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Military HIV/AIDS Policy in Eastern and Southern Africa

A Seven-Country Comparison

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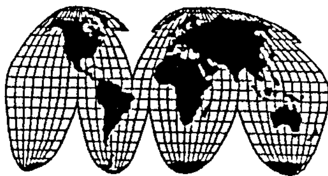

Civil-Military Alliance to
Combat HIV and AIDS

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Introduction

This article compares military HIV/ AIDS prevention and care programmes in seven countries of eastern and southern Africa — Botswana, Kenya, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe.* These countries he in the most affected region of a continent which itself is the most affected by the HIV virus; and, as everywhere else in the world, military personnel are among the region's most susceptible populations to HIV. They are generally young and sexually active, are often away from home and governed more by peer pressure than accustomed social taboo, are imbued with feelings of invincibility and an inclination toward risk-taking, and are always surrounded by ready opportunities for casual sex. Deployment to unsettled areas only increases their chances of acquiring HIV, as they are exposed to socially disrupted local settings where sexually transmitted diseases (STDs) may abound, and also to the possibility of infection through wounding and contaminated blood. A general lack of adequate HIV testing and monitoring equipment, especially under field conditions, further complicates the problem of avoiding exposure to the disease.

HIV transmission is five to 20 times more likely to occur in the presence of other STDs, and empirical studies have concluded that, during peacetime, STD infection rates among military populations are between two and five times the infection rates of the civil societies in which they reside (Kingma, 1995a, pp. 34). Indeed, evidence suggests that soldiers commonly consider the acquisition of an STD to be a peer symbol of sexual prowess and proof of manhood. During wartime deployments, military risk increases to as much as 100 times that for civilians at home (Kingma, 1995a, p. 3). As a result of such factors, the HIV/AIDS pandemic has now reached sufficient proportions to constitute a direct threat not only to socio-economic integration and political stability, but also to national and international security and peace in many parts of the world and perhaps especially in Africa. In this light, the development and implementation of effective military HIV-prevention and AIDS-care programmes assume vital and immediate importance.

Comparative analysis of data gathered from military organizations in eastern and southern Africa suggests that .much has been accomplished in dealing with the dangers posed by HIV and AIDS, but that further action is also required, with donor assistance, at the national and regional levels of research and policy development, implementation, and evaluation. This agenda is made all the more urgent by the fact that, despite all that has been achieved to date in HIV prevention, the AIDS pandemic continues to increase in these and other African countries' militaries and in their civilian populations as well.

The Current **Status of HIV/AIDS in Africa**

Although HIV is spreading most rapidly in Asia, its prevalence is still highest in Africa south of the Sahara. The World Health Organization (WHO) has estimated that between the late 1970s and late 1994, 18 **million HIV** infections had occurred worldwide, and 11 million (61 percent) of these were in Sub-Saharan Africa. During this same period, an estimated 4.5 million full-blown AIDS cases had appeared, and more then 70 percent of these were also in Africa (Kingma, 1995b, pp. 3-6). It generally appears that individuals practicing high-risk sexual behaviours in low-incidence areas quickly become infected. This results in an initial explosion of new HIV cases, which stabilizes into an established, endemic condition in about five years. At this point, as in Africa, the most vulnerable age group shifts from people in their mid-teens to mid-forties to youth who are just entering their sexually active years. For biological, demographic, and socio-cultural reasons, women are also more vulnerable to infection than men, and in Africa there are now between 11 and 12 infected women for every 10 infected men. Many if not most of these new transmissions take place in African urban settings where men still outnumber women by three to two, creating a highly favourable environment for casual and commercial sex. If African women's vulnerability to the HIV virus is not reduced, approximately 55 million of them will have been infected between 1990 and 2000. In this decade, moreover, more than nine million African children will have been orphaned by **AIDS** (Kingma, 1995b, pp. 6-8).

HIV/AIDS and Military Populations in Eastern and Southern Africa

Throughout Sub-Saharan Africa, militaries are now reporting averages of from 20 to 40 percent HIV-seropositivity within their ranks, with rates of 50 to 60 percent in a few countries where the virus has been present for more than 10 years (Kingma, 1995a, p. 5). In eastern and southern Africa, HIV is rapidly spreading from its original epicenter along the western shores of Lake Victoria. U.S. Census Bureau estimates provide evidence of this southward progression. According to these reckonings, HIV seroprevalence among urban dwellers practicing high-risk behaviours is more than 40 percent in Kenya, Uganda, Tanzania, Malawi, and Zambia, and between 25 and 40 percent in Zimbabwe and Botswana. Although comprehensive figures are as yet unavailable, among the most heavily **affected** seg-

ments of these societies are their military and police forces. AIDS is now the leading cause of death in these organizations, in some countries accounting for more than half of in-service and post-service mortality. In Uganda, for example, it was recently found that 7.5 percent of soldiers who had died within one year of discharge were suffering from AIDS. Such attrition causes loss of continuity at command level and within the ranks, increased recruitment and training costs for replacements, and a general reduction in preparedness, internal stability, and external security. In this sense, HIV/AIDS can easily serve as a domestic and regional destabilizer and a potential war-starter.

A major problem heretofore has been that some of these militaries have been slow to initiate HIV/AIDS prevention and care programmes of their own, and have remained essentially disassociated from civilian programmes. More recently, senior commanders and medical officers alike have recognized an urgent need to provide information on how servicemen and women can avoid HIV infection, to promote condom use within the ranks, to ensure that effective blood-safety procedures are followed, and to pay greater attention to the prevention and treatment of other STDs whose presence enhances the risk of HIV acquisition. Eastern and southern African military leaders also now argue correctly that the battle against HIV/AIDS cannot be waged successfully in isolation, but requires close cooperation with civilian agencies in the public and private sectors, and also cross-national collaboration among military organizations themselves. This new awareness derives from an appreciation that HIV/AIDS represents not merely a short-term medical emergency, but also a threat to the very purposes which militaries are meant to help further — domestic peace and stability, national and regional security, and, less directly but equally importantly, long-term social and economic development.

