyen Ngu Edward, Prometre International, Yaoundé, Cameroon; Mr Sebagabo Marcellin, Ministry of Defence, Rwanda; Lieutenant-Colonel (Dr) James Anthony Samba, Sierra Leone Armed Forces, Freetown, Sierra Leone
FAR LEFT: Major-General Solly Mollo, South African Ministry of Defence, Tshwane, South Africa
LEFT: Ms Victoria Lonje, Alliance of Mayors' Initiative for Community Action Against HIV/AIDS at Local Level, Windhoek, Namibia

24 Simon Mulongo, "The African Standby Force: A Case of the Eastern Africa Standby Brigade [Force] (EASBRIG)", presentation made at the *HIV/AIDS, Militaries and Peacekeeping in Central and East Africa* policy advisory seminar, 9 and 10 November 2007, Addis Ababa, Ethiopia.

25 Jakkie Cilliers and Mark Malan, "Progress with the African Standby Force", Paper published by the Institute for Security Studies (ISS), 107, May 2005.

Each sub-regional standby brigade will be expected to maintain a force of about 3,000 infantry soldiers, 1,258 logistical specialists, signallers, engineers, and military police and civilian support staff for rapid deployment to African conflict zones.

Figure 1: African Standby Force Sub-regions



Source: Simon Mulongo, 2007

The African Union faces many challenges in implementing the vision of the ASF. Perhaps one of the greatest challenges to its success is the HIV/AIDS epidemic. The majority of African governments have established HIV/AIDS programmes in their militaries. The Namibian military, for example, has engaged with a range of military and civil society players to develop a comprehensive HIV/AIDS policy, involving HIV awareness-raising activities, voluntary counselling and testing (VCT) and the provision of anti-retroviral treatment. In countries such as Sudan and South Africa, the military is often said to be ahead of governments in putting in place measures to mitigate the spread and effects of the epidemic. UNAIDS and the United States Department of Defence (DoD) are also working to support financially and technically the implementation of prevention, care, support and mitigation activities of many of Africa's militaries. However, the policies of the continent's militaries

vary widely, and both military and national policies are poorly co-ordinated at the sub-regional and AU levels. Policies on HIV/AIDS have also not yet been integrated into defence and security plans for Africa's future peacekeeping operations.

The signing of the African Common Position on HIV/AIDS in the lead-up to the second UN General Assembly Special Session (UNGASS) on HIV/AIDS in New York in June 2006 potentially heralds a greater level of unity in the AU's response to the epidemic. This calls for African leaders to:

- Integrate measures to address the HIV/AIDS epidemic with other efforts to fight poverty and food insecurity;
- Treat essential medicines and other basic services as a human right;
- Provide prevention, treatment and care for people affected by conflicts, such as refugees and internally displaced persons (IDPs);
- Increase the percentage of the continent's healthcare workforce from its current global number of 2.5 per cent;
- Exempt healthcare from the spending ceilings imposed by African finance ministries;
- Cost comprehensive national HIV/AIDS plans; and
- Ensure that officials mandated to respond to HIV/AIDS are accountable to parliaments and civil society through parliamentary reviews of policies and other measures.[26]

The African Union Commission, which is mandated to implement the declarations and commitments made by its member governments, is tasked with building the capacity of the AU's institutions and the RECs to implement an urgent response to the challenges of the epidemic; establish a division of labour that will lead to more harmonised policy responses; and help to mobilise African leaders, AU institutions, the RECs, civil society and the private sector to mount unified and co-ordinated pro-active responses to the pandemic. This includes a specific programme of policy development for AU-REC co-operation on HIV/AIDS, conflict and military issues. The programme aims to identify entry-points and a roadmap for determining a division of labour between peace and security, humanitarian affairs and social affairs actors at the continental and regional levels, and to establish a network among these groups for continued and regular interaction and information-sharing. Other activities entail delivering policy recommendations to AU organs such as the 15-member Peace and Security Council (PSC), and integrating new HIV/AIDS approaches into the AU and the New Partnership for Africa's Development (NEPAD) Post-Conflict Reconstruction Frameworks.

The African Union's Peace and Security department has already taken steps to address HIV/AIDS issues for its 7,000 peacekeepers deployed in Sudan's Darfur region, and is in the process of designing military health guidelines, including HIV/AIDS policies, for the African Standby Force. However, there remain five key challenges to achieving these objectives:

- First, limited human resources: an over-dependence on external consultants and slow levels of institutionalisation within member states, as well as competing agendas within the African Union;

- Second, duplication of activities: poor communication within and between RECs, insufficient resource allocation by member states, and the potential for duplication of activities;

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26 African Union, *Common Position on HIV/AIDS*, Sp/Assembly/ATM/3 (I) Rev.2 (available at http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/UNGASS_Common_Position.pdf).

- Third, political commitment and ownership: the sluggishness and patchiness of the response to HIV/AIDS by African leaders to date suggest a lack of widespread political will to address the epidemic with the urgency required. The extent to which the AU Commission can canvass political will and ownership of interventions by national governments and their national co-ordinating bodies will be critical in achieving these goals;

- Fourth, time and events: ongoing political commitment in future to combating the epidemic, the challenges of finding local technical solutions and innovative tools and strategies that are appropriate to the African context, as well as ensuring responsive, timeous resource allocation supporting such innovation; and

- Finally, AIDS fatigue: HIV/AIDS is a long-wave event that is likely to be played out over several decades. "AIDS fatigue" and changes in the international funding environment can seriously threaten the sustainability of interventions. Ongoing donor commitments to addressing HIV/AIDS in Africa over the long-term will be critical to implementing successful measures to address the epidemic.[27]

ABOVE: *From left:* Mr John Opoku, Kofi Annan International Peacekeeping Training Centre, Accra, Ghana; Dr Kwesi Aning, Kofi Annan International Peacekeeping Training Centre, Accra, Ghana; Mr Bereng Mtimkulu, African Union Commission, Addis Ababa, Ethiopia

RIGHT: Mr Sam Kona, Centre for Conflict Resolution, Cape Town, South Africa, *left;* Professor Gilbert Khadiagala, University of the Witwatersrand, Johannesburg, South Africa

27 Angela Ndinga-Muvumba, "An African Agenda: HIV/AIDS", presentation made at the *HIV/AIDS and Militaries and Peacekeeping in North and West Africa* workshop in Cairo, Egypt, 8 and 9 September 2007.

3. HIV/AIDS, Regional Security and Conflict

While the state of the HIV/AIDS epidemic differs between countries, and prevalence rates are likely to vary in militaries across the continent, the disease is an important issue within national militaries, particularly given the changing role of militaries in Africa.

While the mandate of the uniformed services has traditionally been confined to defence, Africa's militaries increasingly take on important additional roles, from auxiliary policing to emergency management and response. In the context of expanding mandates, and the prospect of greater peacekeeping responsibilities heralded by the African Standby Force, HIV/AIDS could compromise the operational capacity and capability of the armed forces and, particularly in high-prevalence countries, have significant budgetary consequences.[28] This has potential implications for the ability of governments to defend themselves from attack, as well as both nation-building within African states and peacekeeping abroad.

Some have argued that features of the military environment, including certain levels of redundancy and duplication of skills; proactive personnel management strategies that help armies protect their strategic advantages; and the technical capacity and institutional authority to institute the necessary measures to mitigate the effects of HIV/AIDS may make armed forces more resistant to the effects of the epidemic.[29] These arguments raise important questions about assumptions that militaries are excessively – and equally – vulnerable to epidemic. Yet, they do not adequately address the costs of HIV/AIDS to post-Cold War militaries that are now confronted with deployment to multi-dimensional peacekeeping operations, managing humanitarian crises, and serving policing functions in newly democratic and post-conflict societies. These responsibilities are likely to see military personnel deployed more consistently than if tasked only with their traditional defensive role. They therefore place a premium on soldiers with specific, acquired skills. In the absence of comprehensive programmes to prevent and manage HIV/AIDS within the ranks, militaries faced with ongoing demands on their capacity may find it increasingly difficult to fulfil their mandates effectively in the face of even moderate levels of HIV/AIDS-related illness and death.

Arguably, a soldier's involvement in conflict and post-conflict environments may also place him or her at high risk of contracting HIV. Some have also argued that this situation could create the risk of HIV-positive personnel transmitting the virus to host populations – and their sexual partners on their return home. Key features of these environments – including the large-scale loss of livelihoods; population movements; the separation of families; and often high levels of prostitution – create ample opportunities for sex.[30] Frequently lengthy deployments and high-stress working conditions also increase the chances of personnel engaging in risky sexual behaviour. Furthermore, both regular and irregular forces may spread the virus through sexual violence.

There is evidence to suggest that peacekeepers may be particularly vulnerable to infection. Estimates in 1989/90 showed that the prevalence of HIV among Nigerian army troops was less than one per cent; by 1997,

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28 Lindy Heinecken, "Living in Terror: The Looming Security Threat to Southern Africa", *African Security Review* 10(4), (2001), 12. See also Lindy Heinecken, "HIV/AIDS, the Military and the Impact on National and International Security", *Society in Transition* 32(1), (2001), pp.120-127.

29 Alan Whiteside, Alex de Waal and Tsadkan Gebre-Tensae, "AIDS, Security and the Military in Africa: A Sober Appraisal", *African Affairs*, January 2006, pp.201-218.

30 See, for example, Michael Fleshman, "AIDS Prevention in the Ranks: UN targets peacekeepers, combatants in war against disease", *Africa Recovery* 15(1-2), June 2001, p.16.

this figure had increased to five per cent; and by 1999 to ten per cent. This increase coincided with a return of troops from the Economic Community of West African States Ceasefire Monitoring Group (ECOMOG) which was an ECOWAS peacekeeping operation deployed to Liberia between 1990 and 1998.[31] The same study found that levels of prevalence among Nigerian peacekeepers in Sierra Leone (where a 12,000-strong Nigerian contingent was deployed between 1997 and 2000) increased from seven per cent after one year of deployment, to ten per cent after two years, to more than 15 per cent after three years of duty in the operational area. Finally, the Civil-Military Alliance (CMA) investigated HIV levels among Nigerian peacekeepers returning from Liberia and Sierra Leone, and found that infection rates were more than double those of personnel not involved in peacekeeping. This research also showed that a soldier's risk of infection doubled with each year spent on deployment in conflict zones, suggesting a direct link to duty in such military theatres.[32]

Analysts have further argued that the military environment is particularly conducive to successful prevention activities and messaging – and that soldiers can become change agents in the communities in which they live and work. The hierarchical structure of militaries, and their well-developed command and control mechanisms, often present unique opportunities for integrating HIV/AIDS prevention, care and treatment services into their systems.[33] These characteristics can facilitate, for example, sustained, habit-creating condom promotion.[34] Similarly, being a captive audience, large numbers of soldiers can be targeted for behavioural change messaging on an ongoing basis. The very qualities that may put some personnel at risk, such as their greater status and wealth, can also be harnessed in the fight against HIV/AIDS. Better informed soldiers may not only be in a stronger position to protect themselves against infection, but could also become champions of safer sex in the communities linked to army bases. In the Democratic Republic of the Congo, for example, peacekeepers have organised World AIDS Day events with local community groups, while in Sudan, the UN is trying to integrate HIV/AIDS issues into disarmament and reintegration processes.[35]

From left: Colonel (Dr) Ambrose Musinguzi, Uganda People's Defence Forces, Kampala, Uganda; Dr Monde Muyangwa, Africa Centre for Strategic Studies, Washington, United States; Mr Paul Bradnum, Centre for Conflict Resolution, Cape Town, South Africa

31 A Adefolalu, "HIV/AIDS as an Occupational Hazard to Soldiers – ECOMOG Experience", paper presented at the third All Africa Congress of Armed Forces and Police Medical Services, Tshwane, 1999, cited in Whiteside et al, "AIDS, Security and the Military in Africa: A Sober Appraisal".

32 Fleshman, "AIDS Prevention in the Ranks".

33 Robert Ritzenthaler, "On the Front: HIV/AIDS and the Uniformed Services", Family Health International, September 2005.

34 Rodger Yeager, Craig Hendrix and Stuart Kingma, "International Military Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome Policies and Programs: Strengths and Limitations in Current Practice", *Military Medicine* 165(2)87:92, February 200.

35 CCR, "HIV/AIDS and Militaries in Southern Africa".

4. Lessons on Prevention, Treatment and Care

Responding effectively to HIV/AIDS in the uniformed services requires that militaries not only acknowledge that HIV/AIDS is a unique and urgent challenge, but that they also explore new ways of engaging around HIV/AIDS prevention, treatment, care and support.

While many African militaries have been slow in developing partnerships with civilian institutions and actors, interventions by civilian non-governmental organisations (NGOs), faith-based organisations (FBOs), and other actors could provide lessons for African militaries on how to address HIV/AIDS holistically. In Egypt, for example, CARITAS – the Catholic agency for overseas aid and development – has put in place innovative programmes to prevent the spread of HIV among high-risk groups, to reduce the individual and social impacts of HIV/AIDS, and to mobilise and promote inter-sectoral and inter-agency collaboration within the HIV/AIDS sector.[36] CARITAS's experience in tackling sensitive issues such as the risk of infection among men who have sex with men; concurrent sexual relationships and drug and substance abuse through peer education; interventions to reduce needle-sharing; and foundational training in values for behaviour-change, could all provide particularly important lessons for African militaries, few of which have systematically addressed these issues. This suggests scope for greater civil-military dialogue on addressing the spread and effects of HIV/AIDS within military populations.

