HIV/AIDS: DESTABILISING NATIONAL SECURITY AND THE MULTI-NATIONAL RESPONSE

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--------- SUMMARY ----------

Introduction *HIV/AIDS contributes to social and political destabilisation in vast regions of the globe, and complicates the international response of peacekeeping forces and relief agencies.*

Impact on Civil Society *In regions where HIV is expanding, it threatens the socio-economic fabric of whole nations. The disappearance of productive members of society threatens national development, households, health care and all economic sectors, eventually eroding family and community viability.*

Impact on Fragile Geo-Political Systems *Projections of the HIV/AIDS pandemic portray a grave public health and development emergency in regions most affected. It is a factor in social disruption, poverty and crumbling economic and political infrastructures, leading to civil unrest that threatens security. There is a growing awareness of the interplay between HIV/AIDS and complex humanitarian emergencies.*

Impact on the Military *For armed forces personnel, HIV transmission presents a constant, two-fold threat – soldiers risk both receiving and passing on the infection, often in HIV-rich environments. The HIV/AIDS risk environment found in complex emergencies thus affects all populations, military and civilian. The situation in Africa, and its established impact on African militaries, is especially alarming.*

Conclusions *(1) All armed forces can confront this challenge by undertaking comprehensive HIV prevention programmes, centred on training adapted to all levels of the military, and focused on behavioural issues. (2) Inter-country linkages for these efforts can be enhanced through military support networks. (3) Regional linkages can be used for wider crisis prevention and response, building on support available through existing multi-national agencies such as the ICMM, the All Africa Congress of Armed Forces and Police Medical Services, and the Civil-Military Alliance to Combat HIV and AIDS.*

Keywords: Human Immunodeficiency Virus; Acquired Immunodeficiency Syndrome; health threats to national and international security; military, civil-military, and regional cooperation in HIV/AIDS control.

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THE EFFECTS OF HIV/AIDS ON THE MILITARY AND ON CIVIL-MILITARY RELATIONS

Military forces perform a major protective role for most societies, and are called upon to serve internally and to deploy outside their national boundaries. Today, militaries are challenged by the changing nature of threats to national and international peace and security. These include an increasing number of post-Cold War internal and cross-border conflicts, often accompanied by genocidal ethnic and religious confrontations and massive displacements of populations, combining to produce highly complex humanitarian emergencies. In 1999 alone, some 17 African countries were engaged in such conflicts or had just emerged from crises of this sort.

To a greater extent than in the past, national militaries and international peacekeeping forces are deployed to assist civilian relief agencies in addressing the human impact of these crises, in addition to fulfilling their already difficult task of defusing active or smouldering conflict. This means that military and civilian populations face a common enemy, epidemic disease, that is especially strong under conditions of massive social disruption. In many conflicts throughout history, rapidly spreading diseases have killed many more combatants and non-combatants than the fighting itself.

Omnipresent among wartime and post-wartime maladies are sexually transmitted diseases (STDs). Even today, and even in peacetime, military STD infection rates are generally 2 to 5 times higher than STD rates in comparable civilian populations. In domestic and foreign conflict situations, risk of STD infection becomes much higher for both military personnel and the civilians among whom they are deployed. Since World War II, advances in medicine have rendered STDs and other infectious diseases less dangerous to military and civilian populations alike. Especially in technologically advanced societies, reduced threat of epidemics has also turned public health concerns away from disease prevention and toward curative medicine.

In the past two decades of escalating human conflict, however, one lethal STD has emerged for which medicine has no cure. This is the Human Immunodeficiency Virus (HIV) which results in the Acquired Immunodeficiency Syndrome (AIDS). In many parts of the world, HIV and AIDS pose a far more serious threat to military populations than the inherently hazardous nature of their occupation.

The armed forces recruit people at a time of their greatest risk of HIV infection, in the 15-24 year old age group where more than half of all HIV infections occurs. Military personnel are also vulnerable in

that they are regularly away from home for long periods, are often in need of recreation to relieve stress and loneliness, and are subject to risk-enhancing alcohol and drug use. They may have feelings of invincibility, at an age and in a profession that often excuse and even encourage risk-taking. Military camps and other installations are known to attract sex workers and those who deal in illicit drugs, enticing off-duty soldiers who are sure to have cash - but not necessarily condoms and sterile syringes - in their pockets.