From an overall public-policy perspective, HIV and AIDS present two basic problems. First, and for the indefinite future, the disease will probably not run its course and subside either of its own accord or because of medical breakthroughs. Second, without concerted human intervention and cooperation, the number of HIV infections and AIDS cases will continue to rise exponentially well into the next century.

The Peacekeeping Factor

HIV prevention has gained a new sense of urgency with the increasing deployment of African soldiers on United Nations and other peacekeeping missions.[2] By their very nature, these operations increase exposure to disease. This enhanced risk is compounded by the role now often assigned to peacekeeping contingents, which is not only to separate contending forces, but also to help effect demobilizations and create institutions that will maintain the peace. In other words, short-term peacekeeping assignments can be subtly transformed into lengthy peacemaking efforts, often in situations where HIV-seroprevalence is already high. The presence of large numbers of refugees and displaced persons further exacerbates risk of exposure to HIV and other STDs, and by late 1994 there were about 22 million of these uprooted people in Africa, most of whom located in eastern and southern Africa (United Nations High Commission on Refugees estimate).

In earlier times, military STD cases were usually cured before the troops returned home. With HIV, however, both military and civilian populations must deal with a chronic and incurable disease having a high efficiency rate of transmission from the field to home and vice versa. From the standpoint of countries contributing peacekeeping contingents, concern is expressed that troops returning from the field may bring with them HIV infections which they will then transfer to their families. Host country leaders express equal worry that foreign peacekeepers may transmit HIV to their own people. Apprehensions such as these have lately prompted military organizations to seek assistance from their governments, and also from public and private international agencies, in the development of workable and affordable HIV/AIDS prevention and care programmes for their personnel and dependents.

Prominent among these international sources of cooperation and support have been the World Health Organization's Global Programme on AIDS (soon to be reorganized as UNAIDS), the Economic Development Institute of the World Bank, the UN Department of Peace-Keeping Operations (DPKO), and the non-governmental Civil-Military Alliance to Combat HIV and AIDS.[3] In May and June 1995, these institutions jointly sponsored an Africa Regional Policy Seminar in Harare, Zimbabwe to discuss prevention and care in the armed services of Botswana, Kenya, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe. Each of these militaries is highly active domestically, regionally, and globally through international training and peacekeeping activities,. The integrity and future viability of each is also singularly threatened by HIV and AIDS, and the following discussion is based on what the Regional Seminar revealed about how the seven militaries are coming to grips with this grim reality (For the proceedings of this seminar, see Yeager, 1995. See also the summaries of HIV/AIDS policies in Appendices 1 and 2).

Military HIV/AIDS Prevention and Care Programmes: A Seven-Country Comparison

Areas of General Agreement on Policy and on Issues Requiring Policy Decisions. Military medical officers in the seven study countries generally agree that workable approaches to HIV prevention and AIDS care must embody eight main components: information, education, and communication (IEC) aimed at HIV prevention; condom procurement, dissemination, and promotion; IEC to advance STD care-seeking behaviour; prevention of HIV transmission through blood transfusions; prevention of perinatal transmission; care and support for those afflicted with AIDS, both before and

after discharge from service, to mitigate the personal, familial, and wider social ramifications of the disease; close integration of military prevention and care initiatives within civilian national AIDS programmes; and testing for the HIV virus combined with pre- and post-test counselling. The only controversial aspect of these policy elements concerns whether HIV testing should be voluntary or mandatory for recruits and in-service personnel, with those opposed to mandatory testing arguing that compulsory tests are inconclusive, expensive, and in direct violation of the human right to privacy and to be free from adverse discrimination. For their part, advocates of universal HIV testing maintain that the statistical data thus obtained are very important in maintaining military readiness, in extending the length and quality of life of military personnel and those with whom they come in contact, and in producing evaluations of the disease that help to suggest sound programmes of preventive intervention.

As will be shown, only one military in this survey requires HIV testing of all recruits, although all prescribe such examinations for people assigned to certain duties. Several militaries in the group are beginning to consider the need for universal testing, however, as the number of new HIV infections and AIDS cases continues to rise. In any case, it is generally agreed that testing can serve several useful purposes; for sentinel surveillance, to improve safety in blood transfusions and organ transfers, for diagnosis of HIV and other STD infections, and to facilitate pre- and post-test counselling. Nevertheless, crucial policy choices must be made about the scope of testing and counselling, and about whether to maintain strict confidentiality of test results or to share them with the commanding officers and families of those tested. Other questions arise requiring decisions. Should special AIDS clinics be established for soldiers and their families? At what point should HIV/ AIDS patients be discharged and sent home, and with what consequences for spread of the disease? Should HIV-positive troops be deployed abroad? Should they be selected for advanced training courses and promotion in rank? There are likewise the issues of funeral expenses of the deceased and medical-legal care of dependents, including the number of months of further salary payments to survivors and whether or not to award them death gratuities.

Some of these concerns must be resolved in the context of external influences. Militaries selecting officers for foreign training must comply with the HIV-screening requirements of those countries offering this training, which bear implications for the pool size of applicants and thus for the number of personnel with sufficient training to compensate for officers who have already died from AIDS-related diseases. Equally significant to the militaries in the present study group, the DPKO applies the following guidelines to national contingents operating under its aegis.

