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NAMIBIA’S CHAIR OF
THE SADC ORGAN:
HIV/AIDS AND MILITARIES IN
SOUTHERN AFRICA

POLICY ADVISORY GROUP MEETING

9 – 10 FEBRUARY 2006

SAFARI COURT HOTEL
WINDHOEK, NAMIBIA
1. INTRODUCTION

The Centre for Conflict Resolution (CCR), based in Cape Town, South Africa, and the University of Namibia (UNAM), will hold a two-day policy advisory group seminar on 9 and 10 February 2006. The seminar will take place at the Safari Court Hotel in Windhoek, Namibia, on the theme: “Namibia’s Chair of the SADC (the Southern African Development Community) Organ: HIV/AIDS and Militaries in Southern Africa”. This meeting follows a series of CCR policy meetings which focused on 1) Supporting South Africa’s role as the chair of the SADC Organ for Politics, Defence and Security (OPDS) held in Tshwane in November 2004; 2) Southern Africa’s post-apartheid Security Agenda held in Cape Town in June 2005; and 3) the African Union’s strategic plan for accelerating the continent’s response to HIV/AIDS held in Addis Ababa in September 2005.1

On 23 November 2005, CCR and the University of Namibia organised a half-day policy seminar on the theme “Strengthening Namibia’s Chair of the SADC Organ: HIV/AIDS and Southern Africa’s Security Architecture” in Windhoek, Namibia. The meeting examined ways of supporting and strengthening the government of Namibia’s role as chair of the SADC Organ and addressed the policy implications of the SADC HIV/AIDS Strategic Framework and Plan of Action: 2003-2007, adopted in Maseru, Lesotho in July 2003. Major-General (Rtd) Charles Namoloh, the Namibian Minister of Defence, delivered an opening address entitled “Strengthening Namibia’s Chair of the SADC Organ: HIV/AIDS and Southern Africa’s Security Architecture” which outlined the Namibian government’s objectives as Chair of the Organ. Subsequently, the government of Namibia suggested that a follow-up meeting to examine prospects for strengthening Southern Africa’s response to HIV/AIDS in the defence and security sectors would enhance its leadership and the evolution of SADC’s security architecture.

The February 2006 Windhoek seminar will critically assess the response to the impact of HIV/AIDS on Southern Africa’s defence and security. Participants will examine HIV/AIDS management and mitigation programmes undertaken by the sub-region’s militaries to address the pandemic. The seminar will also evaluate the SADC Strategic and Indicative Plan for the Organ’s (SIPO) HIV/AIDS objectives and strategies, and address the challenges confronting the organisation as it embarks on implementing its post-apartheid security agenda. An objective of the Windhoek meeting is to provide a platform to consider the work of key actors in the peace and security fields on peace and security as well as in the area of HIV/AIDS mitigation at the sub-regional and continental levels. The meeting will therefore also review the AU’s strategic objectives for accelerating a continental response to HIV/AIDS, as well as its initiative to establish an African Standby Force (ASF). Senior representatives from the AU, the SADC secretariat, Southern African governments, donor countries, non-governmental organisations (NGOs) and civil society, and universities are expected to participate in the Windhoek policy advisory group seminar. A report of the seminar proceedings will be produced and widely disseminated in 2006.

The following four themes will be the basis of presentations and discussions during the CCR seminar:

SADC Policy Frameworks for Human Security and HIV/AIDS
- SADC’s defence and security agenda in the post-apartheid era;
- Strengthening the SADC Organ;
- The human security objectives of SIPO;

Integration of the SADC Regional Indicative Strategic Development Plan (RISDP) and SIPO; and
Strategies for harmonising national and sub-regional frameworks for HIV/AIDS management and mitigation.

HIV/AIDS and the Military: The Impact and Response
- The context and impact of HIV/AIDS on Southern African states and societies;
- HIV/AIDS prevention, care and support and treatment challenges within the context of defence structures; and
- Best practices for HIV/AIDS management and mitigation from a military perspective.