Civilian and military leaders in a number of countries are concerned that HIV and other sexually transmitted infections can compromise military readiness, and the costs of replacement training can place a heavy burden on military budgets. When a unit is missing several key members, sick for increasingly long intervals or deceased and not yet replaced, the unit cannot be considered to be fully functional and thus deployable. Readiness is further eroded when those sick or lost to AIDS include members of the senior-officer ranks. Diminished capacity in the defence establishment becomes part of a larger AIDS-related threat to socio-economic well-being and development, and to national and international security.

THE DESTABILISING SOCIO-ECONOMIC CONSEQUENCES OF HIV/AIDS

In countries where the HIV/AIDS pandemic is far advanced, the disease has become a development crisis of the first order. It now threatens the social and economic fabric of whole societies, and the political stability of whole nations and regions. Its long-term impact on economically impoverished and politically unstable countries is as bad as or worse than as that caused by civil strife and warfare, which HIV/AIDS itself helps to precipitate and prolong.

For many countries in Africa, HIV/AIDS has become an inherent part of an unfolding series of complex humanitarian emergencies, building on and exacerbating the severe poverty-related crises that grip most of the continent and reversing decades of progress toward social and economic modernization. As such, exploding rates of HIV infections have far-reaching consequences at all levels of society and their socio-economic repercussions extend far beyond the domain of public health.

By killing large numbers of economically productive and sexually reproductive adults, AIDS

% erodes social, economic, and infrastructure development;

% increases health and welfare demands, adding to the cost of providing services;

% increases the total number of children orphaned or living in families profoundly disrupted by AIDS, producing successive generations of homeless and increasingly desperate youths;

% reduces formal and informal sector productivity;

% increases labour costs produced by staff turnovers, absenteeism, loss of skills, and rapidly recurrent recruitment and training outlays.

Studies on the impact of AIDS on household economies have documented the tremendous burden of loss of income, large health care expenditures, and consumption of family savings to pay for funeral and mourning costs. Decreases in family income lead to reductions in consumption and savings. An HIV/AIDS impact study of urban areas in Côte d'Ivoire found that attrition from the disease caused outlays for school expenses to be halved, per capita food consumption to decline by 41 percent, and expenditures for health care to increase by more than 400 percent (1).

Health-care systems in countries that are hardest hit by HIV/AIDS are stressed and later inundated, as the HIV-infected of past years become AIDS-symptomatic. For poor countries, AIDS attacks the health sector in two ways; it dramatically increases the number of people seeking services, and it creates a demand for care that is more expensive than that required for more-treatable conditions. HIV/AIDS has already overwhelmed health care systems in several African countries where infected patients occupy up to 70 percent of all beds in urban hospitals (2). This worsens problems of overcrowding and increases risk of secondary infections such as TB and diarrhoea. Treatment facilities are often inadequate, diagnostics and drugs are in short supply, and operational procedures have not been adjusted to meet the needs of people living with HIV/AIDS. Staffs are often inadequately trained to identify opportunistic infections at an early stage, and therefore to improve quality and length of life through appropriate treatment. Fear and stigma may result in discrimination against HIV-infected patients.

Problems of understaffing can also quickly become acute. In highly endemic countries, many caregivers are themselves HIV seropositive, others are seriously ill, and still others have already died. Growing numbers are unable to continue work or are frequently absent because they are caring for their own sick relatives and, increasingly, attending funerals. The overall result is a rise in the cost of health care and a progressive loss of resources - beds, essential drugs, doctors, nurses, orderlies, and laboratory staff.

AIDS affects the education sector in at least three ways. AIDS-related illness and death reduce the supply not only of students, but also of experienced and recently trained instructional staffs. For example,

between January and November 1998, 1,300 Zambian teachers were lost to AIDS. This number equaled two-thirds of the country's annual production of new teachers (3). In addition, children are kept out of school to care for sick family members and to perform substitute work in their household economies. Finally, AIDS-afflicted families often cannot afford school fees because of drastic reductions in household income created by the disease.

In general, HIV/AIDS undermines formal economic sectors by increasing expenditures and reducing revenues. An assessment of one sugar estate in Kenya revealed that illness resulted in 8,000 days of lost labour between 1995 and 1997, a 50 percent decline in the conversion of raw to processed sugar, a 500 percent increase in workers' spending for funerals, and more than a 1,000 percent increase in medical costs. The company estimated that over 75 percent of employee illnesses were related to HIV infection. Between the 1980s and 1997, illness and death advanced from last to first place as a reason for separation from company employment (4).