- Training in HIV prevention is requested of all militaries supplying troops.
- Voluntary or mandatory testing prior to deployment is highly recommended.
- Troops infected with HIV and/or other STDs should not be deployed.
- Troops with AIDS must not be deployed.4

These constraints also carry implications for defence funding, in that African militaries typically use the proceeds from peacekeeping operations to help fund their budgets.

Several internal imperatives also figure into the policy-making equation, including the need to translate policies on prevention, counselling, and care which exist on paper into practical programmes of action; the need for the military share of HIV/AIDS donor funding to be increased, given that the military does not exist in isolation from society and yet receives very little funding of this sort; the need to address the problem that military health educators tend to be of relatively low rank; the need to correct the inequities and health risks associated with some militaries' restrictive policies on marriage; and the need to improve the educational level of those on duty in order to maximize the impact of HIV information transfer.

Similarities and Differences in Specific Programmes: General Policy. National HIV/ AIDS policies are in effect in all but two study countries, and in Malawi and Tanzania they are currently under development. Not surprisingly, military HIV/ AIDS programmes have been or will be brought into compliance with these national directives, and especially in the controversial area of HIV testing. To a greater or lesser extent, military programmes are also conducted in cooperation with civilian government agencies and private non-governmental organizations (NGOs). In Kenya, for example, military activities are part of a multisectoral civil-military effort overseen by a National AIDS Council, which operates under the authority of the country's current national development plan and its Sessional Paper on AIDS. In cooperation with local and international NGOs, preventive work is performed with prostitutes, on funding and training, and in the provision of social amenities in the barracks. In Uganda, the Ministry of Defence works in conjunction with the National AIDS Control Programme, the Uganda AIDS Commission, the Ministries of Health and Education, and the Uganda Joint Clinical Research Centre in the provision of condoms, in combating discrimination against AIDS patients, and on care for AIDS orphans. And in Zambia, the military is assisted by the U.S. Morehouse School of Medicine in the development of STD control programmes and in the operation of two STD clinics.

Within the broad parameters of national policy, only minor differences appear among the seven militaries in how they deal with HIV prevention and with HIV-infected personnel and their families. Under the provisions of specific civilian and military policies (Botswana, 1993; and Botswana, 1994), HIV-positive members of the Botswana Defence Force are treated in the

same manner as uninfected personnel. They are fully deployable until a medical officer advises otherwise, and may not be discharged from service until they fall below minimum performance standards. Soldiers who no longer meet these criteria are discharged for medical reasons, with full medical benefits for themselves and their beneficiaries. HIV-positive soldiers who choose not to remain on active duty may apply for discharge on compassionate grounds, and also with full medical benefits. Including ordinary recruits and officer cadets, domestic military trainees who are HIV-positive complete their training and are then assigned to duty until there is evidence of clinical deterioration falling below retention standards, at which time they are discharged on medical grounds. Whether or not they are HIV-positive, all members of the BDF and their families are educated and counselled on preventive measures and on the risks of transmission.

Other countries maintain similar policies regarding retention, discharge, benefits, education, and counselling. The Malawi Army offers regular health education classes at unit level and in military school, with special emphasis on HIV/STD transmission and preventive condom use. For the most part, HIV is treated as any other chronic disease, with home-based medical care prescribed for discharged AIDS patients which is closely linked to the civilian health system. In the Tanzania People's Defence Forces (TPDF), HIV-positive troops are counselled and AIDS-symptomatic personnel are provided with one-year sick leaves to allow them to prepare for retirement. HIV-infected senior officers may retire at any time with full allowances and benefits. If they wish, military AIDS patients may also be transferred to units nearest their homes in preparation for medical discharge with benefits. On their death, all burial expenses are covered by the TPDF and widows are entitled to six months' salary and to a death gratuity and pension. Tanzania does not yet have a policy on military AIDS orphans, and the TPDF follows the civilian practice of encouraging that they be raised by relatives rather than in orphanages. The Ugandan National Resistance Army (NRA) operates nine health education centres that offer training, counselling, and other services. Broad-based patient care is emphasized at these centres, including assistance to asymptomatic HIV cases as well as to AIDS patients. Special provision is also made for the care of AIDS widows and orphans, but policies covering funeral rites and expenses await further policy development. Additional policies are under consideration to protect the legal rights and property ownership of AIDS survivors. At present, Ugandan military AIDS patients are ultimately discharged with free medical services. Following death, spouses receive the deceased's pay for six months and orphans are entitled to free primary and secondary education.

In Zambia, all military cantonments now have trained HIV/AIDS counsellors, and all military service chiefs (in addition to the national service commander, police chief, and head of prisons) have been sensitized to the disease. Similar education has also been extended to commanders at lower levels in the chain of command. HIV-positive enlisted personnel are monitored, counselled, and treated for up to seven years. Officers join the military on a pension basis, and HIV-positive officers with more than 14 years of service can request early retirement and receive the full package of retirement benefits normally offered only after 20 years of service. Most enlisted men and women remain in service until medically discharged, because after discharge they and their families retain hospital services but lose active-duty housing and other benefits. In Zimbabwe, HIV-positive but otherwise fit servicemen and women continue in service and are provided with HIV/AIDS education and counselling. Except for certain classes of officers who may be discharged under the Zimbabwe Defence Act, HIV-infected personnel remain in service indefinitely or may opt for voluntary retirement and receive a more generous pension than is usually offered. Dependents of deceased servicemen are provided for until the children mature or the mothers remarry.