Sub-regional, Continental and International Co-operation: SADC, the AU and the UN
- The AU’s HIV/AIDS Strategic Plan: 2005-2007;
- The Roles of SADC and the AU in combating HIV/AIDS;
- The Role of the United Nations Development Programme (UNDP) and the Joint United Programme on HIV/AIDS (UNAIDS);
- The African Standby Force (ASF) and arrangements for establishing the SADC Standby Brigade (SADCBRIG); and
- Sub-regional approaches for an enhanced response to HIV/AIDS in defence structures.

Tackling Southern Africa’s Constraints and Limitations
- Mobilising political will and financial support for a durable and predictable response to the HIV/AIDS pandemic;
- Translating the policy recommendations contained in SIPO and the RISDP into national frameworks; and
- Strengthening human resources in Southern African militaries and bolstering the capacity of SADC structures.

2. Objectives of the Seminar

The HIV/AIDS pandemic is increasingly recognised as more than a health crisis. The socio-economic impact of the pandemic in Southern Africa has enormous consequences for human security. In Southern Africa, HIV/AIDS is responsible for the deaths of approximately 500,000 people every year in Lesotho, Malawi, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe. Militaries as well as civilian populations are at risk in unique ways. The absence of conclusive statistics presents difficulties in assessing the extent to which HIV/AIDS has affected militaries in Southern Africa. However, with a prevalence rate of at least 25 percent among the population of many SADC countries, it follows that the impact of HIV/AIDS on military personnel is high since this group comprises the population most at risk of contracting HIV.

The Windhoek seminar seeks to provide insights into the individual and collective initiatives that are being undertaken by the AU, SADC, Southern African governments and civil society actors. In this regard, the meeting will provide a forum for key actors to interrogate the objectives and programmes of these actors and institutions and to generate concrete policy proposals on how to achieve the common objectives of addressing HIV/AIDS and building Africa’s evolving security architecture. Specifically, this policy seminar aims to:

- Strengthen the role and capacity of Namibia as Chair of the SADC Organ in its efforts to enhance the Organ’s HIV/AIDS strategic objectives and activities;
- Create a platform for intellectual engagement with the security objectives of the AU, SADC, Southern African governments and civil society as well as HIV/AIDS management and mitigation programmes in Africa;
- Assess the progress of the AU, SADC, Southern African governments and civil society, focusing on the extent to which they have achieved their aims and objectives;
- Contribute towards policy debates about how to develop further Southern Africa and Africa’s HIV/AIDS management and mitigation strategies within the context of defence and security sectors;
- Produce policy recommendations and promote an informed discussion on the most appropriate division of labour among SADC actors and institutions in developing the basis for a common SADC policy on HIV/AIDS management in the defence and security sectors.

3. BACKGROUND: SADC'S HIV/AIDS CHALLENGE

Southern Africa - the epicentre of HIV/AIDS - is considered a relatively peaceful sub-region: with the end of apartheid in South Africa in 1994 and the resolution of conflicts in Mozambique and Angola, the sub-region has the opportunity to develop stronger democratic governance structures and to improve its economies. Yet, Southern Africa is the worst affected sub-region in the world with HIV prevalence rates well above 25 percent: between 4.5 and 6.2 million people are living with HIV in South Africa alone. Despite relative peace and a history of stability in countries such as Botswana, 20-35 percent of adults in Southern Africa are estimated to be HIV positive. The roots of the sub-region’s HIV/AIDS pandemic are attributable to low-scale violence, poverty and inequality, as well as unprecedented levels of mobility among migrant workers, miners, and traders. Trade routes and seasonal and temporary migration in Southern Africa have contributed to the spread of HIV, with large numbers of men spending the majority of their lives in temporary hostel areas. These routes of transmission through population movements are examples of how HIV reflects existing economic, political and social networks.

