HIV/AIDS AND MILITARIES IN AFRICA

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Introduction

The Centre for Conflict Resolution (CCR), Cape Town, South Africa, and the University of Namibia (UNAM), held a policy advisory group meeting in February 2006 in Windhoek, Namibia, on the theme “HIV/AIDS and Militaries in Southern Africa”.

The following year, CCR, the Kofi Annan International Peacekeeping Training Centre (KAIPTC), Accra, Ghana, and the United Nations (UN) Joint Programme on HIV/AIDS (UNAIDS) held two policy advisory group meetings: the first took place in Cairo, Egypt, in September 2007, and explored the theme “HIV/AIDS and Militaries in North and West Africa”; the second was held in Addis Ababa, Ethiopia, in November 2007, and considered “HIV/AIDS and Militaries in Central and Eastern Africa”. A consolidated report on “HIV/AIDS and Militaries in Africa” was produced in 2008. Its main findings are presented in this updated policy brief.

Background

An estimated 22.5 million people in sub-Saharan Africa were living with the human immuno-virus (HIV) that leads to acquired immune deficiency syndrome (AIDS) in 2009. Women accounted for about 60 percent of these infections on a continent where the average prevalence rate is five percent. The features of the HIV/AIDS pandemic make it altogether unlike any previous epidemics. Working-age adults bear the greatest burden of HIV infections globally and are most likely to be infected with the virus between the ages of 15 and 49. Despite reductions in the national HIV rates of 22 countries in sub-Saharan Africa – Botswana, Burkina Faso, Central African Republic (CAR), Congo-Brazzaville, Côte d’Ivoire, Eritrea, Ethiopia, Cabon, Guinea, Guinea-Bissau, Malawi, Mali, Mozambique, Namibia, Rwanda, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Zambia, and Zimbabwe – the region bore 72 percent of global AIDS-related deaths in 2009.

The scale of the epidemic in Africa means that a large percentage of its military populations has contracted or will contract HIV. The litany of potential consequences to militaries resulting from HIV/AIDS illnesses and deaths has included: a heavy toll on the decision-making command structure; rising costs in retraining highly skilled personnel; and delayed deployment to international peace operations. As the African Union (AU) prepares to coordinate a 75,000-strong African Standby Force (ASF) for peacekeeping based on five sub-regional brigades, and as an AU force continues to struggle to keep peace in Somalia, this issue is particularly critical. In 2011, 70 per cent of the UN’s peacekeepers globally were deployed to five African countries: Western Sahara, Sudan, the Democratic Republic of the Congo [DRC], Côte d’Ivoire, and Liberia.

Additional concerns have included the vulnerability of peacekeepers to HIV within conflict zones, and the risk of these troops spreading the virus among civilian populations at home and abroad. Although many of these
assumptions have been difficult to prove or disprove through comparable, reliable data, governments at the national level, and the United Nations at the international level, have put in place policies for managing the epidemic’s impact on peacekeeping and military life. UN Security Council Resolution 1983 of June 2011 reinforced this approach.

HIV/AIDS and Africa’s Militaries

HIV infection rates among the continent’s militaries vary considerably, and are not uniformly higher than those among civilian populations. However, the constraints on preventing and treating an incurable disease such as HIV/AIDS present new challenges for Africa’s militaries. HIV/AIDS treatment, care, and support require a lifetime provision of anti-retroviral (ARV) therapy, nutrition, and psycho-social support. The burden of the disease also poses questions for the management of human and financial resources in all sectors of society.

Most African militaries are implementing comprehensive HIV/AIDS prevention, treatment, and care programmes. Although these programmes are under-resourced and limited in scale, they hold promise for mitigating the pandemic’s long-term impact on Africa’s security sector. A consensus is increasingly emerging on existing best practices for HIV/AIDS prevention, treatment, care, and support, and it is important to continue sharing policy lessons across Africa’s five sub-regions. Common HIV prevention and treatment practices include:

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

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

The past decade of the HIV/AIDS pandemic has (2001 – 2011) coincided with the emergence of new African security mechanisms. African armies are deployed to keep peace, manage humanitarian crises, and act as police forces in newly democratic and post-conflict states. African governments are also collectively engaged in establishing new security mechanisms through regional economic communities and the African Union.

Significantly, the AU Peace and Security Council’s 2002 Protocol called for the establishment of an African Standby Force by 2010, and progress has been made in this regard. The ASF is envisaged as an integrated Pan-African force with a robust, rapidly deployable capability to execute a wide range of missions, from disaster relief to conflict interventions. This force is to be composed of standby multi-disciplinary components with civilian, police, and military units. These are to be based in their countries of origin, ready for rapid deployment at between 14 to 90 days’ notice. The ASF will comprise standby brigades in Southern, Eastern, West, Central, and North Africa, and will undertake traditional peacekeeping functions, as well as observer missions and post-conflict peace support activities. In some sub-regions, the brigades are being organised in line with the building blocks of the AU - the regional economic communities, including the Southern African Development Community (SADC), the Economic Community of West African States (ECOWAS), the Intergovernmental Authority on Development (IGAD), the Economic Community of Central African States (ECCAS), and the Arab Maghreb Union (AMU).