One major policy difference separating the Kenyan armed forces from the others concerns the marital status of women in uniform. Women are included in the militaries of all seven countries and are subject to the same terms of service as apply to men, although Malawi and Kenya employ restrictive policies on in-service marriages. The Malawi Army prohibits all marriages during basic training. In Kenya, however, women enlistees (but not men) must remain unmarried for their three-year tours of duty and during any further periods of enlistment. This policy obviously discriminates against women soldiers and may enhance their risk of acquiring HIV, but in spite of its incongruity with the equal status afforded military women in the other countries, Kenya has defended its stand as necessary to the maintenance of discipline and efficient military operations. Kenya's isolation on this issue is further widened by the thought now being given by several militaries, and most explicitly by those in Uganda and Zimbabwe, toward the further empowerment of women in the fight against HIV/AIDS by overcoming sexual harassment in the ranks, by providing better living conditions for married couples, and, in cooperation with NGOs, by helping to secure better health care and alternative sources of income for camp-following prostitutes.

Controversy and Potential Change in Specific Programmes: HIV Testing. For armed services throughout the world, no other STD-related issue has emerged as controversial as the issue of testing for HIV infection. On medical and economic cost-benefit grounds, and also for human rights reasons, the World Health Organization is officially opposed to routine mandatory testing without consent (World Health Organization, 1992), and only a few militaries have adopted mass testing policies. The United States armed forces lead this group by requiring compulsory HIV screenings of all recruits, biannual phased serological testing of active-duty and reserve units, screening of blood donors,

and periodic testing of groups exposed to high risk including STD patients and some recipients of blood and blood products (Kelley, n.d.). On the other hand, the mounting costs, organizational dislocations, and threats to mission fulfillment created by the HIV virus are prompting military leaders in many countries to rethink the merits of universal testing in a variety of possible configurations. This process is well underway in eastern and southern Africa.

Among the militaries under consideration, only the Malawi Army screens all recruits and candidates for officer training, accompanied by pre- and post-test counselling and guaranteed confidentiality of test results. Screening is also mandatory for troops selected for deployment abroad and for training in countries requiring HIV tests. Pilots are tested annually and those who become AIDS-symptomatic are grounded. Universal military HIV testing and the screening of applicants for promotion to the rank of brigadier general and above are presently under debate in the Malawi Government.

The Botswana Defence Force lies at the other end of the policy spectrum. Except under explicitly stipulated conditions, HIV testing is entirely voluntary for recruits, for personnel suspected of being HIV-positive, for STD patients, for rape victims, and for all military medical beneficiaries and non-beneficiaries with whom on-duty personnel may have had sexual contact or from whom they have received blood. BDF members selected for training in countries requiring testing are given the option of being screened or declining the training opportunity with no adverse consequence for advancement in a career stream different from that for which foreign training is required. For those who agree to be examined, their test results are held in strictest confidence and are only released to relatives and/or partners with their consent. Pilots and troops slated for peacekeeping missions provide partial exceptions to this voluntaristic approach. If a fighter pilot becomes HIV-symptomatic, he is tested and if found to be HIV-positive, his pilot's commission is cancelled. HIV-positive transport pilots may continue to fly until they fall below an established medical standard of fitness, after which they are retired with full benefits. HIV-positive soldiers and aircrews are not eligible for deployment outside Botswana.

Even the BDF's commitment to voluntary screening is not without ambiguity. In 1990, senior commanders drafted a policy paper on HIV, according to which certain types of personnel were to be tested twice each year. When the paper was submitted to the Botswana National Assembly, an uproar ensued concerning the purposes and timing of such testing. The issue was rendered moot when, by a presidential directive of November 1993, the government adopted the Botswana National Policy on HIV/AIDS which specifies that "HIV testing will not be carried out against the will of individuals" (Botswana, 1993, p. 12). Other countries are not as restrictive. The Kenya military maintains a policy of voluntary testing on recruitment and subsequently, except that mandatory tests are annually administered to pilots and to other officers whose positions require high employment standards. Personnel identified for overseas training courses and troops about to embark on peacekeeping missions are also routinely tested.5 Unit commanders as well as test subjects are informed of test results, and anyone found to be HIV-symptomatic must appear before a medical board and may be assigned to a non-fighting role prior to discharge. Kenyan military medical leaders are currently discussing the desirability of universal pre-service screening and the dissemination of in-service test results to partners and/or spouses as well as to commanders.

Tanzania's policy, and possible extension of policy, on testing differs little from Kenya's HIV examinations are voluntary, but commanders can prescribe tests for troops going abroad for pilot training and for others whose study courses will keep them away from home for more than three months. Troops assigned to peacekeeping duties are likewise screened before departure. Asymptomatic HIV patients may not leave the country and continue to be observed, subject to grounding in the case of pilots, and also to sick leaves, assignment to bases near their homes, and eventual discharge. To protect unit safety and readiness, officers are informed of HIV-positive cases under their command. As in Kenya, Tanzanian military medical staff are presently considering the mandatory screening of recruits and, additionally, yearly follow-up testing.

HIV testing is also mostly voluntary in Uganda, with mandatory screening reserved for NRA members selected for overseas and/or pilot training and for foreign deployment. The Uganda military is considering the possibility of screening all recruits, however, but with more permissive consequences than those under discussion in Kenya and Tanzania. Under this option, those disqualified as HIV-positive would still be offered full long-term counselling and enjoy full power of consent over the release of their test results. Personnel testing HIV-negative would continue to be administered regular fitness examinations, but, except for those already subject to compulsory in-service HIV testing, further screenings for the virus would be limited to those displaying symptoms of infection.