The most recent UNAIDS epidemiological report, published in November 2005, notes that between 1990 and 2000, South Africa’s national adult HIV prevalence went from less than 1 percent to approximately 25 percent. Although the overall prevalence rate in Namibia has slightly declined since 2004, HIV rates vary across the country (from 42 percent to 8.5 percent) and adult mortality among women has tripled in the last decade. The estimated national adult HIV prevalence in Mozambique is over 16 percent, with the virus spreading most rapidly in provinces that are linked by transport routes to Malawi, South Africa and Zimbabwe.

The southern African sub-region is shifting into the next stage of the pandemic: mortality. Life expectancy has dropped below 40 years in Botswana, Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. Overall HIV prevalence among pregnant women is very high. In Botswana, Lesotho, Namibia and Swaziland, HIV prevalence rates exceed 30 percent. All indications are that the disease is reaching unprecedented levels and is becoming a threat to the social, economic and security fabric of many countries. South Africa’s death registration data shows a 40 percent rise in the total number of adult deaths in the past six years and amongst women between 20 and 49 years, an increase in deaths of 150 percent. Finally, in 2002, Angola - which is the anomaly in the region with a median HIV prevalence rate of 3 percent - had high levels of HIV among sex workers estimated at 33 percent.

Tanzania, which is connected to Central, Southern and Eastern Africa through complex trade networks, movement of refugee populations, and migrant labour, has not shown a decline in

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prevalence rates, despite the intensive efforts of governments, NGOs and international aid agencies to scale up prevention programmes. However, UNAIDS and the World Health Organisation (WHO) report that HIV rates in Mbeya, Tanzania, where prevention programmes have been operating for the last 13 years, HIV prevalence among the most vulnerable group - women between 15 and 24 years - has fallen from 20.5 percent in the mid-1990s to 14.6 percent in 2000. This is an illustration of how prevention can work – the same cohort data includes signs of increased condom use, treatment of sexually-transmitted infections (STIs) and delay in age of first experience of sexual intercourse.6

4. SEMINAR THEMES

The Windhoek seminar will focus on the following four broad themes:

- SADC Policy Frameworks for Human Security and HIV/AIDS;
- HIV/AIDS and the Military: The Impact and Response;
- Sub-regional, Continental and International Co-operation: SADC, the AU and the UN; and
- Tackling Southern Africa’s Constraints and Limitations.

1) SADC POLICY FRAMEWORKS FOR HUMAN SECURITY AND HIV/AIDS

A summit of SADC heads of state and government was held on HIV/AIDS in Maseru, Lesotho, on 4 July 2003. The declaration issued from the summit noted the adoption of the SADC HIV/AIDS Strategic Framework and Plan of Action: 2003-2007. The Framework aims not only to enhance existing efforts to address HIV/AIDS, but also to address the various social, economic, and political effects of the pandemic. The Maseru Declaration and Plan of Action highlight the need to harmonise SADC country policies and mobilisation and coordination for decreasing the number of people infected and affected by AIDS. Indeed, the Framework promises a move towards a more coordinated and muscular response to HIV/AIDS.

The operational mechanisms necessary for implementation of the SADC Framework are expressed in specific elements of the 2003 Summit Declaration. SADC member states declared that the Framework would be supported through the establishment of a Regional Fund. Steps to ‘initiate implementation’ of the Fund have begun. In addition to committing new resources, Southern African leaders pledged to pursue the delivery of already promised resources. In particular, they would urge western donors - on the principle that the pandemic constitutes a humanitarian crisis - to increase support substantially through the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative; and the Multi-country AIDS Programme (MAP).

SADC’s Regional Indicative Strategic Development Plan provides further clarity on the organisation’s strategy for combating HIV/AIDS. The RISDP highlights the acute poverty in Southern Africa among child-headed or elder-headed households, which are increasing due to the AIDS pandemic.6 The RISDP also reiterates the outcome of the Maseru summit, where it was also agreed that an HIV and AIDS Unit be established within the SADC secretariat’s Department of Strategic Planning, Gender and Policy Harmonisation. The organisation has acknowledged the need to mainstream HIV/AIDS at both policy and programme levels. SADC’s politics, defence and security plan - encapsulated in SIPO - also acknowledges the impact of HIV/AIDS in the sub-

8 The Regional Indicative Strategic Development Plan, 2003, p9.
region. SIPO notes that the HIV/AIDS pandemic poses a challenge to SADC and to the objectives of the Organ.