Three productive sectors are critically important to the emerging economies of Africa and other less-developed world regions, and all three are threatened by the HIV/AIDS pandemic.

Mining is a key source of foreign exchange for many countries. Mineral extraction is usually conducted at sites far from population centres, forcing many workers to live apart from their families for extended periods. Under these circumstances, miners often resort to commercial sex. Many inevitably become infected with HIV and spread the infection to their spouses and communities when they return home. This process, which is replicated many times in Africa, is accompanied by a long-term consequence for national economic independence and skills-development. In addition to workers in the HIV-endemic environments of mining camps, trained mining engineers, managers, and other skilled personnel can be very difficult to replace. As a result, a severe AIDS epidemic seriously threatens domestically retained and reinvested mining revenues at all levels of present and future production. This situation is worsened by the fact that, as centres of wealth creation, mining areas are often also the scenes of armed conflicts and complex humanitarian emergencies.

Agriculture is the largest sector in most African and other less-developed economies, accounting for a large portion of production and the lion’s share of formal and informal employment. Studies conducted in Zimbabwe and other African countries have shown that AIDS creates adverse effects for

agriculture, including loss of labour supply and remittance income (5). The absence of only a few workers at the critical periods of planting and harvesting can significantly reduce the size of a harvest. In countries where food security has been a continuous issue because of ill-conceived or poorly implemented agricultural policies and/or setbacks caused by man and nature (e.g., flooding and drought), declines in household production can have serious consequences. A loss of agricultural labour diminishes farmers' control over their environment and causes them to switch to less labour-intensive, but also less nutritious, crops grown in smaller quantities. In many cases this may mean switching from export and commercial food crops to subsistence crops, compromising both national and local economies and, in rapidly urbanizing poor countries, national food security as well.

Transport is of obvious importance to the mining and agricultural sectors and to other vital areas of industrial and commercial activity, including tourism. This sector is also especially at risk to AIDS and crucial to AIDS prevention and control. Like mining, the construction, maintenance, and operation of a transport infrastructure usually carries individuals and teams of workers away from their families on lengthy assignments. An informal survey of bus and truck drivers in Cameroon found that they spent an average of 14 days away from home on each trip, that 68 percent had sex during their most recent trip, and that 25 percent had sex every night during which they were away. Most transport engineers and managers are trained professionals who are hard to replace. Confronting HIV/AIDS, governments and private enterprises face the competing financial challenges of improving transport as an essential element of national development while protecting the lives of workers and their families in an industry that is highly at risk to STDs and HIV.

HIV/AIDS, SOCIO-ECONOMIC DESTABILISATION, AND NATIONAL SECURITY

In 1993 the World Bank developed a model to calculate the macroeconomic impact of the HIV pandemic at country level. The model calculated losses in per capita gross domestic product (PC/GDP) for countries with high HIV prevalence rates. The result of this exercise was that, on average, high-prevalence countries lost between 0.5 and 1.0 percent of PC/GDP growth per year (6). More recent studies have confirmed an approximate 1 percent annual loss of growth (7). These figures may not initially appear alarming, but over 20 years the continuous decline accumulates to as much as 25 percent. For Kenya, where a total PC/GDP decrease between 1995 and 2005 has been calculated at about 14.5 percent, the

consequences of HIV/AIDS will devastate an economy that is already beset by unpredictable climate and weather, by often unfavourable international export and import markets, and by official corruption and mismanagement. All of these factors portend domestic instability and potential challenges to sub-regional security in Eastern Africa.

In its 2000 Human Development Report, the World Bank further estimates the impact of HIV/AIDS on a Human Development Index (HDI) whose main indicators are national life expectancy and literacy rates. Currently, Botswana suffers a 36 percent HIV infection rate in the 15 to 49-year age group, which is the world's highest national rate of infection. Because of HIV/AIDS, Botswana's HDI declined by 9 percent during the 1990s. Life expectancy fell from 53 years in the 1970s to 47 years in 2000. By 2020, there will be fewer Batswana in their 40s and 50s than in their 60s and 70s (8). Even in a country that has long served as a model of peace and prosperity in Africa, it is difficult to imagine tolerable levels of socio-economic and political stability under such conditions. Elsewhere in Africa and in other parts of the less-developed world, HIV/AIDS has already become a direct and independent agent of conflict precipitation, extension, intensification, and prolongation.