The HIV/AIDS Response and Continental Peacekeeping

African governments have made key commitments such as the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases (pledging at least 15 percent of national budgets to the health sector); and the SADC ’HIV/AIDS Strategic Framework and Plan of Action: 2003-2007’, adopted in Maseru, Lesotho, in July 2003. However, national health services across Africa remain poorly resourced, inadequately staffed, and barely able to cope with the demands of civilian populations, let alone those of militaries, which often rely on them. Furthermore, African defence and security practices and policies often fail to acknowledge the national security and human security aspects of the HIV/AIDS pandemic. Regional economic communities have not yet implemented strategies for coordinated regional responses to the disease. SADC’s peace and security plan - encapsulated in the Strategic Indicative Plan for the Organ on Politics, Defence, and Security Cooperation (SIPO) of 2004 - acknowledged the impact of HIV/AIDS in Southern Africa, but the policy document provided no guidance to policymakers for developing a regional approach to
managing HIV/AIDS within national militaries. ECOWAS devised a Plan of Action for 2004-2006 for the control of sexually transmitted infections and HIV/AIDS within the armed forces sector through its West African Health Organisation (WAHO). However, the sub-regional body is yet to incorporate the WAHO plan fully into its conflict management strategic planning or operations. Indeed, the plan was not widely known in ECOWAS's defence and security department. HIV/AIDS and military preparedness thus needs to be better prioritised by the sub-regional groupings of the African Standby Force. These gaps in knowledge, perception, and action could pose significant challenges to the effective operationalisation of the African Standby Force, if not urgently addressed.

Policy Recommendations

Four key clusters of recommendations emerged from CCR’s policy meetings on HIV/AIDS and militaries in Africa’s five sub-regions:

1. Leveraging the Military for a Better Response to HIV/AIDS

Militaries in Africa represent a unique demographic group because they are a captive audience for instruction and education. The hierarchical nature of military institutions also provides a unique environment for transferring values and standards of behaviour from senior officers to younger serving members. Furthermore, militaries are part of broader communities and their behaviour sometimes has a direct impact on values within society. HIV/AIDS programmes in African militaries present a unique opportunity to halt the epidemic within a key sector of society. Since soldiers can be champions of safer sex and can carry HIV prevention messages to local populations, HIV/AIDS programmes in the defence sector can also have a ripple effect on societies across Africa.

2. Promoting Good Practice Based on Effective Collaboration

Building on the leveraging of the military to improve policy responses to HIV/AIDS, African actors and institutions should base good practice on collaboration across all sectors and strata of society. Such cooperation should involve consultation and information-sharing with militaries and their families, local communities, the private sector, and civil society. Military health programmes
should share lessons with, and be encouraged to build on, multisectoral cooperation between government ministries. Bridging the civil-military divide will also prove critical to providing training, support, and knowledge on broader societal issues, such as gender and tradition, which can influence the effectiveness of HIV/AIDS prevention, treatment, care, and support programmes.

3. Developing Regional Harmony on HIV/AIDS and Military Policies

The initiatives undertaken to develop HIV/AIDS policies at the national and regional levels and the efforts to establish the five sub-regional brigades of the African Standby Force, have not been adequately integrated. Steps should be taken by the African Union and Africa's regional economic communities, in collaboration with the United Nations, to: co-ordinate national HIV/AIDS policies; rationalise and popularise Africa's regional approaches such as the West African Health Organisation's policy; and bring together brigade-level planners and military health officers to develop a continental HIV/AIDS policy as part of the process of the operationalisation of the ASF. The West Africa policy should be widely examined in regional fora in Southern, Central, Eastern, and North Africa, and can potentially provide a starting point for developing a continental approach. The lessons learned by the UN in managing its HIV/AIDS and peacekeeping policies should also be closely examined and carefully integrated into strategies developed by Africa's regional economic communities and the AU.

4. Accelerating the Consolidation of a Continental HIV/AIDS Response

Africa has already developed a roadmap for a more effective response to the HIV/AIDS pandemic. The AU Commission’s HIV/AIDS Strategic Plan 2005-2007 and the African Common Position of 2006 both embody the objectives and policies for a more coherent strategy. However, an urgent need has been identified to integrate, harmonise, and promote the implementation of both policy frameworks at national and regional levels. Efforts to domesticate the legal and policy implications of these commitments should be made through African parliamentary fora and with national executives and ministerial institutions. Civil society organisations engaged in peace and security issues should also be exposed to, and mobilised around, the AU Commission’s Plan and the African Common Position.