Civilian experiences also provide lessons on scaling-up responses to HIV/AIDS. Scaling-up in the context of the epidemic involves ensuring equitable, accessible, affordable, sustainable, universal access to prevention, care and support.[37] Accumulated experience over the last two decades suggests that scaling-up responses to the epidemic requires not only recognising that this will require long-term interventions, but an integrated approach built on prevention and broadening access to primary healthcare services. The escalating cost of the epidemic will also require new approaches to addressing the epidemic. The estimated cost of achieving universal access to care globally rose by $7.2 billion between 2006 and 2008 alone – from $14.9 billion to $22.1 billion respectively – with African governments currently providing less than a third of the money required to address the epidemic. This suggests that both military and civilian actors will need to explore innovative ways of mobilising resources, as well as measures to ensure accountability and efficiency. They will also need to develop new models of care, including:

- The expansion of community-based health services involving people and families living with HIV/AIDS and other grassroots actors;
- Developing the skills of auxiliary and community health workers; and
- Implementing creative measures to accredit, retain and motivate healthcare workers, educators and community workers.[38]

This will require collaboration across many sectors, and most pertinently, co-operation and information-sharing both between militaries on the continent and across the civil-military divide. This agenda can be advanced not

36 Sany Kozman, "CARITAS and HIV/AIDS", presentation made at the *HIV/AIDS and Militaries and Peacekeeping in North and West Africa* workshop in Cairo, Egypt, 8 and 9 September 2007.

37 Bola Omoniyi, "Scaling-up Treatment, Care and Support", presentation made at the *HIV/AIDS and Militaries and Peacekeeping in North and West Africa* workshop in Cairo, Egypt, 8 and 9 September 2007.

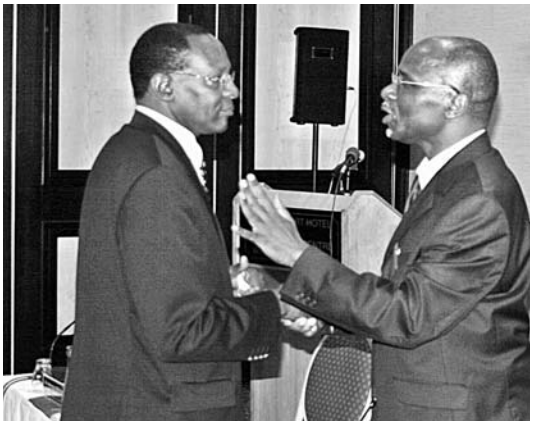
38 Bola Omoniyi, "Scaling-up Treatment, Care and Support".

only by greater civil-military dialogue, but also multi-sectoral planning between militaries and other public sector institutions, and the creation of fora where actors working to address HIV/AIDS in military populations could share their experiences and identify best practices.

While African militaries must strengthen their capacity to provide treatment and care, preventing the transmission of HIV remains the greatest weapon in the fight against the epidemic. As in civilian populations, this approach involves the difficult challenge of changing the attitudes, principles, ethics and behaviour of soldiers. But, as already noted, the military environment also presents unique opportunities not only for prevention activities, but also for integrating care and treatment services into their systems.[39] These characteristics can facilitate condom promotion, for example, and encourage sustained condom use.[40] Militaries also do more than just train people to fight, they also develop discipline, social skills and other lifeskills, all of which can be harnessed to prevent the transmission of the virus. Moreover, because military personnel are essentially a captive audience, large numbers of soldiers can be targeted for behavioural change messaging on an ongoing basis. As earlier noted, better informed soldiers may not only be in a stronger position to protect themselves against HIV infection, but could also become champions of safer sex in the communities linked to army bases.

Prevention activities further need to adopt a holistic approach that encourages abstinence, faithfulness, and condom use. They should seek to build on the traits that militaries try to instil in soldiers including integrity, moral courage, loyalty and discipline. There is scope for greater engagement across the civil-military divide to adapt civilian prevention tools to the military environment. Given the hierarchical nature of the military environment, senior personnel have a key role to play in encouraging behaviour change, and interventions should target all personnel including senior officers, who are often excluded from prevention initiatives. Those responsible for interventions should also examine ways of including traditional healers in both prevention and treatment. Large numbers of Africans (some estimates say 70 per cent) visit traditional healers, and involving these actors in prevention programmes could not only ensure consistent, accurate messaging and responsible care, but could serve as an additional entry point for disseminating information on HIV/AIDS, treatment and care.

RIGHT: The Hon Victor Simunje, Deputy Minister of Defence, Windhoek
FAR RIGHT: Dr Kaire Mbuende, former Executive Secretary, Southern African Development Community, left; and Mr Tomaz Augusto Salomão, Executive Secretary, Southern African Development Community



39 Robert Ritzenthaler, "On the Front".
40 Rodger Yeager, Craig Hendrix and Stuart Kingma, "International Military Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome Policies and Programs: Strengths and Limitations in Current Practice", *Military Medicine* 165(2)87-92, February 200.

5. Responses to HIV/AIDS in Southern African Militaries

As with many of the highest rates of HIV/AIDS prevalence globally, the epidemic stands to impact both the operational effectiveness of southern African militaries and the Southern African Development Community's efforts to ensure stability in the sub-region, and the continent more generally. Several southern African militaries have pioneered efforts to address and manage the epidemic within their armed forces.

The Windhoek policy seminar of 2006 organised by the Cape Town-based Centre for Conflict Resolution and the University of Namibia 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 Tanzania 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 falls under the SADC Inter-State Defence Committee. The presentation also provided useful perspectives on the relationship between gender and HIV/AIDS in Zimbabwe's defence force.

Namibia[41]

Namibia's HIV prevalence rate among pregnant women was approximately 4.2 per cent in 1992. By 2004, the rate was estimated to be 19.7 per cent. The Namibian Ministry of Defence and the Namibian Defence Forces (NDF) estimate that the overall prevalence of HIV in the country's armed forces is higher than 19.7 per cent. 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; it is thus common practice to have multiple sexual partners. Namibia's 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, other 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 VCT services; facilitates treatment of opportunistic infections through ARV therapy, as well as care and support for affected and 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 as well as the Social Marketing Association. Its HIV-prevention awareness programme has developed a programme that includes an HIV-prevention video – "Remember Eliphas" – that

41 Major Marianne Muvangua, "HIV/AIDS and the Military: Lessons in Prevention, Management and Treatment in the Namibian Defence Force", presentation at the CCR/University of Namibia (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.

has reached 10 000 uniformed personnel. (A second part of this video was produced by 2007.) Senior defence sector managers have been informed about the national plan and the role of ARVs in responding to HIV/AIDS. Namibia's prevention programme conducts training projects for peer educators; counsellors; home-based caregivers; 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. 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 purchased 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 of HIV; 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.

Lesotho[42]

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; and care and support, including counselling and home-based care. The LDF's prevention programmes include health education and the distribution of condoms, as well as an HIV-prevention team that 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 had enrolled 129 patients, including uniformed personnel and their dependents. Six children are among those on treatment. By 2006, there had been two deaths and a 98 per cent rate of adherence to the drug regimen since the programme started.

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42 Colonel 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.

ABOVE: *From left:* Mr Sam Kona, Centre for Conflict Resolution, Cape Town, South Africa; Dr Jane Ansah, AIDS Control Programme, Accra, Ghana; Dr Safiedin Elnour Ali, Ministry of Defence, Khartoum, Sudan
TOP RIGHT: Dr Edna Adan Ismail, founder, Edna Adan Hospital, Hargeisa, Somaliland
RIGHT: Professor Margaret Vogt, United Nations Department of Political Affairs, New York, United States

Since December 2004, the Makoanyane Military Hospital in Lesotho has provided free ARV therapy to patients. All active-duty personnel are screened periodically for HIV, and 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 their 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 HIV/AIDS. 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 caregiver 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, 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 were enrolled in the Lesotho army's home-based care programme. The LDF reported a decline in the number of patients needing home-based care since the initiation of its ARV programme in 2004.

Lesotho's army has identified a number of challenges for sustaining its HIV/AIDS programme, particularly its home-based care project. These difficulties 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 has been a source of frustration for many of southern Africa's military HIV/AIDS programmes.

BELOW: Mr Ibrahim Nawar, Regional Security Programme, Al Ahram Centre for Political and Strategic Studies, Cairo, Egypt, *left;* General Charles Namoloh, Namibian Minister of Defence, Windhoek, Namibia

ABOVE : *From right:* Lieut-Col Dr James Anthony Samba, Joint Medical Unit, HIV/AIDS Focal Point, Sierra Leone Army, Freetown; Dr Christine Sadia, Independent Consultant, Johannesburg, South Africa; Colonel Bob Kershaw, Centre for Strategic and Security Studies, United Kingdom; Dr Safiedin Elnour Ali, Ministry of Defence, Khartoum, Sudan

RIGHT : *From left:* Mr Amr Koraim, Institute of Diplomatic Studies, Cairo, Egypt; Mr Ibrahim Nawar, Regional Security Programme, Al Ahram Centre for Political and Strategic Studies, Cairo, Egypt; Lieut-Col AJ Bello, ECOWAS Commission, Abuja, Nigeria

Tanzania[43]

Tanzania's HIV-prevalence rate is estimated to be seven per cent, although in urban centres such as the capital of Dar es Salaam, prevalence rates are as high as 11 per cent. 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 carry 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.

In October 2004, the Tanzanian ministry of health, the United States Agency for International Development (USAID) and the US 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 offered second-line medications for AIDS treatment at a military hospital in Dar es Salaam. A total of 1,500 individuals were enrolled in the programme in 2006, which was treating between 20 and 40 patients each day. Military personnel and 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 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 beliefs about 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 that must be taken consistently and permanently. Where free treatment is provided and healthcare is easily accessible, adherence rates can be as high as 90 per cent.[44] Other factors, such as awareness campaigns to reduce stigma and the dissemination of simple and accurate information about HIV transmission, could 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 Tanzanian army's medical services included the following personnel to implement its HIV/AIDS programme in 2006: nine clinicians; ten counsellors; five pharmacists; eight laboratory technicians; four home-based care staff; and eight support staff. All staff members (except 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 people living with HIV/AIDS. The

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43 Colonel (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.

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

government of Tanzania has relied on a grant from the Global Fund to fight Aids, Tuberculosis and Malaria 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 donors. The TPDF reports that the dangers of staff burnout will require new measures to recruit, train and keep additional staff. In 2006, the hospital in Dar es Salaam had only one fax machine and needed a standby machine; indeed, the frequent breakdown of lab equipment was a critical challenge. As with other military health services in the SADC sub-region, home-based care remained a challenge. The TPDF has also experienced difficulties in procuring condoms, and expressed 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.

Zimbabwe

SADC has established a Military Health Services Work Group under its Inter-State Defence and Security Committee to address a broad range of military health issues in the sub-region.[45] The military health services group meets annually. The group made a number of observations about the role of SADC's militaries in addressing HIV/AIDS.

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 needs of southern African military environments. 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 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 have collaborated in devising national policies.

In undertaking these initiatives, defence forces have acknowledged that HIV/AIDS in southern African militaries can be examined at the individual and organisational levels. Experts have noted that HIV-positive status converts to AIDS illness at a rate of between 3 and 5.5 per cent in the first year of service, and that the vulnerability to STIs

45 This section is based on the presentation by Brigadier-General (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.

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 SADC 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 encouraged 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 counselling 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.

Broader lessons in HIV/AIDS management and mitigation are discernible here. Nutrition, stress and previous exposure to STIs can all 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 also increases the likelihood of unprotected sex, and casual sex with multiple partners often accelerates the spread of HIV and other STIs. Militaries in southern Africa must therefore acknowledge the negative impacts of such behaviour in order to enhance HIV-prevention programmes and to reduce rates of HIV transmission. The Zimbabwean Defence Force's military health service has also emphasised the critical need to bolster the capacity of HIV/AIDS health professionals to carry out action-based research.

ABOVE: *From left:* Mr Ibrahim Nawar, Regional Security Programme, Al Ahram Centre for Political and Strategic Studies, Cairo, Egypt; Dr Adekeye Adebajo, Centre for Conflict Resolution, Cape Town, South Africa; Lieut-Col A.J. Bello, ECOWAS Commission, Abuja, Nigeria

LEFT: *From left:* Professor Malek Naim, Department of Microbiology, Military Hospital, Algiers, Algeria; Colonel Ardjoun Mohamed, HIV/AIDS Focal Point, Ministry of Defence, and Algerian Military Health Services, Algiers, Algeria; Dr Mohamed Sammud, National AIDS Programme Manager, Tripoli, Libya; Dr Neijib Doss, HIV Prevention Programme, Tunis Military Teaching Hospital, Tunis, Tunisia

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, the Namibian Defence Force, 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 Wives and Women's Association (ZAWWA) was 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 Zimbabwe Defence Force has noted that existing strategies for HIV/AIDS management and mitigation have prompted a review of the experiences of gender relations in its military.[46] There are six important dimensions of this issue:

- First, the social and sexual identities of women 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 certain 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; and
- Finally, the economic power gained from allowances for deployed troops encourages men in the Zimbabwean military to visit sex workers.

Gender issues should thus be incorporated into the planning of the SADC standby brigade of the African Standby Force to be established by 2010, 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.