THE EFFECTS OF HIV/AIDS ON FRAGILE GEOPOLITICAL SYSTEMS

HIV/AIDS and other poverty-related factors that threaten social and economic development naturally pose a threat to political stability. Current epidemiological observations and projections portray a major public health and social development emergency that continues to unfold across Sub-Saharan Africa and is beginning to follow suit in large areas of Asia, the Caribbean, Central America, and Eastern Europe. This particular crisis affects all sectors of society, including the military, in much the same manner as other complex human emergencies have evolved throughout history. Social disruption, poverty, hunger, and crumbling socio-economic and political institutions lead to a growing sense of helplessness and anger among disaffected populations, which may be already divided along ethnic, religious, and/or territorial lines of conflict. Governments are further weakened by their inability to respond, and are increasingly perceived to be more a part of the problem than an instrument of its solution.

Climatic vagaries, particularly flooding and drought, may contribute to a collapse of food security in parts of some affected regions, further affecting populations already weakened and reduced by HIV/AIDS. Such a crisis in food production has recently occurred in drought-prone Northeastern Africa,

leading to an intensification of armed clashes among pastoralists in northern Kenya and southern Ethiopia (9). History has shown how failed harvests and widespread hunger can compound the risks of social and political destabilisation. Reconstruction after natural disasters is also more difficult in HIV-endemic countries, where more than 25 percent of adults may also be or soon be AIDS patients.

Changes in national population profiles produce fewer economically active adults and more destitute young people. Forced as orphans into urban centres, children begin working at an earlier age and for lower wages, and additional young sex workers enter a marketplace that is susceptible to STD and HIV transmission. Increasing numbers of socially alienated children and adolescents roam the streets, creating a new threat of hunger, disease, and crime, and forming a ready clientele for armed conflict. A rising middle class with high rates of HIV infection forms another part of these profiles. It is composed of educated young adults who know that life-prolonging drugs exist but are still too expensive to be offered by their own government. Their urgent but unsatisfied demand for such therapies merely adds to the mounting political tensions that may lead to state failure and civil breakdown.

A reciprocity exists between HIV/AIDS, socio-economic and political disintegration, armed conflict, and complex humanitarian emergencies. Warfare places cross-border refugees and internally displaced persons on the move and into an environment of extreme vulnerability, where risk of death from HIV infection may equal or exceed risk from other deadly threats that abound for civilians (especially women and children), combatants, and peacekeepers alike. What has become a culture of violence partly because of HIV/AIDS also helps to extend the chance of acquiring HIV. Taken in its totality, this situation reflects the structural nature of the risk environment for all population groups caught up in humanitarian emergencies, and highlights the fundamental importance of behavioural factors in HIV transmission.

This highly charged HIV risk environment remains intact even after the fighting has stopped, in that the aftermath of complex humanitarian emergencies is consistent with conditions that maintain and even accentuate susceptibility to infection and eventual death:

% Social disruption results in sudden, widespread, and profound poverty. One of the first consequences of this situation is acute and often severe health and food insecurity suffered by displaced family units.

% Lack of income and employment opportunity leads to the sale of sex by often-illiterate young women, men, and children as a last recourse toward meeting their basic needs. Hyper-expansion of an

unregulated informal sex industry occurs primarily among recent urban migrants, many of whom are "pushed" unprepared into an alien urban lifestyle by socio-economic breakdown in the rural areas including loss of relatives to AIDS.

% Exploitative child-labour markets expand, made possible by acute labour shortages and by orphaned "street urchins" who are reduced to shortened lives of violence, poverty, ignorance, and disease.

% Migration of surviving rural breadwinners to find wage employment further disrupts family integrity and local economies and exposes migrants to an enhanced possibility of acquiring HIV in labour camps.

% Refugees and internally displaced persons face lives of desperation that foster sexual abuse and domestic violence, rape, and gender inequality. Women are at least six times more likely to become HIV-infected in refugee and displacement camps than in the surrounding general population.

% Decimated health-care infrastructures become unable to maintain or create sexual and reproductive health services, blood-safety protocols, sterile equipment, STD/HIV counselling services, and facilities for the care for those who become symptomatic with AIDS-related diseases.

% Reduced access to education is extended to the next generation, including training in employment skills and HIV-prevention education appropriate to local belief systems and capacities to act.