Though these responses can be considered to be a step in the right direction, many of the policies enshrined in SADC’s policy frameworks have not yet been adequately translated into viable strategies. SIPO fails to address the specific challenges to the sub-region’s security posed by HIV/AIDS. The link between HIV/AIDS, state security and human security has not been fully articulated. Moreover, while the Maseru Declaration of 2003 and SADC’s HIV/AIDS Strategic Framework both stress the need for harmonisation of national policies, concrete strategies for integrating national initiatives into a sub-regional framework have yet to be identified and implemented. Encouragingly, several Southern African militaries, such as those of Angola, Botswana, Namibia, Tanzania, Swaziland, South Africa, and Zimbabwe have adopted national policies and undertaken various HIV/AIDS prevention, care and support, and treatment programmes. These measures could constitute the basis for a common SADC policy on HIV/AIDS management in the defence and security sectors.

Criticisms of SIPO on its objectives and strategies have revolved around the fact that the plan is too broad and general in its goals. SIPO notes that the HIV/AIDS pandemic poses a challenge to SADC and to the political, defence, state security and public security sectoral objectives of the Organ. However, the plan fails to articulate clear and measurable strategies beyond general statements relating to the HIV/AIDS pandemic. Specifically, the strategic plan puts forward objectives that articulate the need to 1) devise measures to combat the HIV/AIDS pandemic in the political sector; 2) prevent the spread of HIV/AIDS through public awareness and advocacy campaigns, while undertaking HIV/AIDS education against stigmatisation and discrimination in the state security sector; and 3) devise effective measures to address HIV/AIDS in the sub-regional law enforcement agencies in the public security sector. There is no objective related to HIV/AIDS articulated for the defence sector.

Yet, it is precisely in the defence sector that the SADC Organ could make a unique contribution to Southern Africa’s HIV/AIDS response: opportunities exist to share information and training between Southern African militaries on managing HIV/AIDS. More importantly, the SIPO document delineates activities for bolstering humanitarian and disaster relief; establishing standby arrangements; promoting professionalism of the sub-region’s defence forces; conducting joint trainings and operations; mobilising resources to enhance regional capacity training; and identifying and implementing common community-based approaches to domestic security and policing. These are all opportunities to integrate HIV/AIDS into peace and security initiatives in Southern Africa. It is vital to include HIV/AIDS in some of these strategies, and to address directly the need to harmonise mitigation strategies for the short-term and long-term impacts of HIV/AIDS.

2) HIV/AIDS AND THE MILITARY: THE IMPACT AND RESPONSE

One of the current challenges facing African actors and institutions is how best to develop their structures to offer more effective assistance to governments and their militaries in combating the pandemic. HIV/AIDS poses a unique threat to the stability of traditional defence structures, which in turn affects steps being taken to build Africa’s peace and security architecture. There are a number of implications relating to the virus’ impact on militaries, and how HIV/AIDS relates to efforts made by regional economic communities (RECs) such as SADC, to ensure stability, and ultimately, sustain the continent’s peacekeeping capacity.