Zambian military medical officers are also discussing the advantages of universal HIV testing, but their Zimbabwean counterparts appear not yet to have reached this point. In both countries screening of recruits is voluntary, and one cannot be rejected for service on the basis of his or her HIV status. Officers applying for overseas training may have to submit to tests, but only if host countries require them. Zambian policy only recommends that troops deploying abroad and applying for pilot training be tested, although Zimbabwe now requires such screenings and both countries specify regular HIV tests for assigned aircrews. Grounding, reassignment, and discharge requirements apply to HIV-positive pilots in both countries, and also to HIV-positive medical officers in

Zimbabwe so that authority can be granted to recruit replacements. Confidentiality of HIV-test results is also respected in both countries, with commanders informed only of their units' ready strengths. A major reassessment of these policies is currently underway in Zambia but not yet in Zimbabwe. At present, 25 percent of Zambian army and air force recruits is estimated to be HIV-positive, and because up to 50 percent may be infected by the mid-point of their seven-year tours of duty, it is thought that a more realistic and cost-effective approach to recruitment should involve compulsory HIV screenings for all persons seeking entry into military service and for those seeking reenlistment. In future, universal screening and HIV counselling may also become the rule for officers chosen for foreign training lasting more than three months, for all pilot trainees, and for officers and enlisted men leaving for and returning from international deployments including peacekeeping missions.

The Stakes of Military HIV/AIDS Policy in Eastern and Southern Africa

On economic, security, and human-rights grounds, the relationship between HIV testing and recruitment, training abroad, deployability, and promotion in rank must be carefully examined and evaluated. Overseas training, in particular, represents a sizeable investment in officer trainees, and governments have a right to expect that such investment will be returned by extended service after training is complete. This issue is made more critical by the high attrition rates presently occurring among senior officers in African militaries, which also raises the question of whether officers should be screened for HIV before they are promoted to senior ranks. On the other hand, negative social consequences can also accompany universal testing and screening. Most countries in the study group seem to be moving toward the general HIV screening of recruits and, in some instances, toward periodic testing of officers and enlisted personnel. Stigmatization of those who may be rejected before or after enlistment may result in serious decreases in the pool of potential candidates — already depleted by AIDS — who are inclined to seek military careers. More conclusive evidence is needed about human environmental factors which may slow or hasten the development of symptoms resulting from HIV infections. If debilitating symptoms are slow to emerge or can be postponed in certain controllable situations, there may be no valid justification for depriving the HIV-positive of active service and of career-enhancing training, deployment experience, and promotion in rank. In this regard, STDs increase risk of acquiring HIV, and HIV increases morbidity in STDs. STD control through education and counselling should therefore be viewed as a vital means of protecting against HIV, and close management of HIV patients should be enforced in an effort to delay the onset of AIDS. Highly regulated military environments seem especially conducive to these kinds of regimens.

Three other policy imperatives emerge from the experiences of militaries in eastern and southern Africa; the need to develop and utilize more effective information, education, and communication materials and techniques; the need for more effective HIV prevention through better programme monitoring and evaluation; and the need for more external support, in that none of the seven countries provides STD and HIV funding specifically for its military. This latter problem stems from a widely held misconception, shared by foreign donor agencies, that African defence ministries are already over-funded. It is also evident that successful prevention and care programmes must embody several simultaneously occurring and sequential policy responses. Spread of the virus must be checked by strong preventive measures while not abandoning human rights. HIV infections and AIDS-related illnesses must be accompanied by socio-psychological counselling, together with employment and income guarantees, care and ameliorative treatment, and legal protection including confidentiality and adequate provision for widows and orphans. On a broader scale, the immediate and extended impact of HIV/ AIDS can only be softened through social-sector strengthening at both the community and national levels, and particularly through economic improvements that accelerate economic growth and increase governmental capacity for revenue generation (Cf., United Nations Development Programme, 1991). Today, approximately 74 percent of all public health expenditures in Africa are devoted to the campaign against HIV and AIDS. If HIV and other diseases are not to overwhelm civil and military populations alike, the sources of these outlays simply must be expanded.

The consequences of failure are ominous — social, economic, and political destabilization, permanent depletion of scarce financial resources from national recurrent and development budgets, civil-military strife, and loss of domestic and international security. For these outcomes to be averted, prevention and care programmes must accomplish several purposes.

- Greater training cooperation and epidemiological data sharing must take place between the civil and military sectors.
- Greater international cooperation in HIV prevention and AIDS mitigation must be encouraged through increased South-South, South-North, and North-South information and resource sharing.
- The limited perception of HIV/AIDS as an immediate medical crisis and domestic political issue must be replaced by one that treats the disease as a serious but approachable long-term obstacle to national and international integration and peace.
- Workable responses to HIV/AIDS can only emerge from intersectoral cooperation that moves beyond traditional ministerial distinctions in government, and also beyond time-honoured distinctions between the roles of military and civilian institutions in promoting the common welfare.

In eastern and southern Africa as elsewhere, inter-

sectoral and international collaboration are essential because HIV and AIDS continue to spread and respect no human categories and boundaries. For military and civilian populations together, the HIV/ AIDS pandemic has now become a global threat to security of the same magnitude as those posed by nuclear proliferation, ethno-religious hatred, and endemic poverty.

NOTES

1. Admittedly, these countries represent a biased sampling in that their civilian and military HIV/AIDS policies are among the most advanced in Africa south of the Sahara. On the other hand, the policy initiatives of these states could serve as models for other countries.

2. At its 31st summit held in June 1995, the Organization of African Unity (OAU) has taken the latest step in this direction by authorizing African armies to establish specially trained and equipped peacekeeping units within their ranks. Mark Thomas, "OAU Approves Peace-Keeping Units," *Africa* Recovery (United Nations), 9 (August 1995): 1.