If left unchecked, these conditions promise a continuing downward spiral into instability and violence on a wider and wider scale.

The structural nature of the HIV risk environment is also an important factor to consider when military forces are deployed as combatants or as peacekeepers. It must be remembered that HIV transmission is a two-way street. Troops may bring HIV home with them, or they may be unwittingly responsible for the onward transmission of the infection to others in the field.

HIV/AIDS AS A PRIORITY CONCERN OF MILITARY MEDICINE AND CIVIL-MILITARY COOPERATION

Instead of resulting in a more unified and secure global community, the post-Cold War period has witnessed an increasingly bi-polar world of have and have-not countries and also a multi-polar have-not world of unresolved internal and regional conflicts. It has also become clear that, in an age of increasing globalisation in human affairs, public-health status has joined economic and geo-political self-interest as a

critical measure of national and international security. According to Nils Daulaire, president of the Global Health Council, three reasons explain this shift in paradigm:

% Because of vastly improved physical communications, conditions of ill health in any part of the world can now rapidly and profoundly affect health conditions in any other part of the world. (The appearance, during the summers of 1999 and 2000, of the deadly West Nile virus in New York City provides a case in point.)

% Because the greatest challenges to public health predominate in the world's majority of impoverished countries that also contain a majority of the world's population, health-related threats to national economic and political self-interest now extend to all countries.

% Because global health crises are among those that contribute to and result from armed conflicts in less-developed countries, national and multinational responses are now required that must inevitably involve developed countries as well (10).

These new realities were confirmed on 10 January 2000, when the UN Security Council - for the first time in its history - acknowledged a public-health problem, the scourge of HIV/AIDS in Africa, as a threat to international peace and security. Actions were immediately undertaken to strengthen HIV/AIDS prevention training in the UN Department of Peacekeeping Operations (DPKO), both at pre-deployment training sites and for peacekeepers already in the field. The sense of urgency and intensity of political will associated with this initiative are reflected in a statement by Richard Holbrooke, U.S. Ambassador to the UN, in his March 8 report to the U.S. Congress. "As long as I am ambassador, the United States will never again vote for a peacekeeping resolution that does not require specific action by the (UN) to prevent AIDS from spreading by or to peacekeepers" (11). Holbrooke spoke as preparations were underway for the latest DPKO deployment, the 5,537-troop UN Mission in the Congo (MONUC) which was delayed by sporadic fighting in Kisingani and in other parts of the country. In late April, the U.S. government's National Intelligence Council released a declassified version of its own first-ever intelligence estimate on a public-health problem, declaring the HIV/AIDS pandemic to be a direct threat to U.S. national security (12).

Barely ten years ago, perceptions of HIV/AIDS varied between denial of its existence, or at least of its existence as a major health threat, to acceptance of the virus as a deadly but demographically and geographically isolated health crisis. In succeeding years, HIV/AIDS became more accurately viewed as a

short-term socio-economic catastrophe and a long-term challenge to global public health and socio-economic development. During this period, high incidences and prevalences almost invariably appeared as co-factors with extreme poverty and social dislocation, and with political instability and violence, thus also revealing HIV/AIDS as a manifest threat to national, regional, and global security.

This ominous relationship is especially evident in Sub-Saharan Africa, where 79 percent of all AIDS deaths in 1999 occurred, where 71 percent of all adults and children living with HIV/AIDS were to be found, and where the adult rate of infection was 7.5 times the global infection rate (13). Africa is likewise the least stable world region. By the late 1990s, the continent was embroiled in more armed struggles than any other, producing millions of deaths and more than eight million refugees and internally displaced persons who, even by African standards, were placed at an elevated risk of HIV infection. Internal and cross-border disputes pose great peril to helpless civilian populations caught up in the violence. There is even documented evidence of HIV infection by rape being used as a weapon. By early 1999, fighting in West and Central Africa included about 120,000 voluntary and conscripted child "soldiers" (14), many untrained and undisciplined, some themselves AIDS orphans, but all potential HIV carriers and AIDS victims.