In all nation states, the military is mandated to defend a country’s territorial integrity. Beyond its borders and in its national interest, a country’s military also provides peacekeeping in conflict areas and humanitarian assistance in times of natural and/or human disasters. However, armed forces are considered vulnerable to sexually transmitted infections such as HIV, particularly during conflict and/or peacekeeping missions. Information and data on rates of HIV infection within African military populations is uneven and marred by inconsistencies. However, it is generally accepted that rates within military populations are at least equal to those of civilian
populations, and, in many cases, are higher than the average HIV/AIDS prevalence rate in individual countries. For example, Botswana - one of the countries hardest hit by HIV - had a national HIV/AIDS prevalence rate of 32.9 percent in 2000, while it was estimated that over 40 percent of its uniformed services (armed forces and police) were HIV-positive. Similarly, in Kenya in 2005, HIV/AIDS prevalence in the military was approximately 9.4 percent while the overall rate for the population was 6.4 percent.⁹

Because younger military recruits and soldiers generally fall within the age range of the most vulnerable group for HIV (15 – 49 years), the pandemic’s impact on the military has long-ranging and nuanced impacts. Senior officers within militaries - who are central to political life and have important skills and knowledge - are also not immune. Yet, the early illness or death of these officers can hamper the building of national forces. The further weakening of national defence forces will undermine efforts to build an effective state. The fact that AIDS still carries enormous social stigma continues to undermine morale and cohesion and corrodes the effectiveness of defence forces. Increased absenteeism and an inability to fulfil the duties of active service will lead to poorer performance, posing further challenges for command decision-making processes. In addition to the adverse effects on operations, more resources will have to be committed to testing, counselling, treatment (including nutritional regimens) and support and care. AIDS deaths, especially in militaries, which are responsible for caring for service men and women as well as their dependents, are a serious cause for concern and will necessitate long-term planning. Militaries will be expected to care for increasing numbers of AIDS orphans. Country-level programmes are faced with the task of implementing a broad range of HIV/AIDS prevention, care and support, and treatment programmes. Some examples of these programmes are listed below:¹⁰

- The medical corps of the Botswana Defence Force (BDF) announced in March 2005 that it would provide anti-AIDS drugs at three sites, targeting five thousand soldiers and their families. Antiretroviral treatment (ARVs) will be distributed at Thebephatswa Air Base, 90 kilometres west of the capital, Gaborone; a barracks in Francistown, the country’s second city; and at Sir Seretse Khama barracks in the capital.

- The Namibian government’s HIV/AIDS control programmes targets high-risk uniformed services, including an ambitious programme promoting condoms and behaviour change. 9,000 Namibian Defence Force (NDF) soldiers as well as 10,000 police, prison, and justice staff will benefit from this programme.

- The Health Services of the Tanzania People’s Defence Force (TPDF) is undertaking an HIV/AIDS control programme in 99 of the 120 districts in Tanzania in collaboration with civil society and local partners. The TPDF plans to provide voluntary counselling and testing (VCT); access to care and support; and access to highly active anti-retroviral therapy (HAART) to all members, grades, and levels of the armed forces and communities surrounding bases.

- The South African National Defence Forces (SANDF) implements an HIV/AIDS intervention strategy with wide-ranging programmatic reach that includes education, prevention, treatment and clinical research initiatives through two major programmes.¹¹

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¹⁰ The United States President’s Emergency Plan for AIDS Relief (PEPFAR) is also actively supporting about 26 African military HIV/AIDS programmes.

SANDF’s prevention programme fosters knowledge about the transmission of STIs and HIV through education and mass-marketing campaigns. South Africa has also established a treatment programme - project Phidisa - a managed clinical research programme that seeks to generate new knowledge related to the challenges of management of antiretroviral treatment. An important aim of the project is to build capacity within the military health service so that it can conduct research on other diseases of critical importance to military force preparedness.

- The Zambian Defence Force (ZDF), through its Medical Services, provides health education, voluntary counselling and testing; a comprehensive peer-to-peer programme and condom distribution. The ZDF is also starting an orphans and vulnerable children programme in parallel to its HIV prevention strategy. The ZDF policy aims, most of all, to mainstream HIV/AIDS prevention into the military culture in order to reduce fatalism and despair, as well as to reduce stigma and discrimination.