3. Formed in 1993, the Civil-Military Alliance is an international interest group organized on behalf of HIV prevention and AIDS care, with individual members drawn from the civil and military sectors of more than 30 countries throughout the world. See Rodger Yeager and Norman Miller (eds.), ***HIV/AIDS in Military Populations Around the Globe.*** Proceedings of a Seminar Jointly Sponsored by the United Nations Development Programme and the Walter Reed Army Institute of Research, 6-7 June 1993, Berlin, Germany (Hanover, NH: ***AIDS and Society: International Research and Policy Bulletin,*** 1993); and Rodger Yeager, Eliot Perlman, and Sven Groennigs (eds.), ***Civil-Military Alliance to Combat HIV and AIDS.*** Planning Conference Jointly Sponsored by the Walter Reed Army Institute of Research, the U.S. Agency for International Development, and the Henry M. Jackson Foundation for the Advancement of Military Medicine, Rockville, Maryland, 20-21 November 1994 (Hanover, ***NH: AIDS and Society: International Research and Policy Bulletin,*** 1994).

4. With the help of the World Health Organization (WHO), the DPKO has also gone to great lengths to inform active-duty peacekeeping troops about the threat posed by HIV and AIDS. ***See Are You Being Deployed on a Peace-Keeping Mission? AIDS May be a Bigger Threat than Bullets,*** draft briefing document for United Nations Peace-Keeping Forces prepared by the Global Programme on AIDS of the World Health Organization (Geneva: WHO, January 1995).

5. These testing policies may not always be successful. For example, concern arose in Nairobi several years ago that certain HIV-positive military personnel designated for training in the United States had submitted false HIV test results to the U.S. embassy, after paying HIV-negative surrogates to take the test for them. In addition, several African contingents deployed to Somalia in the early 1990s were not tested before their departure. None of the non-African governments participating in the Somali peacekeeping mission questioned this lapse for fear that African governments would cancel their ***own*** participation.

REFERENCES

Botswana. 1993. Botswana ***National Policy on HIV/ AIDS.*** Approved and Adopted by Government through Presidential Directive CAB: 35/93, 17th November 1993. Gaberone: Ministry of Health.

Botswana. 1994. ***Botswana Defence Force Policy on Administration of Personnel Infected with Human Immunodeficiency Virus (HIV).*** Gaberone: Ministry of Defence.

Kelley, Patrick, W. et al. n.d. "The Importance of HIV Infection for the Military," in Gary P. Wormser, ed. ***AIDS - Acquired Immune Deficiency Syndrome - and Other Manifestations of HIV Infection.*** Park Ridge, NJ: Noyes Publications.

Kingma, Stuart J. 1995a. "HIV and the Military - Prevention Education is the Key to Protection." Address by Dr. Stuart J. Kingma, Medical Officer, Planning and Policy Coordination Unit, Global Programme on AIDS, World Health Organization, to the 1st International Conference of Military and Police Medicine, Yaounde, Cameroon, 23-24 February 1995. Geneva: WHO.

Kingma, Stuart J. 1995b. "Current Status of the HIV Epidemic." Address by Dr. Stuart J. Kingma, Medical Officer, Planning and Policy Coordination Unit, Global Programme on AIDS, World Health Organization, to the 1st International Conference of Military and Police Medicine, Yaounde, Cameroon, 23-24 February 1995. Geneva: WHO.

United Nations Development Programme. 1991. ***The HIV Epidemic as a Development Issue. New*** York: HIV and Development Programme, UNDP.

World Health Organization. 1992. ***Statement from the Consultation on Testing and Counseling for HIV Infection.*** Geneva, 16-18 November 1992. Geneva: Global Programme on AIDS, WHO.

Yeager, Rodger. ed. 1995. ***AIDS Prevention in Military Populations.*** Proceedings of an Africa Regional Training Seminar Jointly Sponsored by the Economic Development Institute/World Bank, the World Health Organization/Global Programme on AIDS, and the ***Civil-Military Alliance to Combat HIV and AIDS,*** in Consultation with the United Nations Department of Peace-Keeping Operations. Hanover, NH: Civil-Military Alliance.