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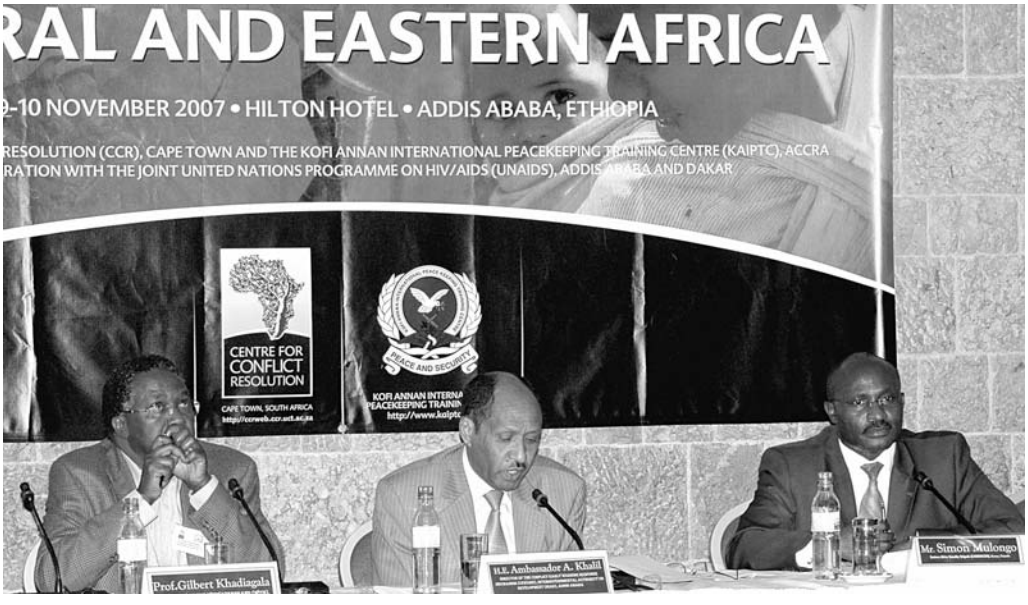
46 Colonel Gertrude Mutasa, "HIV/AIDS and Women in the Military in Zimbabwe: A Review of Response Activities Hitherto", presentation at the CCR/UNAM policy advisory group seminar, "*Namibia's Chair of the SADC Organ: HIV/AIDS and Militaries in Southern Africa*", Windhoek, Namibia, 9 and 10 February 2006.

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 put in place. Similarly, efforts should be made to increase the role of women in decision-making and policy development for the SADC sub-regional brigade. Remuneration for deployment should be monitored, with a percentage of each soldier's allowance sent home to spouses in order to decrease soldiers' 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:

- First, implementing troop-level HIV/AIDS education and behaviour change communication strategies;
- Second, increasing testing of all military personnel;
- Third, nurturing value-based life-style and decision-making skills;
- Fourth, providing prevention training for HIV testing and counselling staff;
- Fifth, securing and maintaining medical infrastructure and equipment for HIV management;
- Sixth, facilitating home-based care for military personnel and their dependents;
- Seventh, strengthening traditional leadership for HIV prevention and addressing AIDS-related illnesses;
- Eighth, supporting vulnerable communities (the elderly, widows, women and girl children) as well as people living with HIV/AIDS;
- Ninth, scaling up healthcare capacities and systems;
- Tenth, utilising international support for accelerating access to treatment;
- Eleventh, managing treatment regimens during service; and
- Twelfth, planning contingent responses to imminent treatment challenges.



From left: Professor Gilbert Khadiagala, University of the Witwatersrand, Johannesburg, South Africa; Ambassador Abdelrahim A Khalil, Intergovernmental Authority on Development, Addis Ababa, Ethiopia; Mr Simon Mulongo, Eastern Africa Standby Co-ordination Mechanism, Nairobi, Kenya

6. Responses to HIV/AIDS in West African Militaries

A key theme emerging at the CCR/KAIPTC Cairo policy seminar of September 2007 from discussions on West Africa, and to an extent on other sub-regions, was the insularity and opaqueness of military responses to the HIV/AIDS epidemic.

While African militaries have put in place responses to the epidemic, and ECOWAS and the West African Health Organisation (WAHO) have drawn up a plan of action on HIV/AIDS in the military, there appears to be little information-sharing across the sub-region – and the civil-military divide – and the components of ECOWAS/WAHO have yet to be integrated into country-level responses to the pandemic.

The presentations at the Cairo conference on Sierra Leone and Ghana also suggest that West African militaries – like most other militaries on the continent – have yet to respond to HIV/AIDS as an important strategic issue that could compromise their effectiveness. While militaries in the sub-region have fairly well developed prevention programmes, and are expanding their voluntary counselling, testing, care and support infrastructure, there has been little attention paid to the prospect of increasing staff losses to HIV/AIDS, and what this may mean for the long-term effectiveness of military institutions.

Sierra Leone[47]

Estimates by the Republic of Sierra Leone Armed Forces (RSLAF) suggest that levels of HIV prevalence may be higher than in the general population – although damage to the HIV/AIDS surveillance infrastructure in the country which experienced a civil war between 1991 and 2000 may affect the accuracy of the available civilian statistics. While it is estimated that 1.6 per cent of adults in Sierra Leone between the ages of 15 and 49 are infected with HIV/AIDS,[48] a study of 700 randomly selected personnel suggests that approximately 3.2 per cent of the RSLAF's 10, 843 personnel were living with HIV/AIDS in 2007. Battalions in the north and south have higher prevalence levels. Prevalence was also higher among married personnel in the 40 to 59 age range (4.9 per cent compared to 2.9 per cent in the 20 to 39 age range), most of whom are thought to have contracted the virus during Sierra Leone's civil war. This lends support to the argument that conflict may help to spread HIV. In a recent "Knowledge, Attitudes and Practices" (KAP) survey, over half of personnel in Sierra Leone's army reported that they have more than one sexual partner, while only one in ten reported consistent use of condoms.

The Sierra Leonean military has put in place the first HIV/AIDS workplace policy in the country. This policy protects military personnel from being sacked because of their HIV status, and calls for ARVs to be provided to soldiers for free through grants from the World Bank and the Global Aids Fund. The Sierra Leone military's HIV/AIDS programme involves:

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47 Dr James Samba, "HIV Prevention and Mitigation: the Republic of Sierra Leone Armed Forces", presentation made at the *HIV/AIDS and Militaries and Peacekeeping in North and West Africa* workshop in Cairo, Egypt, 8 and 9 September 2007.

48 UNAIDS/WHO, "2006 Update: Sierra Leone", *Epidemiological Fact Sheets* (available at www.who.int/GlobalAtlas/predefinedReports/EFS2006/index.asp ; accessed March 2008).

- Education activities, including the integration of HIV/AIDS awareness into the military training curriculum, and sensitising trainers to the importance of HIV/AIDS and regular workshops with battalion commanders;
- Training soldiers' wives, female soldiers and the leaders of women's groups – "Mammy Queens" – to act as peer educators and counsellors;
- Training counsellors in each brigade and battalion;
- Establishing voluntary counselling and testing centres for each brigade;
- Establishing a programme to improve knowledge of reproductive health;
- Better treatment of STIs;
- The distribution of condoms;
- Conducting ongoing research to monitor prevalence in the RSLAF, as well as regular KAP surveys;
- Encouraging the establishment of support groups for those infected and affected by HIV/AIDS; and
- The provision of ARVs to soldiers living with HIV/AIDS and their families.

The Sierra Leone army has explored new media for spreading HIV/AIDS messaging. Since 2002, for example, it has used annual music concerts to raise awareness about HIV and how soldiers can protect themselves and their families from the disease. It has also recorded short audio-visual dramas for distribution to all brigades, battalions and garrisons. The RSLAF has adopted this national media approach, and plans to screen the dramas produced by the armed forces on national television. The actors include service personnel and senior commanders, as well as the US Ambassador to Sierra Leone, and the former president of Sierra Leone, Ahmed Tejan Kabbah.

Despite these plans, the RSLAF faces several challenges in implementing its HIV/AIDS programme. As in North Africa, Sierra Leone's army relies heavily on external financial, technical and capacity support from stakeholders such as the US Department of Defence, the United Nations Population Fund (UNFPA), UNAIDS, the Co-operative for Assistance and Relief Everywhere (CARE), and local NGOs, raising questions over the sustainability of the programme. Related challenges include: limited human capacity to manage the roll-out of ARV therapy; the difficulty of retaining skilled personnel; and limits to STI treatment activities due to budgetary constraints. It is also often difficult to spread HIV/AIDS messaging in remote deployment areas where there is no access to television or radio. As in most other countries, the armed forces are also grappling with how to ensure that knowledge about HIV/AIDS translates into less risky behaviour, as well as how to encourage the use of condoms and resources such as VCT centres.

Ghana[49]

The first recorded case of HIV/AIDS in the Ghana Armed Forces (GAF) was diagnosed in 1987. Ghana has a national adult prevalence level of two per cent. According to military records, the rate of new infections in the GAF has decreased over the last five years (2002 - 2007), and is now lower than that in the civilian population. The military recognised early on that the HIV/AIDS epidemic could have serious implications for its effectiveness, and established a Technical Committee on AIDS, which was tasked with planning and implementing HIV/AIDS activities and setting up an effective mechanism for HIV/AIDS surveillance. The

49 Dr Jane Ansah, "HIV/AIDS and Militaries in West Africa: The Ghanaian experience", presentation made at the *HIV/AIDS and Militaries and Peacekeeping in North and West Africa* workshop in Cairo, Egypt, 8 and 9 September 2007.

Ghana army's initial response was formalised in 1989, with the launch of the Ghana Armed Forces AIDS Control Programme (GAFACP), which aimed to design and sustain HIV/AIDS programmes to reduce the spread of STIs and HIV/AIDS within its ranks. In the same year, a policy on HIV/AIDS was formulated to promote the health of troops and families, as well as address HIV/AIDS. Key activities under this policy include awareness-raising and advocacy among the military high command; ongoing HIV/AIDS education, including incorporating an HIV/AIDS component into the training curricula for young recruits and ongoing awareness-raising among in-service personnel, as well as refresher and upgrade courses; the provision of voluntary testing and counselling facilities for both troops and their families; and the training and deployment of STI/HIV/AIDS counsellors and peer educators.

As in most militaries on the continent, this policy precludes HIV-positive potential recruits from joining the GAF; in-service personnel are also tested prior to deployment, and those found to be HIV-positive are not allowed on peacekeeping missions or other local deployments, but are allowed to remain within the Ghana Armed Forces and to continue to work for as long as they are able to. Both soldiers and their families have access to full medical facilities and are provided with treatment for opportunistic infections, as well as ARVs which are provided as needed. The policy also stipulates that all Ghanaian troops going on overseas courses must be HIV-negative.

As in other militaries, it is argued that the stresses and often poor living conditions associated with deployment may critically undermine the health of personnel living with HIV/AIDS. But as elsewhere, the Ghana Armed Forces has not tackled the question of whether it is possible to deploy HIV-positive soldiers who are on ARVs, are healthy, and have achieved maximum and durable viral load suppression. However, small-scale research among 525 personnel conducted by the Ghana Armed Forces' AIDS committee in 2005, suggests that despite the controversies surrounding mandatory HIV/AIDS testing, this approach may, in fact, have positive spin-offs, including encouraging personnel to ascertain their status when they would otherwise not know it, thus creating incentives to remain HIV-negative, and helping them plan more effectively for the future.

ABOVE: *From left:* Colonel Pierre Lamizana, Ministry of Defence, Burkina Faso; Colonel (Dr) Ambrose Keith Musinguzi, Uganda People's Defence Forces, Uganda; Dr Stanley Saiwhean, Ministry of Defence, Monrovia, Liberia; Colonel Ardjoun Mohamed, Ministry of Defence and Algerian Military Health Services, Algiers, Algeria

RIGHT: *From left:* Ms Robyn Pharoah, Independent Consultant, Cape Town, South Africa; Mr Abdoul Dieng, UNAIDS, Addis Ababa, Ethiopia; Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town, South Africa; Dr Bomby Kabongo, Brits District Hospital, Johannesburg, South Africa

7. Responses to HIV/AIDS in North African Militaries

North Africa has the lowest HIV/AIDS prevalence levels on the continent. The epidemic is less mature, and infections are more concentrated in high-risk groups, such as sex workers and injecting drug-users. In this context, effective prevention programmes have the potential to stem the spread of the virus, and to prevent the epidemic from reaching the proportions found in the rest of Africa.

However, North African militaries – and governments – have generally been slower to respond to the epidemic than their southern African counterparts. The Cairo policy seminar organised by CCR and KAIPTC in September 2007 included presentations on the responses adopted by the Algerian and Tunisian militaries, as well as input on the programmes within the Moroccan armed forces. These inputs suggest that, while military authorities acknowledge the need to address HIV/AIDS, many North African countries are only just beginning to confront the spread and management of HIV/AIDS in their armed forces. HIV/AIDS is still seen primarily as a health issue, and militaries have yet to tackle the implications of the epidemic, both within the forces themselves and for peacekeeping.

Algeria[50]

At the end of 2005, UNAIDS estimates that there were 19 000 people between the age of 15 and 49 living with HIV/AIDS in Algeria, amounting to 0.1 per cent of the adult population.[51] The first infections were diagnosed in the military population in 1987, but incidence of the disease remains low – estimates suggest levels of between 0.2 per cent and 0.01 per cent – with only 30 cases of HIV/AIDS identified between 1990 and 2003.

Algeria's Ministry of Defence took early steps to prevent the spread of HIV/AIDS in its ranks. Following the diagnosis of the first HIV/AIDS cases in 1997, an HIV/AIDS committee was established to co-ordinate a response. This response has included: awareness-raising and education, including modes of transmission through brochures and articles in military publications; the distribution of condoms; monitoring of transfused blood supplies, and improving practices among medical staff through workshops and the publication of articles in journals of military medicine; improved identification and management of sexually-transmitted infections; and improved surveillance. These activities target both new recruits and serving personnel. With assistance from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the Algerian military has also started to provide treatment to all eligible patients. Every military unit now has an Information and Communication Officer who disseminates information on the epidemic.

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50 Colonel Ardjoun Mohamed, "*Expérience Algérienne en Matière de planification VIH/SIDA pour les Services en Uniforme*", presentation made at the *HIV/AIDS and Militaries and Peacekeeping in North and West Africa* workshop in Cairo, Egypt, 8 and 9 September 2007.