Since its creation in 2002, the AU has laid out a comprehensive framework for managing conflicts in Africa as well as in responding to the HIV/AIDS crisis. Recognising that HIV/AIDS was a “state of emergency” on the continent, African leaders met in Abuja, Nigeria in April 2001 to develop strategies to stem this trend. The outcome of the 2001 summit was the Abuja Declaration and Plan of Action, which, among other goals, committed leaders to allot at least 15 percent of their annual budgets to fight HIV/AIDS, tuberculosis and other infectious diseases. Thus far, only Botswana has met this health expenditure budget. However, African countries such as Gambia, Ghana, Tanzania, Uganda and Zimbabwe have all made progress towards reaching this goal by devoting between 12 and 14.5 percent of their national budgets to health.

The AU’s most recent initiative has been the development of an HIV/AIDS Strategic Plan 2005-2007, which is to be implemented in partnership with RECs such as the Economic Community of West African States (ECOWAS); the Economic Community of Central African States (ECCAS); the Intergovernmental Authority on Development (IGAD); the Arab Magreb Union (AMU); and SADC, as well as external donors. The AU Commissioner of Social Affairs, Ms Bience Gawanas, together with civil society, governments and partners, is undertaking efforts to implement this continental strategy to heighten and enhance Africa’s response to the HIV/AIDS pandemic.

The AU’s HIV/AIDS plan positions the AU as an advocate and coordinator of a continental response to the emergency posed by the pandemic.

In terms of Africa’s efforts to manage and build peace at the continental level, the AU has put in place a proposal to establish an African Standby Force by 2010. The ASF’s five sub-regional brigades of between 3,000 to 4,000 troops will be developed under corresponding RECs. An additional sixth brigade is expected to be located at the AU’s headquarters in Addis Ababa,
These troops will, in turn, be drawn from African militaries, many of which have developed policies over a broad range of HIV/AIDS issues such as mandatory testing, voluntary counselling and provision of treatment. Policies to deal with the HIV/AIDS pandemic are simultaneously being developed by the RECs, but these have generally failed to be co-ordinated.

The African Common Defence and Security Policy (CDSP) is the central guideline for the continent’s defence and security policies and the foundation of the ASF. The doctrine establishing the military operational guidelines of the ASF emanates from the CDSP and is to follow existing best practices and guidelines from UN peacekeeping doctrine. As such, policy formulation for the ASF, including policies and practices relating to HIV/AIDS and security, is evolving. While HIV/AIDS has been shown to constitute a security threat, little work on the conceptual and operational implications of the pandemic for Africa’s peacekeeping has taken place within the AU Commission or at the level of the RECs. Moreover, the AU’s Peace and Security Department has yet to begin developing or coordinating HIV/AIDS policies with other departments. This is particularly worrying considering the vulnerability of peacekeepers to HIV. UNAIDS has offered to organise a technical consultation to integrate HIV/AIDS into these next steps for operationalising the ASF and examining the possibility of developing an HIV/AIDS mitigation strategy (largely focused on prevention) for African peacekeepers. UNAIDS has also announced that it is working with SADC’s Inter-State Defence and Security Committee (ISDSC) to assist in harmonising the sub-region’s programmes and policies.

4) Tackling Southern Africa’s Constraints and Limitations

As SADC and the AU begin to implement their strategic plans for HIV/AIDS, two key issues will have to be addressed. Both the RECs and the AU have critical resource limitations. SADC faces a shortage of relevant expertise, as well as human and financial resources. The SADC secretariat is struggling with implementation of SIPO and the RISDP, which urgently need to be further developed into coherent, practical and complementary strategies for implementation. The AU’s department of Social Affairs - which has approximately six professional staff - is also expected to implement the AU’s initiatives related to population and development; migration issues; health and nutrition; the social welfare of vulnerable or disadvantaged groups; children; adolescents; the disabled and the aged; the promotion of sports, scouting and family life; drug control and crime prevention; and promotion of African art and culture. Experts are beginning to assert the importance of external linkages and partnerships with civil society in order to support SADC and the AU to ensure that HIV/AIDS is effectively addressed in their work. Moreover, there may be untapped resources, strategies and opportunities for synchronising HIV/AIDS initiatives with a broader human security agenda, and subsequently ensure operational capacities. Commitment is needed from all stakeholders in order to maximise opportunities for collaboration.