Appendix 1

Military HIV/AIDS Policy in Eastern and Southern Africa: General

Country	Policy
Botswana	Source: Military policy in keeping with the Botswana National Policy on HIV/AIDS. Policy: 1. No involuntary discharge except on medical grounds if patient falls below performance standards. 2. HIV-positive troops fully deployable until a medical officer advises otherwise. 3. Voluntary testing available to all military health-care beneficiaries. 4. "Need to know" confidentiality on HIV test results, not extending to relatives without prior consent of HIV patient. 5. All military medical health-care beneficiaries counselled on preventive measures and risks of transmission. Counselling techniques documented by the BDF Medical Corps and become an integral part of BDF policy on HIV. 6. Policy subject to change in light of medical and scientific developments and new knowledge. Recommended Imurovements: 1. Establishment of an STD/AIDS unit in BDF headquarters, close to senior military policymakers, whose r responsibilities would encompass HIV/AIDS policy development, implementation, monitoring, and evaluation. 2. More efficient distribution of condoms and provision of counselling services in the BDF.
Kenya	'Source: National Development Plan and Kenya Government Sessional Paper on AIDS. Military policy coordinated with Kenya National AIDS Council. Policy:ti-sectoral civil-military approach to HIV prevention and AIDS care in such areas as work with prostitutes, funding and training, and provision of social amenities in the barracks. 2. Programmatic cooperation with NGOs. 3. Women serving in the military must remain unmarried during their three-year service commitments and for any further periods of enlistment. Recommended Imurovements: 1. Pre-service HIV screening for recruits and officer cadets. 2. No punitive measures for in-service personnel testing Hiv-positive. 3. Continued testing of those applying for foreign training and of units slated for foreigr deployment. 4. Unit commanders, sexual partners, and/or spouses informed of soldiers' HIV sero-status. 5. Provision of additional resources for institutional and barracks/home-based care. 6. Enhanced civil-military cooperation in condom distribution, health education, and HIV/AIDS counselling.
Malawi	Source: Malawi Army policy. Policy: 1. HIV screening of recruits and officer cadets, and annual testing of pilots. Pre- and post-test peer and professional counselling, with those tested having the option of learning about test results. 2. Regular health education classes at unit level and in military school, with special emphasis on HIV/STD transmission and condom use. 3. Testing required for study abroad and deployment, but not for in-country training if trainee is physically fit. 4. HIV treated as any other chronic disease, with home-based AIDS care linked to civilian health-care system. 5. No restrictions placed on marriage except during basic training. Recommended Imurovements: 1. Deployments away from home limited to a maximum of 6 months. 2. HIV screening of applicants for promotion to senior staff ranks.
Tanzania	Source: National HIV/AIDS policy still in draft form, but will incorporate the Tanzania People's Defence Forces as well as civilian institutions. Policy: 1. Current military policy provides that AIDS-symptomatic personnel are provided with one-year sick leaves to allow them to prepare for retirement. For those who wish it, military AIDS patients may also be transferred to units nearest their homes. 2. At death, all burial expenses covered and widows also entitled to 6 months of salary, in addition to death gratuities and pensions. 3. At present, there is no national policy on AIDS orphans, but common practice encourages that they be raised by relatives rather than in orphanages. 4. Implementation of AIDS policy is the responsibility of unit commanders, who are informed of HIV-positive cases under their command. These cases are submitted to counselling. Recommended Improvements: 1. Mandatory HIV screening of recruits, with those testing positive ineligible for service. 2. Yearly follow-up screening for all personnel. 3. Additional screening of trainees who will be out of the country for more than 3 months and of troops assigned to foreign peacekeeping duties and other foreign deployments. 4. AIDS orphans guaranteed free education to Form IV level. 5. Since military HIV/AIDS is a regional as well as national issue, and also because of large populations of migrating refugees and displaced persons in eastern and southern Africa, national disaster committees should be formed and meet often with each other to encourage cooperation among affected states and their militaries. Military AIDS should also be placed on the permanent agendas of regional development organizations such as the Southern African Development Community (SADC). 6. At the national level, a monitoring group should be formed at TPDF headquarters to review HIV/AIDS policy implemented at unit level, including condom distribution and the utilization of other resources made available from internal and external sources.

Country	Policy
Uganda	Source: National AIDS Control Programme adopted in 1987. In 1990, a Uganda AIDS Commission established to coordinate and control HIV/AIDS prevention and control activities of all ministries including the Ministry of Defence. Policy: 1. In conjunction with the National AIDS Control Programme, the Uganda AIDS Commission, the Ministries of Health and Education, and the Uganda Joint Clinical Research Centre, the Ministry of Defence has developed policies providing for condom distribution and use, combating discrimination against AIDS patients, and ensuring care for AIDS orphans. 2. Additional policies are under development to protect the legal rights and property ownership of AIDS survivors and to cope with human-resource depletion caused by the disease. 3. The National Resistance Army operates 9 health-education centres that offer military personnel counselling and testing services. Patient care is emphasized at these centres, including care for asymptomatic HIV cases as well as for AIDS patients. Special assistance programmes are also available for the care of AIDS widows and orphans. 4. Issues targeted for further policy development include funeral rites and expenses, non-clinical circumcism, and the health-care role of traditional healers, but public education must precede the adoption of public policies in these controversial areas. Recommended Imnrovements: 1. Screening of all recruits as part of their medical fitness tests, with those testing HIV-positive provided with full counselling and power of consent over release of test results. 2. Regular fitness examinations for active-duty personnel, but further HIV testing required only for those showing symptoms of disease. 3. Regular testing of pilots, with HIV-positive pilots grounded and provided benefits. 4. Mandatory screening of all personnel assigned to overseas training and peacekeeping missions. 5. Provision for HIV briefings to form a continuous educational process and not just a series of isolated events. 6. Provision that all STDs treated as other diseases, with no special clinics for them in order to avoid social stigmatization. 7. Whenever possible, deployed troops should be afforded periods off duty to join their families. 8. Women in the ranks should be empowered to combat HIV/AIDS, within established channels of communication and command. 9. Increased capacity for the quality testing and safe storage of condoms. 10. NGO assistance should be sought to help provide health care and alternative sources of income for prostitutes. 11. Peer education should be encouraged throughout the ranks, together with literacy campaigns for those in service and discouragement of the recruitment of illiterates. 12. More civil-military cooperation in the development and exchange of HIV-related educational and training materials.
Zambia	Source: Military policy in congruence with the National AIDS Programme, headquartered in the Ministry of Health. Policy: 1. All military cantonments now have trained HIV-AIDS counselors, and all military service chiefs and unit commanders have been sensitized to the disease. 2. In cooperation with the Ministry of Health, HIV-prevention seminars and moral support are offered to military personnel. 3. Two military clinics conduct STD-control programmes. Recommended Imnrovements: 1. Screening of all recruits and officer cadets. A second test should be required for all personnel seeking to become pilots and commandos, and also for troops reenlisting after their 7-year periods of service. (Air crews already subjected to annual tests, with medical officers having an option to be tested.) School-based education, followed by in-service seronegativity campaigns, should supplement testing to encourage personnel to remain HIV. negative. 2. Regarding troops available for deployment, unit commanders and their superiors should have special medical examinations including HIV tests. Annual medical examinations, not necessarily including HIV tests, should be required of other officers. HIV tests for enlisted ranks should be limited to re-enlistment, but freedom-from-infection examinations should be required for personnel assigned to peacekeeping missions and other foreign deployments. HIV screening should also be applied to officers selected for foreign training programmes of more than 3 months. 3. HIV/AIDS treated like any other service-terminating illness, with retirement benefits expedited and retirees receiving full medical attention for life, preferably in home-based care if logistically and financially feasible. 4. AIDS orphans and widows provided with employment advantages for at least 1 year after their fathers'/spouses' death. Widows' property rights also protected, as part of support programmes developed in cooperation with relevant government ministries and NGOs.
Zimbabwe	Source: Policy in keeping with the Zimbabwe National Policy on AIDS. Policy: 1. Mainly voluntary testing of recruits and in-service personnel, with commanders only having to know about their units' aggregate ready strength. 2. HIV-positive but otherwise fit cases continue in service and are provided with education and counselling. Some HIV-positive officers, for example pilots of high-performance aircraft, may have to be reassigned. 3. AIDS patients must appear before medical boards and be discharged if found no longer able to perform their duties. 4. Dependents of deceased male personnel provided for until their children mature or their wives remarry. Recommended Improvements: 1. Overcome sexual harassment in the ranks by empowering women through promotions and other measures. 2. Abandon socially stigmatizing freedom-from-infection campaigns, which apply negative sanctions to those infected with STDs. 3. Provide better living conditions for married military couples. 4. Limit all individual foreign deployments to 3 months.