51 UNAIDS/WHO, "2006 Update: Algeria", *Epidemiological Fact Sheets* (available at www.who.int/GlobalAtlas/predefinedReports/EFS2006/index.asp ; accessed March 2008).

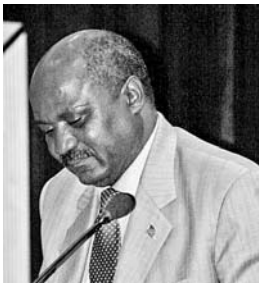
Morocco

The Moroccan Royal Armed Forces (MRAF) implemented a prevention programme for its forces as far back as 1996. By 2001, peer advocacy programmes reached more than 60,000 military personnel through prevention efforts and focus groups. Prevalence data and risk-behaviour information were also collected. These were used to improve and refine the military's prevention efforts. Programming efforts were suspended in 2001 due to a lack of funding, but the US Department of Defence has recently agreed to partner the MRAF in implementing its HIV prevention programme. Goals for restarting the programme include: train-the-trainer and peer education sessions; activities to improve the analytical and epidemiological skills of military health personnel, the provision of the materials to expand existing efforts; distribution of post-exposure prophylaxis kits; and the purchase and distribution of condoms.[52]

Tunisia[53]

By the end of 2005, there were an estimated 8 700 men, women and children living with HIV/AIDS in Tunisia, with most infections among adults over the age of 15. Adult prevalence rates were 0.1 per cent.[54] Prevalence levels within the Tunisian military appear to be lower than in the general population, with approximately 160 new cases diagnosed each year. Levels of sexually transmitted infections are also fairly low; military records suggest that only about one per cent of military personnel have an STI. As in Algeria and Morocco, the Tunisian response takes a strongly biomedical approach to addressing the epidemic, with HIV/AIDS considered to be just one of several STIs that need to be prevented and managed by the military health infrastructure. There are response centres for preventing new infections. Activities to date have included training military health personnel on HIV/AIDS and the identification and treatment of STIs; awareness-raising has included the celebration of World AIDS Day; the provision of condoms; and the tracking of STIs in the military environment. There is no specific budgetary allocation by the government for HIV/AIDS-oriented activities in the armed forces. The military therefore relies on assistance from civilian partner organisations – primarily the public health service – and the Global Aids Fund for financial assistance. Civilian institutions also help with educational tools and provide condoms for distribution.

RIGHT: General Charles Namoloh, Namibian Minister of Defence, Windhoek
CENTRE: Dr Antonica Hembe, Southern African Development Community, Gaborone
FAR RIGHT: Mr Theo-Ben Gurirab, National Assembly of Namibia, Windhoek



52 US Department of Defence HIV/AIDS Programme, country reports (available at http://www.nhrc.navy.mil/programs/dhapp/index.html ; accessed March 2007).

53 Nejob Doss, "Fighting STD-HIV: The Tunisian Experience", presentation made at the *HIV/AIDS and Militaries and Peacekeeping in North and West Africa* workshop in Cairo, Egypt, 8 and 9 September 2007.

54 UNAIDS/WHO, 2006 Update: Tunisia, *Epidemiological Fact Sheets* (available at www.who.int/GlobalAtlas/predefinedReports/EFS2006/index.asp ; accessed March 2008).

8. Responses to HIV/AIDS in Central African Militaries

The conflicts in the Great Lakes region since the Rwandan genocide of 1994 and the Congolese war which erupted in 1997 have caused massive dislocation and the breakdown of health and HIV/AIDS monitoring infrastructure, making it difficult to gauge the extent of the epidemic accurately.

However, these conditions, together with high levels of rape and the military complexity of conflicts – the war in the Congo drew in regular forces from Angola, Namibia, Zimbabwe, Rwanda, Uganda, Central African Republic (CAR), Chad and Sudan, and several irregular forces supported by Uganda, Rwanda and Burundi – may have created an environment that was highly conducive to the spread of HIV.[55] Yet, military responses to the epidemic have been uneven: while countries like Rwanda have been tackling HIV/AIDS for well over a decade, others, like the DRC, have only just started to address the epidemic.

The DRC

National HIV/AIDS prevalence rates in the DRC are estimated at about four per cent. There are no official estimates for prevalence in the armed forces, but a 2005 behavioural survey financed by the UN Population Fund suggested that prevalence may be high. This study showed that 80 per cent of the soldiers interviewed said they either had, or had previously, contracted an STI. Only one soldier in four had used a condom during his most recent sexual encounter, and 70 per cent admitted that they knew of someone who had either been the victim of forced sex, or who had raped someone else.[56]

The Congolese Armed Forces (FAC) has, by their own admission, been slow to respond to the threat of HIV/AIDS in their ranks. However, an Army Programme to Fight AIDS (PALS) was established when the military began losing highly trained officers to HIV/AIDS.[57] The FAC has received funding from the US Department of Defence to buy laboratory and medical equipment needed to test for, and monitor the progression of, HIV/AIDS. The FAC has also received support from the Johns Hopkins University Cameroon Program (JHCP), which has provided technical assistance to militaries all over Central Africa in the implementation of HIV prevention and surveillance activities. The FAC reported some positive early results from their prevention programming, in collaboration with JHCP. During the 2006 fiscal year, 307 troops were reached with comprehensive prevention messages (299 men, eight women), and another 50 were trained in the provision of these messages. One medical provider was trained in blood and injection safety, and another three received training in prevention of mother-to-child transmission.[58]

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55 Bomby Kabongo, "Stinger Killer in the Jungle: HIV/AIDS in the Militaries of the Great Lakes Region", unpublished paper prepared for the *HIV/AIDS and Militaries and Peacekeeping in North and West Africa* workshop in Cairo, Egypt, 8 and 9 September 2007..

56 "DRC: Army needs help to tackle HIV and the attitudes that spread it", *IRIN PlusNews Special*, 2007 (available at www.irinnews.org/pdf/in-depth/PlusNews-ART-on-the-frontline.pdf ; accessed March 2008).

57 Ibid.

58 US Department of Defence HIV/AIDS Programme, *Country Reports: Democratic Republic of Congo.*

Rwanda

It is thought that HIV prevalence in the Rwandan military is slightly higher than in the general population, at four per cent compared to approximately 3.1 per cent respectively. The Rwandan military began raising awareness about its HIV/AIDS prevalence in 1995, as part of a broader response to national security. In addition to more general awareness-raising methods, the Rwanda Defence Force's (RDF) HIV prevention programme emphasises peer education through "HIV/AIDS clubs" in each battalion.[59] The RDF's prevention activities have received support from the US, which in 2006 helped to train 902 educators, as well as provided and maintained condom service outlets.[60] The RDF has also put in place mobile voluntary counselling and testing facilities; treatment and psychosocial support for HIV-positive personnel and their families; and began to provide ARV treatment in 1997.[61] The US-based Charles R. Drew University of Medicine and Science Center for AIDS Research (DREW Cares) implements the RDF's treatment programme at the country's main military hospital. In 2006, 1078 military personnel and their families were receiving ARVs, while 42 military health workers were trained in the provision of ARVs.[62]

From right: General Charles Namoloh, Minister of Defence, Republic of Namibia; Ms Brigitte Quenum, UNAIDS Regional Support Team, West and Central Africa; Lieut-Col Dr James Anthony Samba, Commanding Officer, Joint Medical Unit, HIV/AIDS Focal Point, Sierra Leone Army, Freetown; Dr Christine Sadia, Independent Consultant, Johannesburg, South Africa; Colonel Bob Kershaw, Centre for Strategic and Security Studies, United Kingdom

59 Sebagabo Marcellin, "*Rwanda*", presentation at the *HIV/AIDS, Militaries and Peacekeeping in Central and East Africa* policy advisory seminar, 9 and 10 November 2007, Addis Ababa, Ethiopia.

60 US Department of Defence HIV/AIDS Programme, *Country Reports: Rwanda* (available at http://www.nhrc.navy.mil/programs/dhapp/index.html ; accessed March 2008).

61 Marcellin, "*Rwanda*".

62 US Department of Defence HIV/AIDS Programme, *Country Reports: Rwanda*.

9. Responses to HIV/AIDS in Eastern African Militaries

Turning to our fifth and final sub-region, Eastern African militaries have a long history of responding to the HIV/AIDS epidemic, and, in many cases, have benefited from high-level government commitment to addressing the HIV/AIDS pandemic. The cases of Ethiopia, Sudan and Uganda are examined in this section.

Ethiopia

The latest UNAIDS estimates suggest that Ethiopia has an adult HIV prevalence rate of between one and four per cent.[63] There are no recent statistics on the prevalence within the military population, although early estimates suggested prevalence levels of up to six per cent.[64] The response to HIV/AIDS in Ethiopia has benefited from high-level political commitment, and specifically command involvement in the military, which has ensured the impetus for a comprehensive military response to the epidemic.

In 2001, the Ethiopian National Defence Force (ENDF), in conjunction with the UN Mission in Ethiopia and Eritrea (UNMEE), launched a five-year strategic plan for HIV/AIDS control in its armed forces. The plan was launched with a two-week training course for 26 HIV/AIDS educators, who were tasked with developing an action plan on HIV/AIDS education.[65] The core activities of the ENDF's HIV/AIDS control programme include: peer education, with 5 000 peer leaders trained by 2006; HIV/AIDS awareness and training; the provision of comprehensive voluntary counselling and testing, and prevention of mother-to-child transmission of HIV services at military health institutions; as well as the provision of ARV treatment at major military hospitals. The programme recognises the vulnerability of healthworkers to HIV infection during their work, and provides them with post-exposure prophylaxis treatment.[66]

HIV testing forms the cornerstone of this strategy. The Ethiopian military's civic and political department (a department responsible for political affairs in the army) uses the results of its screening for sensitisation activities to encourage officers and soldiers to remain HIV-negative. This information has also been incorporated into the army's manuals and promotion procedures, as well as training opportunities for soldiers and officers – the principle being that those who remain HIV-negative after periodic tests would be regularly promoted and given an opportunity for training, while those who are HIV-positive would be made to forego these opportunities.[67]

The US has helped to strengthen the ENDF's HIV/AIDS response by supporting programme services for civilian communities around rural military health establishments, as well as active duty personnel and their

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63 UNAIDS/WHO, "2006 Update: Ethiopia", *Epidemiological Fact Sheets* (available at www.who.int/GlobalAtlas/predefinedReports/EFS2006/index.asp , accessed March 2008).

64 Tsadkan Gebre-Tensae, "HIV/AIDS in the Ethiopian Military: Perceptions, Strategies and Impacts", Draft working paper for the *CSIS Task Force on HIV/AIDS*, Centre for Strategic and International Studies, Washington D.C., February 2003, p.2.

65 "Ethiopia: Army launches HIV/AIDS Strategy", *Medilinks*, 16 October 2001 (available at http://medilinkz.org/news/news2.asp?NewsID=246 ; accessed March 2007).

66 Ambrose Keith Musinguzi, "HIV/AIDS and Eastern African militaries", unpublished paper prepared for the *HIV/AIDS, Militaries and Peacekeeping in Central and East Africa* policy advisory seminar, 9 and 10 November 2007, Addis Ababa, Ethiopia.

67 Whiteside et al, "AIDS, Security and the Military in Africa: A Sober Appraisal".

dependents.[68] The ENDF has also established a military central blood bank, located at the main military referral hospital in order to provide a safe blood distribution network based on both peacetime and operational contingency blood needs.[69]

Sudan[70]

Over 100 000 people serve in the Sudan Armed Forces (SAF), which has been engaged in the longest civil conflict in Africa. Twenty-five years of strife ended in most of the country in 2005, but fighting continues in the volatile Darfur region where over 200,000 people are estimated to have died since 2003. A national survey conducted by the Sudan National AIDS Programme (SNAP) in 2002 suggested national prevalence levels of 1.6 per cent. Rates of HIV infection appear to be lower in the military population than among civilians. The SNAP study found that, while average adult-prevalence was 2.6 per cent, only 0.5 per cent of military personnel were found to be HIV-positive.

The SAF's response is founded on multi-sectoral collaboration between the military, government departments, UNAIDS and other actors. The military has developed a five-year strategic plan to guide its response which focuses on prevention, care and support; the protection of human rights and the elimination of discrimination; and the challenges of addressing HIV among young recruits. The SAF has received assistance in designing and implementing its programmes from UNAIDS, the United Nations Development Programme (UNDP) and SNAP. The Sudanese army's AIDS prevention activities have focused on high-level advocacy among senior military personnel and peer education. By mid-2007, the SAF had held 158 awareness-raising sessions among personnel from across Sudan. The army provides voluntary counselling and testing as well as treatment at its Central Military Hospital. By mid-2007, 104 patients were receiving treatment for opportunistic infections and/or ARV therapy. The SAF has trained medical personnel to provide pre- and post-test counselling, provided 30 medical personnel with training on the identification and syndromic management of STIs, and trained 30 laboratory assistants on blood safety and universal precautions. Under the UNAIDS/UNDP/SNAP Leadership Development Programme, Sudan's army has also established two HIV/AIDS focal point positions to drive its response to the pandemic.

All recruits, and all personnel undergoing training (including foreigners), are required to undergo mandatory testing as part of a comprehensive medical examination. Only those who are found to be HIV-negative may join the military or receive training, although serving HIV-positive personnel remain within the military and have access to treatment, care and support services. Unlike in many other militaries, the SAF advocates mandatory testing among personnel returning from both internal and international postings, again as part of a comprehensive medical examination.

The Sudan Armed Forces faces several challenges in implementing its HIV/AIDS programme. The primary challenge is that its response is almost entirely donor-driven, with little support from the Sudanese government, raising questions over its long-term sustainability. The programme is also constrained by limited capacity on the

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68 *Country Profile: Ethiopia*, President's Emergency Plan for AIDS Relief (PEPFAR), 2008 (available at www.pepfar.gov/press/75876.htm ; accessed March 2008).