Another shortcoming related to undertaking efforts to develop the basis for a common SADC policy on HIV/AIDS management in the defence and security sectors is related to sustaining political will and action. Both SADC and the AU are organisations governed by their member states. Each body is constrained by the many, and at times, conflicting interests of governments. In turn, governments must contend with multiple challenges related to economic development and poverty; democratisation and “good governance”; trade and free movement of peoples and goods; the environment and food security; as well as peace and security. These obligations sometimes pull governments in various directions – yet they are also critical to human security.


Moreover, because HIV/AIDS has historically been relegated to the social and health sectors, a more comprehensive and muscular response has only emerged recently as the preferred strategy for combating the pandemic. These limitations affect the capacity of states to translate continental and sub-regional commitments into national frameworks. Dynamics at the national level also affect the implementation of these commitments: various ministries and other governance structures such as parliaments and the judiciary may not be adequately informed or empowered to implement legal frameworks.

Further constraints such as the continent’s economic marginalisation and a heavy external debt burden of $290 billion have also limited Africa’s response to HIV/AIDS. Consequently, implementation of continental AIDS advocacy and harmonisation will need sustained political will and resources. Various factors must also be addressed in the fight against HIV/AIDS. For example, the production of AIDS treatments and the price of drugs and disputes over patent laws and the clash over the promotion of abstinence over faithfulness and condom use in prevention programmes, are examples of the politics of AIDS. Unresolved tensions at the national level will ultimately shape sub-regional and continental approaches to managing and mitigating HIV/AIDS.

As noted above, countries within the SADC sub-region have instituted a number of HIV/AIDS management and mitigation strategies. Some of the challenges they face include: implementing troop-level HIV/AIDS education and behaviour change communication strategies; increasing testing of all military personnel; nurturing value-based life-style and decision-making skills; providing prevention training for HIV testing and counselling staff; securing and maintaining medical infrastructure and equipment for HIV management; facilitating home-based care for military personnel and dependents; strengthening local alternative/traditional support for HIV and AIDS-related illness; supporting vulnerable communities (the elderly, widows, women and girl children) as well as HIV/AIDS affected people; scaling-up health care capacities and systems; utilising international support for accelerating access to treatment; managing treatment regimens during service; and anticipating and planning contingent responses to treatment challenges on the horizon.

Over the course of its work, UNAIDS has identified key challenges for integrating HIV/AIDS into defence structures. One issue of debate is mandatory testing. Evidence demonstrates that the provision of voluntary confidential counselling and testing services are more likely to lead to positive results in terms of behaviour change. The challenge remains how to operationalise and resource defence structures to provide this benefit, particularly when governments also need to assess the prevalence and incidence of HIV by obtaining accurate statistics. Moreover, African governments are continually challenged to inculcate a culture of HIV/AIDS awareness. Another challenge is to ensure consistent and coherent implementation of HIV/AIDS programmes on the continent. In the midst of conflicts and in sub-regions that are poorly resourced or lack political will, the vulnerability of troops and civilians to HIV/AIDS multiplies.

Perhaps the response to these challenges is in the evidence of past successes. UNAIDS has documented that reaching soldiers with HIV/AIDS services both reduces their vulnerability, and turns them into champions of HIV/AIDS awareness. For example, in 2005, UN peacekeepers in Liberia held three outreach programmes that provided HIV/AIDS leadership and awareness training to religious leaders, the media and women’s groups. An Indian contingent deployed in eastern DRC held an HIV/AIDS sensitisation exercise for the local community, and raised approximately $8000 to support an NGO that cares for victims of rape, sexual abuse and violence, some of whom are HIV-positive in 2005.20 Successes have been linked to strong political commitment from ministries of defence as well as from senior-ranking military leaders.

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