Appendix 2

Military HIV/AIDS Policy in Eastern and Southern Africa: Testing

Country	Policy
Botswana	"Unless under specifically stipulated conditions, testing for HIV shall be voluntary but is encouraged." 1. Patients suspected to be HIV-positive will be tested, **subject to their consent.** 2. Patients with STDs will be tested, **subject to their consent,** if clinical indication of HIV infection is present. 3. All medical health-care beneficiaries having had sexual contact with infected persons are **encouraged** to test. Where interviews determine that HIV-infected beneficiaries have had sexual relations with non-beneficiaries, military health authorities will inform appropriate civilian authorities, **subject to the consent** of the infected beneficiaries. 4. Rape victims are **encouraged** to test and to make themselves available for periodic evaluation. 5. Beneficiaries who received blood transfusions before 1986 are **encouraged** to test. 6. Personnel selected for foreign training courses will, if host countries require HIV testing, be given the option to test or to decline training opportunity. If testing HIV-positive or declining training course interferes with a person's career progression, person may be transferred to a different career stream. 7. Concerning pilots, if a tighter pilot becomes HIV-symptomatic, he is tested and if found to be HIV-positive, his pilot's commssion is cancelled. If an HIV-positive transport pilot falls below a certain medical standard of fitness, he is retired with full benefits. 8. HIV-positive personnel are not eligible for UN peacekeeping missions.
Kenya	1. Testing is voluntary on recruitment and in-service, except that testing is employed yearly for pilots and other personnel whose positions require high employment standards. 2. Personnel going abroad for training or on peacekeeping missions are always tested, 3. HIV-symptomatic troops appear before a medical board and may be assigned to non-fighting roles. 4. Commanders as well as test subjects are informed of test results
Malawi	1. Testing is mandatory for recruits, together with pre- and post-test counselling and guaranteed confidentiality of results. Testing is also mandatory for troops being deployed to countries requiring testing. 2. Candidates applying for officer training must be tested before joining the army. 3. Pilots are subject to annual HIV tests and those who become AIDS-symptomatic are grounded. 4. Personnel with AIDS-related illnesses may not be deployed abroad. 5. Routine testing of all personnel is currently under debate in government.
Tanzania	1. Testing is voluntary, but commanders can require testing for troops going abroad for more than 3 months of training and/or are candidates for major training as in the case of pilots. 2. Pilots are tested yearly for HIV-related neuropsychiatric manifestations. 3. Troops embarking on peacekeeping missions are tested. 4. HIV-positive but asymptomatic individuals are observed, but symptomatic personnel may go on sick leave or be attached to units near their homes. Symptomatic pilots are grounded and may be assigned to other duties. 5. Senior officers can decide to retire with allowances and benefits. 6. To protect unit safety, commanders are informed of persons suffering from HIV/AIDS.
Uganda	1. Testing is voluntary and is supported by counselling so that HIV-positive personnel can make informed decisions at various stages of the disease. 2. Testing is mandatory for personnel selected for overseas training and for pilot training. 3. AIDS patients are discharged with free medical services. Following death, spouses receive the deceaseds' pay for six months, and orphans are entitled to free primary and secondary education.
Zambia	1. There is no HIV testing on recruitment, and if personnel are later found to be HIV-positive, the military looks after them for up to 7 years. 2. Officers join fhe military on a pension basis, and HIV-positive officers are cared for until they die. 3. HIV-positive officers with more than 14 years of service can request early retirement on medical grounds and receive the full retirement package normally offered only after 20 years of service. 4. Most enlisted personnel remain in service because, after discharge, they lose housing and other benefits although they continue receiving hospital services. 5. Zambian policy recommends testing for personnel being deployed abroad. For pilot training, some host countries require prior testing.
Zimbabwe	1. Testing is voluntary, and one cannot be rejected for service on the basis of his/her HIV status. 2. Infected personnel are treated until they die while remaining in the force, or they may opt for voluntary retirement and receive a better pension package than is normally offered. 3. Persons applying for pilot training must first be tested because of the high cost of this education. 4. Personnel slated for overseas training are tested to comply with requirements set by host countries. 5. HIV-positive pilots are counselled. If there are no apparent symptoms, a pilot may continue flying, but if the pilot becomes HIV-symptomatic, he is grounded and if AIDS-symptomatic discharged. Medical officers with AIDS are also discharged, otherwise there would be no authority to recruit replacements. 6. Personnel thus discharged are entitled to free medical care until they die, a provision that does not apply to dependents who are eligible for free medical care only while still living at post.