Although the close association of poverty, communicable disease, and war in Africa's complex humanitarian emergencies is well known to relief and development workers, this relationship is only now receiving the serious consideration of governments, international organizations, policy scientists, and defence analysts. Their attention is increasingly focused on the centrality of HIV/AIDS and on the urgent need for effective control over this deadly enemy. An essential part of the effort is to identify agencies that are already in place and in a position to offer catalytic assistance on behalf of HIV/AIDS prevention and control. Prominent among such groups are those that promote international cooperation in military health affairs, and in Africa these include the Civil-Military Alliance to Combat HIV and AIDS (CMA), the All Africa Congress of Armed Forces and Police Medical Services (AACAFPMS), and, potentially, the International Committee of Military Medicine (ICMM).

The Civil Military Alliance to Combat HIV and AIDS

The CMA was conceived in 1993 at a satellite seminar of the 9th World AIDS Conference in Berlin, whose members pledged "military and civilian cooperation in response to the HIV and AIDS

epidemic." At this time it was acknowledged that military personnel, both at home and on deployment, formed an often-overlooked population at special risk to STD and HIV infections. It was further realised that close collaboration and integration of prevention programmes between the civilian (both public and private) and military sectors is an indispensable element in successful STD/HIV prevention and management.

Since 1993, the CMA mandate has been extended to the peacekeeping, police, and prisons sectors. Populations in these groups share with national militaries many of the same risk and vulnerability factors, and yet are also largely neglected in conventional AIDS programmes. This expansion of commitment was formalized in 1998, when the CMA was designated a Collaborating Centre of the Joint United Nations Programme on HIV/AIDS (UNAIDS), with responsibility for HIV/AIDS prevention and mitigation in the world's uniformed services.

The CMA now has contacts in and working relations with the militaries of nearly 100 countries. CMA-sponsored civil-military linkages have also been established among countries in virtually all world regions, reflecting a recognition that cross-national cooperation forms another key element in strengthening local responses to the HIV/AIDS pandemic. Three sub-regional technical support networks have been created in Africa:

% **Anglophone West Africa (CMA/AWA)**, 5 countries including The Gambia, Ghana, Liberia, Nigeria, and Sierra Leone, with coordinating headquarters located in Accra, Ghana;

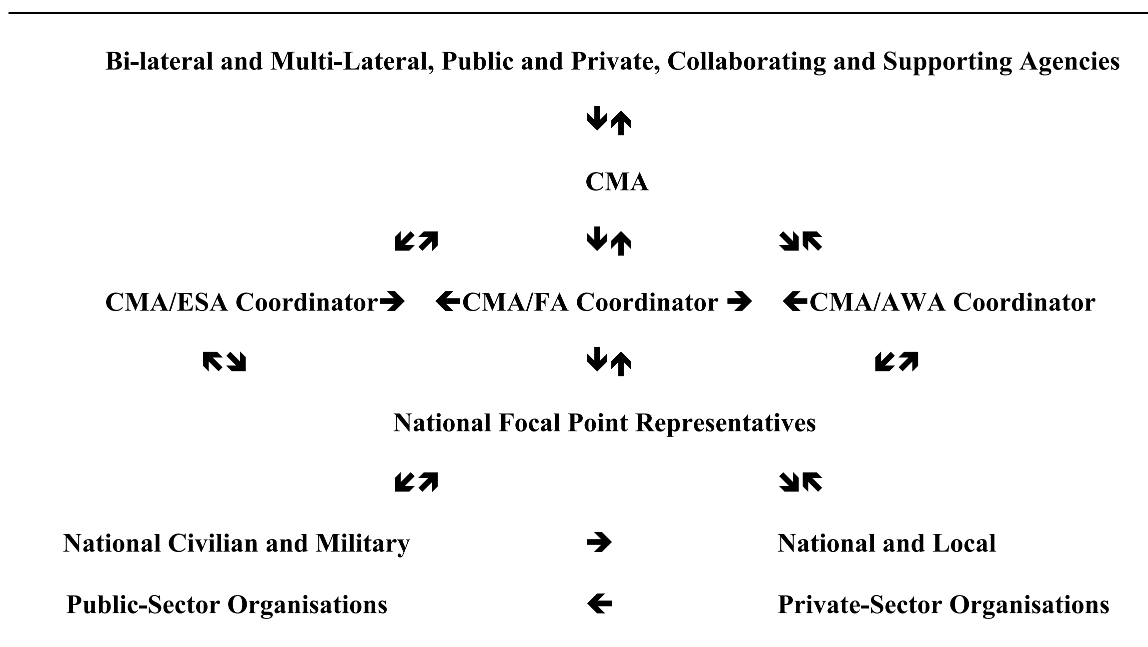
% **Francophone Africa (CMA/FA)**, 20 countries including Algeria, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Guinea, Mali, Mauritania, Morocco, Niger, Rwanda, Senegal, Togo, and Tunisia, with coordinating headquarters located in Dakar, Senegal;

% **Eastern and Southern Africa (CMA/ESA)**, 15 countries including Angola, Botswana, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe, with coordinating headquarters located in Lusaka, Zambia.