69 Musinguzi, "HIV/AIDS and Eastern African militaries".

70 Dr Safi Eldin Elnur Ali, "The Sudan Experience", presentation made at the *HIV/AIDS, Militaries and Peacekeeping in Central and East Africa* policy advisory seminar, 9 and 10 November 2007, Addis Ababa, Ethiopia.

part of the military to implement, and, in particular, scale-up its activities, as well as by poor commitment on the part of frontline commanders. With its long history of conflict, the Sudanese military faces the additional challenge of addressing HIV/AIDS in a post-conflict environment, especially the implications of demobilising – and in some cases, integrating – large numbers of potentially HIV-positive former combatants. In the context of the ongoing conflict in Darfur, the SAF also confronts the difficulties associated with addressing HIV/AIDS among actively deployed personnel.

Uganda

Uganda has benefited from high-level commitment to combating HIV/AIDS in both its civilian and military sectors. The Uganda People's Defence Force (UPDF) does not have its own sector-specific HIV/AIDS policy, but has in place an HIV/AIDS prevention programme that is guided by the government's multi-sectoral National Strategic Framework on HIV/AIDS.[71]

The UPDF was among the first African militaries to respond to HIV/AIDS, and has been running HIV/AIDS awareness programmes since 1989. These activities have focused on preventing transmission through health education; voluntary counselling and testing; mitigating the effects of HIV/AIDS on those who have contracted the virus through pre- and post-test, as well as ongoing counselling and home care; and strengthening the military's capacity to run and monitor programmes. Health educators are attached to each battalion, and condoms are provided on request. The UPDF is also considering whether to follow the lead of countries like Ghana, Eritrea, Ethiopia and Indonesia, and make a condom pouch part of the standard military equipment for every soldier.[72]

From left: Dr Bola Omoniyi, Medical Scientist, Staten Island, United States; Dr Sany Kozman, Caritas, Alexandria, Egypt; Dr Jane Ansah, AIDS Control Programme, Accra, Ghana

71 Musinguzi, "HIV/AIDS and Eastern African militaries".

72 "HIV/AIDS as a Security Issue in Africa: Lessons from Uganda", International Crisis Group Issues Report No.3 (International Crisis Group: Brussels, April 2004).

Voluntary counselling and testing provides an entry point for treatment, care and support, including access to ARV therapy and prevention of mother-to-child transmission, which are being scaled-up to cover all major military hospitals. The US Department of Defence has helped to fund the provision of ARVs, as well as the medical monitoring of HIV-positive personnel and their families. The UPDF has also partnered with the national Ministry of Health and non-governmental health organisations to build the capacity of both those charged with educating personnel about HIV/AIDS and frontline healthworkers involved in the management of opportunistic infections, STIs, and ARVs.[73]

Despite accessing nearly all the troops and their families with awareness messages, stigma still remains a major issue especially among the officer corps, thus undermining the uptake of VCT services. This could partly explain why, despite the military's programmes, it has continued to face high mortality rates due to AIDS-related illnesses. Research shows, for example, that 84 per cent of all deaths occurring at the general military hospital in Mbuya between August 2005 and August 2006 were due to AIDS-related illnesses[74] – despite the fact that ARVs have been provided in all major military health facilities since 2004. In an effort to understand the reasons for this, one UPDF hospital conducted its own research on access to ARV therapy in December 2006, which showed primarily motivational and behavioural barriers to treatment.[75] More research is needed to understand better not only treatment issues, but also reasons for more people not accessing voluntary counselling and testing and the challenges of ensuring adherence to treatment.[76]

The UPDF faces several other challenges. These include: inadequate and sometimes erratic funding flows, which threaten continuity and sustainability of programmes; often limited interest among frontline commanders; the failure to mainstream operational concerns regarding the implications of HIV/AIDS concerns into policy, planning and budgetary processes; and limited capacity to scale-up care and support, particularly with respect to the laboratory infrastructure and equipment required to monitor the progression of the virus among HIV-positive personnel. The implications of these factors are most profound in northern Uganda, where the long-running insurgency undermined public healthcare provision, denying military populations access to alternative healthcare service facilities outside the military system.[77]

RIGHT: Colonel Gertrude Mutasa, Zimbabwean Defence Force, Harare
FAR RIGHT: Lieutenant-Colonel Petrus Nathinge, Namibian Defence Force, Windhoek

73 Musinguzi, "HIV/AIDS and Eastern African Militaries".
74 Dr G Bwire, "Mortality and causes of mortality in Ugandan People's Defence Force health units: A case study of Bombo, Mbuya and 4 Division hospitals", unpublished report prepared for the military health service, October 2006.
75 Deborah Cornman and Caroline Redding, "Findings from Uganda Needs Assessment", unpublished report prepared for the military health service, 2006.
76 Musinguzi, "HIV/AIDS and Eastern African militaries".
77 Ibid.

10. HIV/AIDS and the African Standby Force

As these examples from five African sub-regions illustrate, most militaries have adopted staple prevention, treatment, care and support programmes. Some RECs have, to an extent, also identified HIV/AIDS as a strategic issue.

In SADC, for example, the Strategic Indicative Plan for the Organ on Politics, Security and Defence Co-operation of 2004 acknowledges the impact of HIV/AIDS in the sub-region, and the challenges it poses for the achievement of the organ's objectives.[78] The organ's Inter-State Defence Committee has established a Military Health Services Work Group that began talks with UNAIDS on developing a regional approach to HIV/AIDS and militaries programme in early 2005. SADC's Executive Secretary, Tomaz Augusto Salomão, has also asserted the need for an HIV/AIDS framework for the sub-region's African Standby Force brigade, SADCBRIG.[79] ECOWAS already has a Plan of Action for 2004 – 2006 for the control of STIs and HIV/AIDS within its armed forces sector, and has also sought to establish a peer education programme for young recruits for the Liberia Armed Forces.[80] IGAD has begun to explore the possibility of integrating HIV/AIDS policies into the East African Brigade.

Central and North Africa, however, have yet to engage significantly around HIV/AIDS on a regional level, and despite these important shows of commitment, the other RECs have yet to implement strategies for their own co-ordinated sub-regional responses to HIV/AIDS on a large scale. Both military and national policies are still largely unco-ordinated at the sub-regional or regional levels. The policy framework outlining planning and mechanisms for the ASF does not address HIV/AIDS. Moreover, while both SADC's Military Health Services Work Group and the West African WAHO policy have adopted a sub-regional approach and drawn on input from military health practitioners from each country in the sub-region, the focus has been on technical health issues rather than on operational questions related to HIV/AIDS. Implementation of existing policy is also slow. In southern Africa, for example, the Inter-state Defence and Security Committee Working Group should have been more urgent in reporting to the Defence Organ in order to accelerate the opportunities to examine and advocate for the inclusion of health aspects into peacekeeping and collective security infrastructures. Similarly, while military practitioners contributed to the development of the WAHO policy for HIV/AIDS in West African defence forces, HIV/AIDS policies have not been widely incorporated into regional defence planning.

There are four key barriers to putting in place comprehensive, co-ordinated responses to HIV/AIDS, including:

- First, uneven and contracting human and financial resources;
- Second, limited transportation, social and health infrastructure;
- Third, declining defence budgets; and
- Fourth, diversity in cultures, standards, doctrines and inter-operability.

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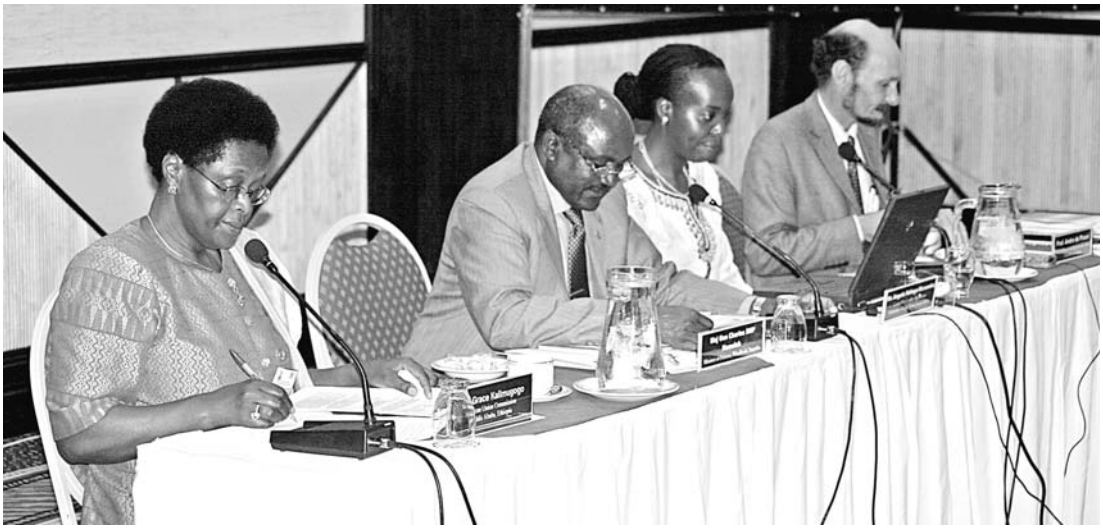
78 "The Regional Indicative Strategic Development Plan", SADC, Windhoek, Namibia, March 2001 (available at www.sadc.int ; accessed 31 March 2006), and "Strategic Indicative Plan for the Organ on Politics, Defence and Security Cooperation", SADC, August 2004 (available at www.sadc.int ; accessed 31 March 2006).

79 CCR, HIV/AIDS and Militaries in Southern Africa, p.41.

80 "Plan of Action (2004 – 2006) of STI/HIV/AIDS Control in the Armed Forces Sector of the Member States of ECOWAS", the West African Health Organisation, Ougadougou, Burkina Faso, April 2002.

More fundamentally, there are few policy or practice fora for developing regional approaches to HIV mitigation and AIDS management, and limited scope for leadership on harmonising African responses. In Central Africa, for instance, there is no sub-regional institution to implement an HIV/AIDS policy, and ECCAS has only recently started to build the institutions needed to drive the promotion of peace and security in this sub-region. North African countries often appear to be more active in Middle Eastern than African institutions, and lack an active regional forum to exchange views on policies. The Arab Maghreb Union, for example, includes Libya, Algeria, Mauritania, Morocco, and Tunisia, but excludes Egypt, while Morocco is not a member of the AU. In many cases, African countries also belong to multiple co-ordinating institutions with different, and often competing, priorities. Tanzania, for example, is part of EASBRIG, but also active within SADC.

This suggests a need for greater advocacy in high-level decision-making institutions on both the importance of integrating HIV/AIDS issues into national and regional planning and the policy tools that do exist. It also suggests a need to create regional fora for practitioners to share experiences and practices. Finally, this situation highlights the importance of creating more coherent structures that are firmly rooted in shared histories, political co-operation, and economic integration.



ABOVE: *From left:* Dr Grace Kalimugogo, African Union Commission, Addis Ababa, Ethiopia; General Charles Namoloh, Namibian Minister of Defence, Windhoek, Namibia; Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town, South Africa; Professor Andre du Pisani, University of Namibia, Windhoek, Namibia

RIGHT: Major Marianne Muvangua, Namibian Defence Forces/Ministry of Defence, Windhoek, Namibia

11. Conclusion

The Windhoek (2006), Cairo (2007) and Addis Ababa (2007) seminars revealed a number of common challenges shared by African militaries in their efforts to respond effectively to the HIV/AIDS pandemic.

The policy meetings all highlighted the gap between national, sub-regional and continental knowledge, perceptions and actions on a number of issues. There is insufficient evidence about the impact of HIV/AIDS on the long-term operability of militaries in Africa. However, the majority of African militaries are implementing comprehensive HIV/AIDS prevention, treatment and care programmes. While these initiatives are under-resourced and limited in scale, they hold promise for mitigating the pandemic's long-term impact on African security.

There is an emerging consensus on existing best practices for HIV/AIDS prevention, treatment, care and support. Common HIV prevention and treatment practices include eight key aspects:

- First, education and awareness-raising;
- Second, promotion of voluntary counselling and testing;
- Third, condom distribution;
- Fourth, systematic HIV testing at recruitment, pre-deployment and post-deployment stages;
- Fifth, peer-to-peer support;
- Sixth, community care and support initiatives including home-based care and referral systems;
- Seventh, access to ARV therapy through military and national hospitals; and
- Eighth, the use of media tools such as videos, plays, film and radio.

While the UN promotes voluntary counselling and testing before deployment of troops to peace operations, routine HIV screening as part of health assessments is an established policy among militaries across Africa's five sub-regions. In most militaries, a sero-positive individual will not be deployed to a peacekeeping mission, but can continue to serve in other functions. However, routine HIV screening in the defence forces presents a number of challenges relating to the human rights of people living with HIV/AIDS. Militaries must pay careful attention to the human rights of their members who are diagnosed as being HIV-positive, and make special efforts to explain the rationale of mandatory testing to the general public.

The involvement of civil society representatives – including a traditional healer – in the three policy seminars also enhanced the discussions on civil-military co-operation and emphasised social issues such as gender, tradition and culture. HIV/AIDS awareness campaigns should be designed to target men and women - including spouses. Military health programmes should involve the life partners of their members in health, life-skills and HIV prevention strategies; provide psychosocial support and substance-free recreational activities to troops deployed to peacekeeping missions; and involve home and host communities in their activities.

The rationale for increased civil-military co-operation in combating HIV/AIDS addresses resource constraints in the public budgets of African countries. Limited resources in many defence and public health budgets suggest that increased co-operation between civil society groups, community-based organisations, defence forces, and social and health services is essential for HIV/AIDS management and mitigation efforts in Africa. Successful co-operation would involve increased information-sharing at the local level, as well as in the host countries of

peacekeeping operations. Policymakers working to operationalise the African Standby Force have little knowledge about the relevance of HIV/AIDS to peacekeeping. In 2007, the West African Health Organisation's policy for HIV/AIDS in the defence forces, for example, was not well known within the ECOWAS secretariat in Abuja, Nigeria. The issue of HIV/AIDS had not yet entered into planning for the West African brigade (ECOWASBRIG) of the African Standby Force. Furthermore, there had not yet been any follow-up on the implementation of the WAHO policy among military health officials in the sub-region's defence forces. HIV/AIDS and military preparedness have not yet fallen under the purview of regional groupings of the ASF in Eastern Africa (EASBRIG) and North Africa (NASBRIG). The AU/UN team that is developing the ASF has not worked closely with the AU's Department of Social Affairs, which has taken the lead within the commission in Addis Ababa on HIV/AIDS issues and developed a comprehensive plan for mainstreaming HIV/AIDS into the organisation's programmes. If not urgently rectified, these gaps in knowledge, perception, and actions could result in significant problems in operationalising the African Standby Force by 2010.

Policy Recommendations

The discussions and research from the CCR project on "HIV/AIDS and African Militaries: Addressing the Pandemic, Strengthening Peacekeeping" resulted in the following four key policy recommendations:

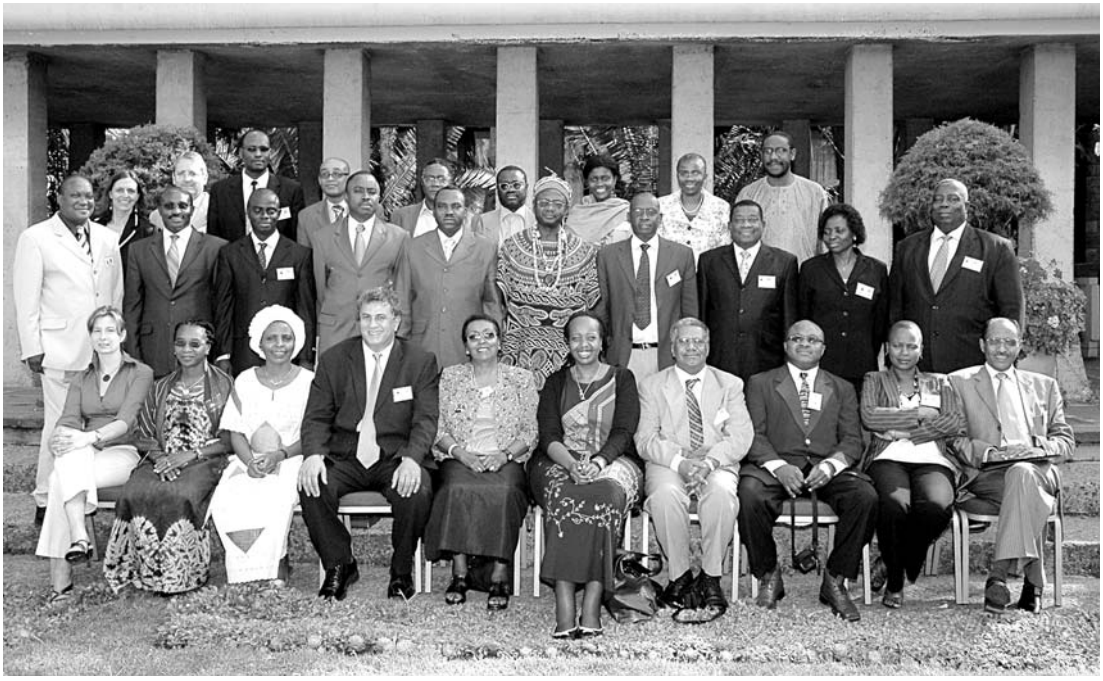
- Address the challenges of scaling-up HIV/AIDS treatment within the context of failing health systems in Africa: Key gaps in the response to HIV/AIDS are linked to poor primary healthcare, poorly-resourced hospitals and local clinics, and a deficit in capable healthcare workers. These facilities at the local and national level require predictable and sustained human and financial resources. African militaries face similar human and financial constraints that impact the quality of care in hospitals and the ability to secure medical equipment and supplies. This often results in a reliance on national health systems, which are also severely under-resourced. Governments, donor partners and civil society organisations should thus revisit the fragile state of health systems in Africa.

- Leverage new avenues for facilitating wider behaviour change among military personnel: Soldiers represent a unique demographic group because they are a captive audience for instruction and education. The hierarchical nature of military institutions also provides a unique environment for transferring values and standards of behaviour from senior officers to younger serving members. Soldiers are part of broader communities and their behaviour directly impacts values within society. Collaboration across all sectors, and most pertinently, co-operation and information-sharing between militaries on the continent and across the civil-military divide, could prove critical to providing training, support and knowledge on broader societal issues such as gender and tradition, which often influence behaviour-change and HIV prevention.

- Convene fora for monitoring military HIV/AIDS approaches at the regional level: Initiatives undertaken to develop HIV/AIDS policies at the national and sub-regional levels and the efforts to establish regional brigades of the African Standby Force have not been effectively integrated. Steps should therefore be

taken by the African Union and the RECs to co-ordinate national HIV/AIDS policies; rationalise regional approaches such as the West Africa Health Organisation's policy; and develop measurable indicators across Africa. The African Union should bring together brigade-level planners and military health officers as part of the process of establishing the ASF. ECOWAS's policies should be widely examined in regional fora in Southern, Central, Eastern, and North Africa as it could provide a model for developing a continental approach. The lessons learned by the UN in managing its HIV/AIDS and peacekeeping policies should also be examined and integrated into the policies of the RECs and the AU.

- Accelerate the implementation of HIV/AIDS plans through sub-regional, continental and international co-operation: Africa has already developed a roadmap for an exceptional response to HIV/AIDS. The African Union Commission's HIV/AIDS Strategic Plan and the African Common Position all embody the objectives and policies for an effective response to the pandemic. There is, however, a need to integrate and harmonise the implementation of both of these policies at the national and sub-regional levels. Efforts to domesticate legal and policy implications of these commitments should be made through African parliamentary fora and with national executives and ministerial institutions. Civil society organisations engaged in peace and security issues should be exposed to, and mobilised around, the AU Commission Plan and the Common Position.



Participants of the seminar, "HIV/AIDS, Militaries and Peacekeeping in Central and Eastern Africa", held in Addis Ababa, Ethiopia, from 8 – 10 November 2007

Annex I

Agendas

1. Seminar on Namibia's Chair of the SADC (Southern African Development Community) Organ: HIV/AIDS and Militaries in Southern Africa (Windhoek, Namibia - 9 and 10 February 2006)

Day One: 9 February 2006

9h00 – 9h15 **Welcoming Remarks**

Dr Adekeye Adebajo, Executive Director, Centre for Conflict Resolution, Cape Town
General Charles Namoloh, Namibian Minister of Defence, Windhoek

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

Chair: **General Charles Namoloh**, Namibian Minister of Defence, Windhoek

Speaker: **Dr Tomaz Augusto Salomão**, Executive Secretary, Southern African Development Community, Gaborone

11h15 – 11h30 Coffee Break

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

Chair: **General Charles Namoloh**, Namibian Minister of Defence, Windhoek

Speakers: **Professor Andre du Pisani**, University of Namibia, Windhoek

Dr Grace Kalimugogo, African Union Commission, Addis Ababa

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

13h30 – 14h45 Lunch

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

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

Speakers: Brigadier-General (Dr) G Gwinji, Zimbabwe Defence Forces and Ministry of Defence, Harare

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

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

Lieutenant-Colonel Paul Kuenane, Lesotho Defence Force, Maseru

17h00 – 17h15 Coffee Break

17h15 – 18h30 Video: "Remember Eliphas", produced by the Social Marketing Association (Namibia) and the Namibian Ministry of Defence; introduced by Major Marianne Muvangua, Namibian Defence Force and Ministry of Defence, Windhoek

18h30 – 20h00 Session Four: 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 that took place in Cape Town, South Africa, in August 2005.)

Chair: The Honourable Theo-Ben Gurirab, Speaker, National Assembly of Namibia, Windhoek

Speakers: 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 Five: Southern Africa's Framework for Security: Constraints and Limitations for Including HIV/AIDS?

Chair: Major-General Solly Mollo, South African Ministry of Defence, Tshwane

Speakers: Dr Kaire Mbuende, former Executive Secretary, Southern African Development Community, Windhoek

Ms Victoria Lonje, United Nations Alliance of Mayors' Initiative for Community Action against HIV/AIDS at Local Level, Windhoek

10h30 – 10h45 Coffee Break

10h45 – 12h30	**Session Six: Halting the HIV/AIDS Pandemic: National and Sub-Regional Approaches**
	Chair: Dr Kaire Mbuende, former Executive Secretary of the Southern African Development Community, Windhoek
	Speakers: Mr Salvator Niyonzima, Joint United Nations Programme on HIV/AIDS, Windhoek
	Mr Benjamin Ofosu-Koranteng, United Nations Development Programme, Windhoek
12h30 – 13h30	Lunch
13h30 – 15h00	**Session Seven: Accelerating the Response to HIV/AIDS: The Role of the UN**
	Chair: Dr Grace Kalimugogo, African Union Commission, Addis Ababa
	Speakers: Dr Antonica Hembe, Southern African Development Community, Gaborone
	Colonel (Dr) Grayson Idinga, Tanzania Peoples Defence Force, Dar es Salaam
15h00 – 15h30	Coffee Break
15h30 – 16h20	**Session Eight: Rapporteurs' Report and the Way Forward**
	Chair: General Charles Namoloh, Namibian Minister of Defence, Windhoek
	Speakers: 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

2. Seminar on HIV/AIDS, Militaries and Peacekeeping in North and West Africa (Cairo, Egypt - 8 and 9 September 2007)

Day One: Saturday 8 September 2007

09h00 – 09h30 Welcome

Dr Adekeye Adebajo, Executive Director, Centre for Conflict Resolution, Cape Town

Mr John Opoku, Technical Adviser, Kofi Annan International Peacekeeping and Training Centre, Accra

9h30 – 11h30 Session One: Context: HIV/AIDS and Security

Chair and Speaker: General Charles Namoloh, Namibian Minister of Defence, Windhoek

Speakers: Dr Oussama Tawil, Regional Director, Middle East and North Africa, Joint United Nations Programme on HIV/AIDS, Cairo, "Global HIV/AIDS and Security"

Ms Angela Ndinga-Muvumba, Senior Researcher, Centre for Conflict Resolution, Cape Town, "Africa's HIV/AIDS Agenda: The AU and Regional Economic Communities (RECs)"

11h30 – 11h45 Coffee Break

11h45 – 13h30 Session Two: Dialogue: HIV/AIDS, Regional Security and Conflict

Chair: Dr George Niouky, Medical Adviser, African Union Mission in Sudan

Speakers: Dr Bomby Kabongo, Principal Medical Officer, Brits District Hospital, Johannesburg, "HIV/AIDS, Security and Conflict"

Ms Angela Ndinga-Muvumba, Senior Researcher, Centre for Conflict Resolution, Cape Town, "Regional Approaches: HIV/AIDS and Security in Africa"

13h30 – 14h30 Lunch

14h30 – 16h00 Session Three: HIV/AIDS Prevention, Treatment and Care

Chair: **Dr Antonica Hembe**, Head, HIV/AIDS Unit, Southern African Development Community, Gaborone

Speakers: **Dr Sany Kozman**, Caritas Alexandria, "Implementing Prevention and Raising Awareness"

Dr Bola Omoniyi, Doctors For Life, United States, "Scaling-up Treatment, Care and Support"

20h00 – 21h30 Dinner

Day Two: Sunday 9 September 2007

9h30 – 11h00 Session Four: Towards an African Standby Force

Chair: **Mr Ibrahim Nawar**, Adviser, Al Ahram Centre for Political and Strategic Studies, Cairo

Speakers: **Colonel Ahmadu Bello**, Head of Mission Planning and Management, Economic Community of West African States, Abuja, "West Africa and the African Standby Force (ASF)"

Colonel Alefati Zrass, Legal Adviser, North African Standby Brigade Co-ordination Unit, Libya, "North Africa and the African Standby Brigade"

11h00 – 11h15 Coffee Break

11h15 – 13h00 Session Five: West Africa

Chair: **Ms Chantal Uwimana**, TrustAfrica, Dakar

Speakers: **Lieutenant-Colonel (Dr) James Samba**, Commanding Officer, HIV/AIDS Focal Point, Sierra Leone Armed Forces, "Sierra Leone"

Dr Jane Ansah, Programme Manager, Ghana Armed Forces, "Ghana"

13h00 – 14h00 Lunch

14h00 – 15h30 Session Six: North Africa

Chair: **Dr Mohamed Sammud**, Manager, National AIDS Programme, Tripoli

Speakers: Colonel Ardjoun Mohamed, Ministry of Defence, Centre de Transfusion Sanguine de l'Armee, Algiers, "Algeria"

Professor Malek Naim, Department of Microbiology, Military Hospital, Algiers, "Algeria"

Dr Nejib Doss, Chief, HIV Prevention Programme in Military Health, Tunis Military Teaching Hospital, Tunis, "Tunisia"

15h30 – 15h45 Completion of Evaluation Forms

15h45 – 16h00 Coffee Break

16h00 – 17h00 Session Seven: Rapporteurs' Report and the Way Forward

Chair and Speaker: Mr Abdoul Dieng, Regional Adviser, African Organisations, UNAIDS, Addis Ababa

Speakers: Ms Angela Ndinga-Muvumba, Senior Researcher, Centre for Conflict Resolution, Cape Town