With local and CMA-provided resources, the mission of each African network is to facilitate STD/HIV/AIDS early warning, prevention, and control through national and international cooperation among civilian and military government organizations and among public and private agencies (Figure 1).

Figure 1

CMA/Africa Lines of Communication and Collaboration



In Africa and in other world regions, the CMA functions as a technical consulting agency addressing HIV/AIDS prevention and training in the military, peacekeeping, police, and prisons sectors - and in all populations involved in complex humanitarian emergencies. Its ultimate goal is to promote inter-sectoral cooperation in combating HIV/AIDS and closely related diseases (e.g., other sexually transmitted infections and tuberculosis), through the promotion of effective prevention policies, strategies, and training programmes in both the uniformed services and their surrounding civilian populations.

In late 1998, the CMA conducted a situation review and strategic policy seminar in Dakar, Senegal, as part of its ongoing series of conferences in Africa and elsewhere. One purpose of the Dakar meetings was to determine the immediate HIV-prevention needs of an area simultaneously engulfed in two complex humanitarian emergencies (in Liberia and Sierra Leone) and a costly sub-regional response (the ECOMOG peacekeeping mission of the Economic Community of West African States - ECOWAS). As a result of conclusions and agreements reached at Dakar, the CMA introduced a new orientation to its work in Africa, termed Crisis Prevention and Response (CPR). The CPR approach identifies HIV/AIDS as a priority issue in crisis, conflict, and post-conflict situations, and emphasizes the essential role that the

uniformed services can play in response to these emerging crises. As already noted, HIV spreads most quickly under conditions of poverty, social instability, familial disruption, and human powerlessness - conditions that reach extreme proportions before and during such emergencies. Under these circumstances, civilian public-health systems are also likely to be severely compromised or to have broken down altogether while military systems may remain relatively intact.

Concern with mitigating the risks of HIV transmission in humanitarian emergencies must extend to the transition from conflict to a restoration of social stability and progress toward socio-economic advancement. Traditional approaches to emergency relief typically ignore the need for such long-term commitments to reconstruction and development through HIV prevention and other contributions to poverty alleviation and improved public health. By remaining engaged in post-crisis situations, here too the military can offer a helping hand.

HIV prevention and control in emergency settings calls for a pro-active approach to crisis early warning and preventive planning and action, to immediate mitigation of impact when crisis occurs, and to concurrent preparation for conflict recovery, rehabilitation, and resumption or improvement of normal development activities. Two additional elements, both critical to success in these efforts, involve enhanced civil-military cooperation and coordination in crisis management and resolution, and sustained inter-country cooperation in emergency planning and response.

The CPR approach stresses the need for better surveillance of STD/HIV/AIDS incidence and prevalence and of deteriorating political conditions, for earlier crisis warning, and for more timely, appropriate, and coordinated educational and other interventions which target, among other public-health initiatives, HIV prevention. All of these relief responses need to be coupled with the smoothest and most continuous transition possible toward socio-economic development with the additional allocation of political, technical, and economic resources. The ultimate goal is to lessen the likelihood of future crises through the mitigation of existing humanitarian emergencies and the enhancement of national and regional capacities to recover from them.

From the standpoint of stabilisation and normalisation through reductions in HIV transmission, a crucial period in the transition from conflict to peace and recovery occurs during the demobilisation of

combatants and their reintegration into civil society. Here again, timely actions directed toward HIV prevention will produce immediate benefits, while the costs of inaction are ultimately unsupportable.

The All Africa Congress of Armed Forces and Police Medical Services

This organization was established in 1989 to provide a mechanism for African military and police health services to exchange ideas and share information, to plan and conduct short courses, and generally to facilitate professional interaction on a continent-wide basis. The police are incorporated into the AACAFPMS because of the close association, especially in Francophone Africa, of the police and military establishments. National membership is open to all African states that are also members of the UN, the Organization of African Unity (OAU), or both.