Ms Robyn Pharoah, Independent Consultant, Cape Town

Dr Bomby Kabongo, Principal Medical Officer, Brits District Hospital, Johannesburg

3. Seminar on HIV/AIDS, Militaries and Peacekeeping in Central and Eastern Africa (Addis Ababa, Ethiopia 8 - 10 November 2007)

Thursday 8 November 2007

18h30 – 20h00 Book Launch: "South Africa in Africa: The Post-Apartheid Era"

Welcome and Introductions: Mr Ben Kioko, Legal Counsel of the African Union Commission, Addis Ababa

Chair: HE Ambassador LC Pepani, Ambassador Extraordinary and Plenipotentiary of South Africa, Addis Ababa

Speakers: Dr Adekeye Adebajo, Executive Director, Centre for Conflict Resolution, Cape Town

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

Professor Gilbert Khadiagala, University of the Witwatersrand, Johannesburg

Major-General Solly Mollo, Chief, Human Resources, South African Ministry of Defence, Tshwane

Day One: Friday 9 November 2007

09h00 – 09h30 Welcome

Dr Adekeye Adebajo, Executive Director, Centre for Conflict Resolution, Cape Town

Colonel George McGarr, Executive Director, Kofi Annan International Peacekeeping Training Centre, Accra

9h30 – 10h45 Session One: Setting the Scene: Africa's HIV/AIDS Challenge

Chair: Major-General Solly Mollo, Chief, Human Resources, South African Ministry of Defence, Tshwane

Speakers: Dr Grace Kalimugogo, Acting Director, Social Affairs, African Union Commission, Addis Ababa, "Africa's Agenda: A Continental Response to HIV/AIDS"

Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town, "HIV/AIDS, Militaries and Peacekeeping in Africa"

10h45 – 11h00 Coffee Break

11h00 – 12h30 **Session Two: The Challenge Ahead: The AU, HIV/AIDS and Security**

Chair: Dr Kwesi Aning, Head, Conflict Prevention, Management and Resolution Department, Kofi Annan International Peacekeeping Training Centre, Accra

Speakers: Mr Bereng Mtimkulu, Head, Peace Support Operations, African Union Commission, Addis Ababa, "What the African Standby Force Needs"

Mr John Opoku, Adviser, Kofi Annan International Peacekeeping Training Centre, Accra, "The Challenges of Peacekeeping and HIV/AIDS"

12h30 – 13h30 Lunch

13h30 – 15h00 **Session Three: Peace and Security in Central and Eastern Africa**

Chair: Ambassador Abdelrahim Khalil, Director of the Conflict Early Warning Response Mechanism, Intergovernmental Authority on Development, Addis Ababa

Speakers: Professor Gilbert Khadiagala, University of the Witwatersrand, Johannesburg, "Security Dynamics in Central Africa"

Mr Simon Mulongo, Director, Eastern Africa Standby Co-ordination Mechanism, Nairobi, "Eastern Africa and the African Standby Brigade"

15h00 – 15h15 **Coffee Break**

15h15– 16h45 **Session Four: HIV/AIDS, Security and Militaries in Central Africa**

Chair: Major-General Henry Anyidoho, Deputy Force Commander, UN/AU Hybrid Mission in Darfur

Speakers: Dr Bomby Kabongo, Principal Medical Officer, Brits District Hospital, Brits, and University of the Witwatersrand, Johannesburg, "The Great Lakes Region"

Mr Sebagabo Marcellin, HIV/AIDS Programme Manager, Ministry of Defence, Kigali, "Rwanda"

Day Two: Saturday 10 November 2007

9h30– 11h00 **Session Five: HIV/AIDS and Militaries in Eastern Africa**

Chair: Ms Chantal Uwimana, TrustAfrica, Dakar

Major-General (Dr) Safiedin Elnur Ali, HIV/AIDS Programme Focal Point, Ministry of Defence, Khartoum, "Sudan"

Colonel (Dr) Ambrose Musinguzi, Director, Public Health, Uganda Peoples Defence Forces, Kampala, "Uganda"

11h00 – 11h15 Coffee break

11h15 – 13h00 Session Six: A Spectrum of New Policies and Practice?

Chair: Professor Margaret Vogt, Deputy Director, United Nations Department of Political Affairs, New York

Speakers: Dr Edna Adan Ismail, former Minister of Foreign Affairs, Somaliland, and founder, Edna Adan Hospital, Hargeisa, "Building Health in the Midst of War and Tentative Peace"

Mr Fai Fominyen Ngu Edward, President, Prometre International, Yaoundé, "Traditional Knowledge, Healing and Medicine and HIV/AIDS"

13h00 – 14h00 Lunch

14h00 – 15h30 Session Seven: UNAIDS and HIV/AIDS in Africa

Chair: Ms Bernadette Olowo Freers, Senior Political Adviser on Advocacy, Joint United Nations Programme on HIV/AIDS; seconded to the African Union Commission, Addis Ababa

Speakers: Mr Abdoul Dieng, Regional Adviser, African Organisations, United Nations Joint Programme on HIV/AIDS, Addis Ababa, "The UN and AIDS, Security and Conflict"

Dr Abdel-Kader Haireche, Team Leader, AU Peace Support Team, United Nations Department of Peacekeeping Operations, Addis Ababa, "Africa's Security Architecture: Entry Points for a Response to HIV/AIDS?"

15h30 – 16h00 Completion of Evaluation Forms and Coffee Break

16h00 – 17h15 Rapporteurs' Report and the Way Forward

Chair: Dr Grace Kalimugogo, Acting Director, Social Affairs, African Union Commission, Addis Ababa

Speakers: Ms Angela Ndinga-Muvumba, Centre for Conflict Resolution, Cape Town, "Southern, North, West, Central and Eastern African Militaries and HIV/AIDS"

Ms Robyn Pharoah, Independent Consultant, Cape Town, "Towards a Continental Response?"

Annex II

List of Participants

Windhoek, February 2006

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. The Honourable Theo-Ben Gurirab
   National Assembly of Namibia
   Namibia

8. Brigadier-General (Dr) G Gwinji
   Zimbabwean Defence Force
   Zimbabwe

9. Brigadier-General NRK Hamata
   Ministry of Defence
   Namibia

10. Dr Antonica Hembe
    Southern African Development Community
    Botswana

11. Colonel (Dr) Grayson Idinga
    Tanzanian Defence Force
    Tanzania

12. Ms Eunice Iipinge
    University of Namibia
    Namibia

13. Mr Andrew Intamba
    Office of the President
    Namibia

14. Mr Phanuel Kaapama
    University of Namibia
    Namibia

15. Dr Grace Kalimugogo
    African Union Commission
    Ethiopia

16. Mr Ulf Källstig
    Regional Swedish-Norwegian HIV/Aids Team
    for Africa
    Zambia

17. Lieutenant-Colonel Micheal J Kelley
    Embassy of the United States
    Namibia

18. Lieutenant-Colonel Paul Kuenane
    Lesotho Defence Force
    Lesotho

19. Professor William Lindeke
University of Namibia
Namibia

20. Ms Victoria Lonje
UN Alliance of Mayors' Initiative for Community Action Against HIV/AIDS at Local Level
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21. Brigadier-General Paulino Macaringue
University of the Witwatersrand
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22. Ms Noria Mashumba
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23. Dr Kaire Mbuende
Former Executive Secretary
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25. Colonel Gertrude PS Mutasa
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26. Major Marianne Muvangua
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27. Mr Peter Mwatile
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28. General Charles Namoloh
Minister of Defence
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29. Lieutenant-Colonel Petrus Nathinge
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30. Ms Angela Ndinga-Muvumba
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32. Mr Veiccoh Nghiwete
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33. Mr Salvator Niyonzima
Joint United Nations Programme on HIV/AIDS
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34. Mr Benjamin Ofosu-Koranteng
United Nations Development Programme
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35. Ms Nadira Omarjee
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36. Mr Hans Poley
Royal Netherlands Embassy
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37. Mr Hoze Riruako
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38. Dr Martin Rupiya
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40. Mr Benjamin Schernick
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42. Mr Petrus Shivute
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43. Lieutenant-Colonel FS Siluzungila
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44. The Honourable Victor Simunje
Ministry of Defence
Namibia

45. Professor Earle Taylor
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46. Captain Matsotestsi Tlelai
Lesotho Defence Force
Lesotho

Cairo, September 2007

1. Dr Adekeye Adebajo
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2. Major-General (Dr) Safiedin Elnur Ali
Ministry of Defence
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3. Dr Jane Ansah
Ghana Armed Forces
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4. Colonel Ahmadou Bello
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African Union Mission in Sudan
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Joint United Nations Programme
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Doctors For Life
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20. Mr John Opoku
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26. Lieutenant-Colonel (Dr) James Samba
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Sierra Leone

27. Dr Mohamed Sammud
National AIDS Programme
Libya

28. Dr Oussama Tawil
Joint United Nations Programme
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Egypt

29. Ms Chantal Uwimana
Trust Africa
Senegal

30. Colonel Alefati Zrass
North African Standby Brigade
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Addis Ababa, November 2007

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Ambassador of South Africa to Ethiopia
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33. Ms Robyn Pharoah
Independent Consultant
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Senegal

36. Professor Margaret Vogt
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Centre for Conflict Resolution
Cape Town, South Africa

1. Ms Elizabeth Myburgh
2. Ms Pippa Segall
3. Ms Selma Walters
4. Ms Dawn Nagar

Annex III

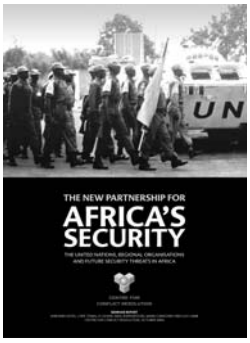
Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMU	Arab Maghreb Union
ARV	Anti-retroviral
ASF	African Standby Force
AU	African Union
CCR	Centre for Conflict Resolution
CEWARN	Conflict Early Warning Response Mechanism (IGAD)
DRC	Democratic Republic of the Congo
EASBRIG	Eastern Africa Standby Co-ordination Mechanism
ECCAS	Economic Community of Central African States
ECOWAS	Economic Community of West African States
ENDF	Ethiopian Defence Force
FAC	Congolese Armed Forces
GAF	Ghana Armed Forces
HIV	Human Immunodeficiency Virus
IGAD	Intergovernmental Authority on Development
ISDSC	Inter-State Defence and Security Committee (SADC)
KAIPTC	Kofi Annan International Peacekeeping Training Centre
KAP	Knowledge, attitudes and practices
LDF	Lesotho Defence Force
MRAF	Moroccan Royal Armed Forces
NASBRIG	North African Brigade
NDF	Namibian Defence Forces
NGO	Non-governmental organisation
OPDSC	Organ on Politics, Defence and Security Co-operation (SADC)
PEPFAR	Presidential Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS
RDF	Rwanda Defence Force
RECs	Regional Economic Communities
RSLAF	Republic of Sierra Leone Armed Forces
SADC	Southern African Development Community
SADCBRIG	SADC African Standby Force Brigade
SAF	Sudan Armed Forces
SANDF	South African National Defence Force

SIPO	Strategic Indicative Plan for the Organ on Politics, Security and Defence Co-operation (SADC)
SNAP	Sudan National AIDS Programme
STI	Sexually transmitted infection
TPDF	Tanzanian People's Defence Force
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UPDF	Uganda People's Defence Force
USAID	United States Agency for International Development
US DoD	United States Department of Defence
VCT	Voluntary counselling and testing
WAHO	West African Health Organisation
ZAWWA	Zimbabwe Army Wives and Women's Association
ZDF	Zimbabwe Defence Forces

Other publications in this series

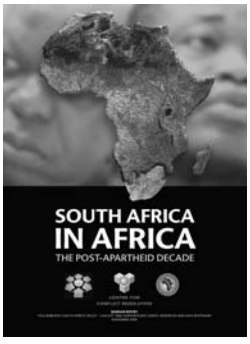
(available at http://ccrweb.ccr.uct.ac.za)



VOLUME 1
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 within the framework of UN reform were the focus of this policy seminar, held from 21 – 23 May 2004 in Claremont, Cape Town.



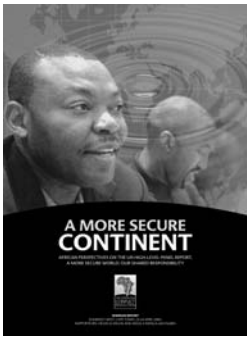
VOLUME 2
SOUTH AFRICA IN AFRICA

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.

VOLUME 3
THE AU/NEPAD AND AFRICA'S EVOLVING GOVERNANCE AND SECURITY ARCHITECURE

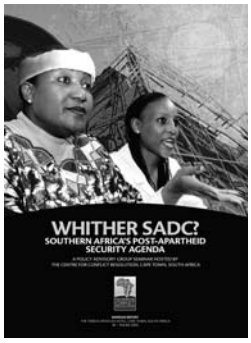
The state of governance and security in Africa under the AU and NEPAD were analysed and assessed at this policy advisory group meeting in Misty Hills, Johannesburg, on 11 and 12 December 2004.



VOLUME 4
A MORE SECURE CONTINENT

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

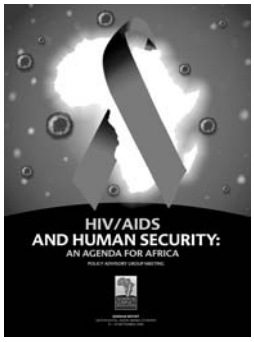
African perspectives on the United Nations' (UN) High-Level Panel report on Threats, Challenges and Change were considered at this policy advisory group meeting in Somerset West, Cape Town, on 23 and 24 April 2005.



VOLUME 5
WHITHER SADC?

SOUTHERN AFRICA'S POST-APARTHEID SECURITY AGENDA

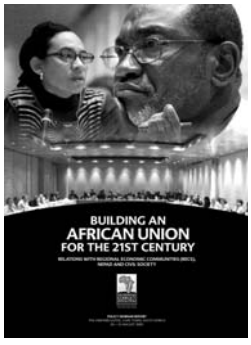
The role and capacity of the Southern African Development Community's (SADC) Organ on Politics, Defence and Security (OPDS) were focused on at this meeting in Oudekraal, Cape Town, on 18 and 19 June 2005.



VOLUME 6
HIV/AIDS AND HUMAN SECURITY:

AN AGENDA FOR AFRICA

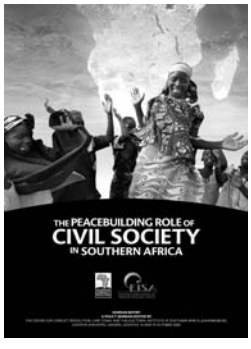
The links between human security and the HIV/AIDS pandemic in Africa, and the potential role of African leadership and the African Union in addressing this crisis were analysed at this policy advisory group meeting in Addis Ababa, Ethiopia, on 9 and 10 September 2005.



VOLUME 7
BUILDING AN AFRICAN UNION FOR THE 21ST CENTURY

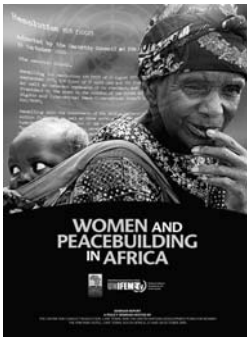
RELATIONS WITH REGIONAL ECONOMIC COMMUNITIES (RECS), NEPAD AND CIVIL SOCIETY

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.



VOLUME 8
THE PEACEBUILDING ROLE OF CIVIL SOCIETY IN SOUTHERN AFRICA

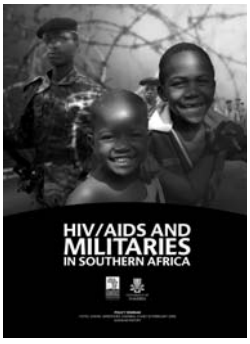
This meeting, held in Maseru, Lesotho, on 14 and 15 October 2005, explores civil society's role in relation to southern Africa, democratic governance, its nexus with government, and draws on comparative experiences in peacebuilding.



VOLUME 9

WOMEN AND PEACEBUILDING IN AFRICA

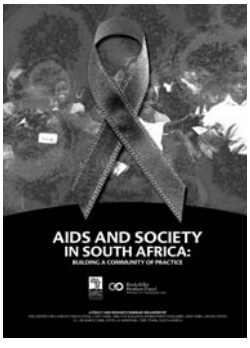
This meeting, held in Cape Town on 27 and 28 October 2005, reviewed the progress of the implementation of UN Security Council Resolution 1325 on Women and Peacebuilding in Africa in the five years since its adoption by the United Nations in 2000.



VOLUME 10

HIV/AIDS AND MILITARIES IN SOUTHERN AFRICA

This two-day policy advisory group seminar in Windhoek, Namibia, on 9 and 10 February 2006 examined issues of HIV/AIDS and militaries in southern Africa.

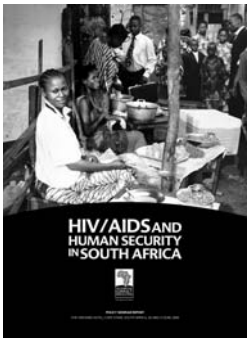


VOLUME 11

AIDS AND SOCIETY IN SOUTH AFRICA:

BUILDING A COMMUNITY OF PRACTICE

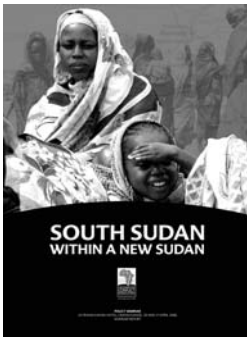
This policy and research seminar, held in Cape Town on 27 and 28 March 2006, developed and disseminated new knowledge on the impact of HIV/AIDS in South Africa in the three key areas of: democratic practice; sustainable development; and peace and security.



VOLUME 12

HIV/AIDS AND HUMAN SECURITY IN SOUTH AFRICA

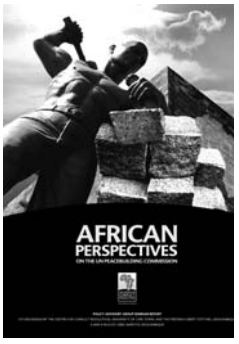
This two-day policy seminar on 26 and 27 June 2006 took place in Cape Town and examined the scope and response to HIV/AIDS in South Africa and southern Africa from a human security perspective.



VOLUME 13

SOUTH SUDAN WITHIN A NEW SUDAN

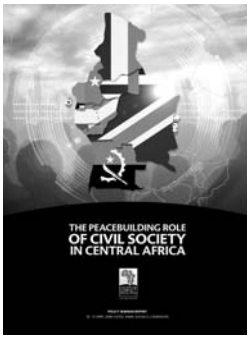
This policy advisory group seminar on 20 and 21 April 2006 in Franschhoek, Western Cape, assessed the implementation of the Comprehensive Peace Agreement (CPA) signed in January 2005 by the Government of the Republic of the Sudan (GOS) and the Sudan People's Liberation Movement/Sudan People's Liberation Army (SPLM/A).



VOLUME 14

AFRICAN PERSPECTIVES ON THE UN PEACEBUILDING COMMISSION

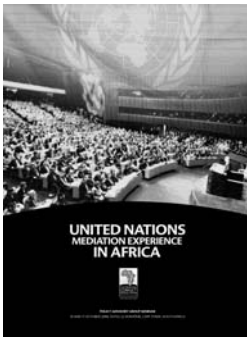
This meeting, in Maputo, Mozambique, on 3 and 4 August 2006, analysed the relevance for Africa of the creation, in December 2005, of the UN Peacebuilding Commission, and examined how countries emerging from conflict could benefit from its establishment.



VOLUME 15

THE PEACEBUILDING ROLE OF CIVIL SOCIETY IN CENTRAL AFRICA

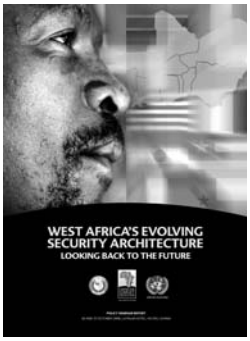
This sub-regional seminar, held from 10 to 12 April 2006 in Douala, Cameroon, provided an opportunity for civil society actors, representatives of the Economic Community of Central African States (ECCAS), the United Nations (UN) and other relevant players to analyse and understand the causes and consequences of conflict in central Africa.



VOLUME 16

UNITED NATIONS MEDIATION EXPERIENCE IN AFRICA

This seminar, held in Cape Town on 16 and 17 October 2006, sought to draw out key lessons from mediation and conflict resolution experiences in Africa, and to identify gaps in mediation support while exploring how best to fill them. It was the first regional consultation on the United Nations' newly-established Mediation Support Unit (MSU).

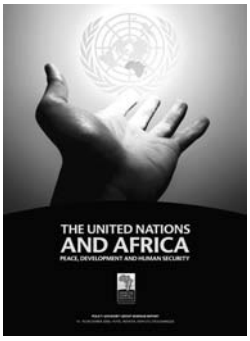


VOLUME 17

WEST AFRICA'S EVOLVING SECURITY ARCHITECTURE

LOOKING BACK TO THE FUTURE

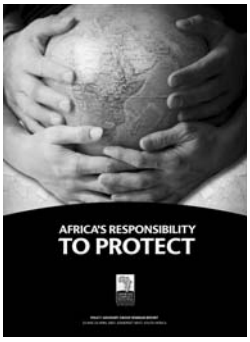
The conflict management challenges facing the Economic Community of West African States (ECOWAS) in the areas of governance, development, and security reform and post-conflict peacebuilding formed the basis of this policy seminar in Accra, Ghana, on 30 and 31 October 2006.



VOLUME 18

THE UNITED NATIONS AND AFRICA: PEACE, DEVELOPMENT AND HUMAN SECURITY

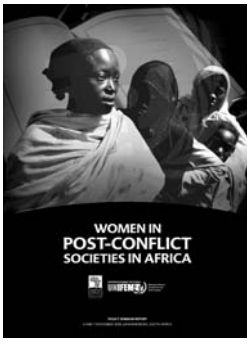
This policy advisory group meeting, held in Maputo, Mozambique, from 14 to 16 December 2006, set out to assess the role of the principal organs and the specialised agencies of the UN in Africa.



VOLUME 19

AFRICA'S RESPONSIBILITY TO PROTECT

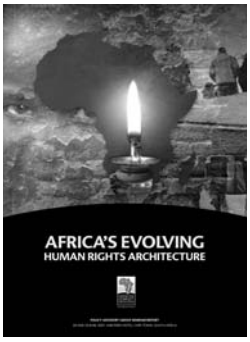
This policy seminar, held in Somerset West, South Africa, on 23 and 24 April 2007, interrogated issues around humanitarian intervention in Africa and the responsibility of regional governments and the international community in the face of humanitarian crises.



VOLUME 20

WOMEN IN POST-CONFLICT SOCIETIES IN AFRICA

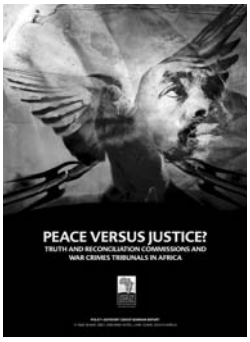
The objective of the seminar, held in Johannesburg, South Africa, on 6 and 7 November 2006, was to discuss and identify concrete ways of engendering reconstruction and peace processes in African societies emerging from conflict.



VOLUME 21

AFRICA'S EVOLVING HUMAN RIGHTS ARCHITECTURE

The experiences and lessons from a number of human rights actors and institutions on the African continent were reviewed and analysed at this policy advisory group meeting held on 28 and 29 June 2007 in Cape Town, South Africa.

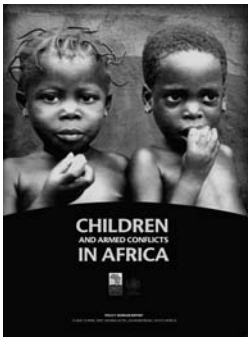


VOLUME 22

PEACE VERSUS JUSTICE?

TRUTH AND RECONCILIATION COMMISSIONS AND WAR CRIMES TRIBUNALS IN AFRICA

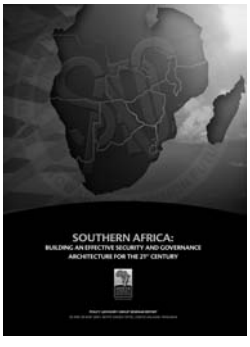
The primary goal of this policy meeting, held in Cape Town, South Africa, on 17 and 18 May 2007, was to address the relative strengths and weaknesses of "prosecution versus amnesty" for past human rights abuses in countries transitioning from conflict to peace.



VOLUME 23

CHILDREN AND ARMED CONFLICTS IN AFRICA

This report, based on a policy advisory group seminar held on 12 and 13 April 2007 in Johannesburg, South Africa, examines the role of various African Union (AU) organs in monitoring the rights of children in conflict and post-conflict situations.

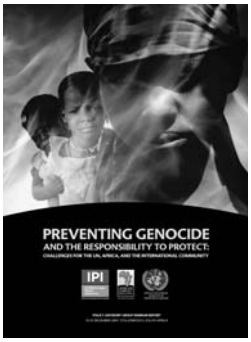


VOLUME 24

SOUTHERN AFRICA:

BUILDING AN EFFECTIVE SECURITY AND GOVERNANCE ARCHITECTURE FOR THE 21ST CENTURY

This report is based on a seminar, held in Tanzania on 29 and 30 May 2007, that sought to enhance the efforts of the Southern African Development Community (SADC) to advance security, governance and development initiatives in the sub-region.



VOLUME 25
PREVENTING GENOCIDE AND THE RESPONSIBILITY TO PROTECT

CHALLENGES FOR THE UN, AFRICA, AND THE INTERNATIONAL COMMUNITY

This policy advisory group meeting was held from 13-15 December 2007 in Stellenbosch, South Africa, and focused on six African, Asian and European case studies. These highlighted inter-related issues of concern regarding populations threatened by genocide, war crimes, "ethnic cleansing" or crimes against humanity.

VOLUME 26
EURAFRIQUE?

AFRICA AND EUROPE IN A NEW CENTURY

This seminar, held from 31 October to 1 November 2007 in Cape Town, South Africa, examined the relationship between Africa and Europe in the 21st Century, exploring the unfolding economic relationship (trade, aid and debt); peacekeeping and military co-operation; and migration.

VOLUME 27
SECURITY AND DEVELOPMENT IN SOUTHERN AFRICA

This seminar, held in Johannesburg, South Africa, from 8-10 June 2008, brought together a group of experts – policymakers, academics and civil society actors – to identify ways of strengthening the capacity of the Southern African Development Community (SADC) to formulate security and development initiatives for southern Africa.

TRUSTAFRICA

A range of military experts, civil society representatives, academics and policymakers from 28 African governments, Regional Economic Communities, the African Union and the United Nations contributed to the findings covered in this report. It addresses prospects for a response to the HIV/AIDS epidemic within the context of African peacekeeping and regional peace and security and is based on three regional advisory group seminars that took place in Windhoek, Namibia (February 2006); Cairo, Egypt (September 2007); and Addis Ababa, Ethiopia (November 2007). The meetings provided a platform for dialogue between experts engaged in African peacekeeping and their counterparts in military health medicine.

CENTRE FOR CONFLICT RESOLUTION
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