The first Congress took place in Lagos, Nigeria, where a basic structure was adopted. It features a governing committee consisting of a chair (the head of delegation for the country hosting the next Congress), several vice-chairs, a secretary-general, heads of national delegations, and chairs of the AACAFPMS Scientific Board and Technical Committees. A modest AACAFPMS secretariat was created in Lagos. At the first Congress it was decided that future meetings should be convened biannually, in alternative years to the biannual congresses of the International Committee on Military Medicine. Accordingly, in 1991 the Egyptian government hosted a second All Africa Congress in Cairo. Logistical and financial difficulties prevented further meetings until October 1999, when the South African Military Health Service sponsored a third Congress in Pretoria. Significantly, the 3rd AACAFPMS devoted its entire agenda to a single theme, "Dealing with HIV/AIDS in the Armed Forces." Delegates also agreed to a fourth Congress, to be held in Luanda, Angola, in 2001.

Major challenges to the AACAFPMS include a weak international infrastructure, the high costs of hosting and attending biannual meetings, and the perennial Anglophone/Francophone language dichotomy in regular communications. Nevertheless, with an infusion of financial and organizational support, the AACAFPMS could become a uniquely important vehicle for regional collaboration among African military medical services and a strong partner in promoting HIV/AIDS prevention and control throughout the continent. As discussed at the most recent Congress, the benefits of this sharing of information and best practices could also extend from the armed services to civil society, through the encouragement and

preparation of active-duty, demobilising, and retired military personnel to serve as STD/HIV prevention advocates and peer-educators within their home communities.

The International Committee of Military Medicine

Founded in 1921, the ICMM is the world's oldest and most extensively supported international military health association. Its premier position was confirmed in 1952, when the 5th World Health Assembly approved the ICMM's status as an Intergovernmental Organization in Official Relation with the World Health Organization. Today, the ICMM has 93 member states in all world regions including eight founder states in Europe and the Western Hemisphere.

National membership in the ICMM is widely distributed on a regional basis. In terms of countries per region, however, ICMM membership is not fully reflective of the post-colonial world. While 86 percent of Western European countries are represented in the ICMM, for example, only 38 percent of countries in Sub-Saharan Africa are current members.

The ICMM can serve as a vital international forum and coordinating body in the struggle against HIV/AIDS as in other important fields of military medicine. A requisite of this leadership is an evolution of membership and priorities in the ICMM that recognizes HIV prevention as an essential part of military preparedness and the military obligation to protect civil society.

CONCLUSIONS

In an era of emergent and newly re-emergent infectious diseases, HIV infection is distinguished by its truly pandemic scope, by its ability to evade vaccines and curative drugs, and by the fatal consequences for virtually all of its victims. Because of these factors, the World Bank has recently declared HIV/AIDS prevention and management to be its top priority. HIV poses an added threat to the armed forces because it is most prevalent among age cohorts that contribute the largest share of military personnel, and also because it is efficiently spread through types of behaviour that are often typical of military personnel. For these reasons, the Joint United Nations Programme on HIV/AIDS and the UN Department of Peacekeeping Operations have extended their own priority attention to HIV prevention and control in the military and other uniformed services.

At present, the only effective weapons against HIV lie in its prevention through changes in behavioural patterns that may vary considerably from culture to culture and are often grounded in deeply

embedded attitudes, values, and beliefs. The enormity and complexity of the task at hand, compounded by the adaptability of the virus, mean that inter-sectoral and international cooperation is a *sine qua non* to any success in combating the HIV/AIDS pandemic. To enable and facilitate such cooperation, local, national, and international networks of communication are needed that bring together the skills, knowledge, and resources of a wide range of individuals and groups.

Sectoral and inter-sectoral networks of governmental and non-governmental agencies are required to advance five major goals:

% to promote sustainable STD/HIV/AIDS prevention education;

% to control the incidence of treatable STDs;

% to ensure the maximum use of condoms in sexual relations;

% to promote medically, morally, and economically enlightened policies of HIV testing and counselling;

% to advance humane and human resource-conserving programmes of support and care for those who are HIV-infected and AIDS-symptomatic.

In all such endeavours, special attention must be paid to regions where HIV/AIDS has become or is now becoming endemic at high levels of morbidity and mortality. The CMA, the ICMM, and regional organizations like the AACAFPMS stand out as institutions with ready-made networks of support to address the tasks at hand, to the benefit of military populations and the vast numbers of civilians who share in their vulnerability.

References

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