Concept Paper
Prepared by
The Centre for Conflict Resolution

Dialogue, Policy and Practice:
HIV/AIDS, Militaries and Peacekeeping in North and West Africa

Policy Advisory Group Meeting jointly organised with
The Kofi Annan International Peacekeeping and Training Centre (KAIPTC), Accra, Ghana

8 – 9 September 2007
Concorde El Salaam Hotel
Cairo, Egypt
1. Introduction

The Centre for Conflict Resolution (CCR), based in Cape Town, South Africa, and the Accra-based Kofi Annan International Peacekeeping and Training Centre (KAIPTC), will hold a two-day policy advisory group meeting in Cairo, Egypt, on 8 and 9 September 2007, titled *Dialogue, Policy and Practice: HIV/AIDS, Militaries and Peacekeeping in North and West Africa*. The Cairo seminar will be the first of two regional policy advisory group seminars, and is part of the CCR project, HIV/AIDS and Militaries in Africa (May 2007 – June 2009), which aims to produce policy-relevant research and training tools for integrating HIV/AIDS policies into Africa’s regional security mechanisms. The project is funded largely by the Dakar-based TrustAfrica.

The overall goal of CCR’s HIV/AIDS and Security Project is to strengthen the capacity of African institutions and actors to manage HIV/AIDS and security issues. This project organised a policy advisory group seminar in partnership with the University of Namibia (UNAM) on Southern African militaries in Windhoek, Namibia in February 2006. The meeting was convened at the request of the Namibian government, the then chair of the Southern African Development Community (SADC) Organ on Politics, Security and Defence. The February 2006 meeting brought together regional armies to share lessons learned and to explore opportunities for developing a policy on HIV/AIDS and militaries in Southern Africa.1 CCR also organised a policy seminar on the African Union’s (AU) HIV/AIDS and human security agenda in collaboration with the AU Commission in Addis Ababa, Ethiopia, in September 2005.2 Finally, CCR has organised two seminars in Cape Town on HIV/AIDS in South Africa. The first Cape Town seminar took place in March 2006 and was organised in partnership with the New York-based Rockefeller Brothers Fund (RBF) on AIDS and society research. The second meeting was organised in Cape Town in June 2006 in order to examine HIV/AIDS and human security in South Africa from a multidisciplinary perspective.3

CCR will convene the second regional meeting in Addis Ababa, Ethiopia in November 2007 to examine the response to HIV/AIDS in Central and Eastern African militaries. This concept paper addresses the themes of both meetings, which will assess the strategic implications of HIV/AIDS for Africa’s peacekeeping from the perspective of Central, Southern, Eastern, North and West African militaries. Senior representatives from the United Nations (UN), the AU, regional economic communities (RECs), militaries, donor countries, non-governmental organisations (NGOs), civil society, and universities are expected to participate in both seminars. Reports of the Cairo and Addis Ababa seminar proceedings will be produced and widely disseminated in 2007. An edited volume will be produced, based on commissioned research, on prospects for regional HIV/AIDS and security policies in Africa.

The seminars and commissioned research will aim to generate new perspectives on the best practices of military programmes among a range of actors and institutions; examine the limitations and constraints of existing efforts to address HIV/AIDS in African militaries; and fill the policy gap between national, sub-regional and continental approaches to controlling HIV/AIDS in Africa’s defence forces. The project will further identify new regional approaches for addressing HIV/AIDS in the context of African-led peacekeeping operations.

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1 See *HIV/AIDS and Militaries in Southern Africa*, Report published by the Centre for Conflict Resolution (CCR) and the University of Namibia (UNAM), available at: [http://ccrweb.ccr.uct.ac.za](http://ccrweb.ccr.uct.ac.za), accessed 19 June 2006.
2. Seminar Themes

The following three themes will be the basis of presentations and discussions during the September 2007 Cairo seminar on North and West African militaries:

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

2. **Sub-regional, Continental and International Co-operation: RECs, the AU and the UN**
   - The AU’s HIV/AIDS Strategic Plan: 2005-2007;
   - The Economic Community of West Africa’s (ECOWAS) Plan of Action for STI/HIV/AIDS Control in the Armed Forces Sector (2004 – 2006);
   - The African Standby Force (ASF) – to be established under the AU’s leadership by 2010 - and regional arrangements for establishing the North and West African standby brigades; and
   - HIV/AIDS mitigation lessons from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the UN Department of Peacekeeping.

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

3. **Background: HIV/AIDS As A Military Issue**

An estimated 24.5 million people in sub-Saharan Africa are infected with HIV/AIDS, an epidemic with widespread implications for all sectors of society. In countries with moderate levels of prevalence, Africa’s militaries can expect to experience challenges which emanate from the pandemic. While HIV prevalence rates in many of the continent’s defence forces are at least the same as, or slightly lower than, rates in civilian populations, in Southern Africa – the epicentre of the global pandemic – it is estimated that as many as 20-40 percent of defence force members may be infected with HIV/AIDS. The disease also continues to spread largely unabated in most African countries, and previously less affected regions, such as North Africa, are seeing steadily rising prevalence levels.

The majority of African governments have undertaken HIV/AIDS programmes in their defence and security structures. However, HIV/AIDS – with its demands for labour-intensive palliative care and a lifetime provision of treatment – presents novel and as yet unexamined questions for the management of human and financial resources. In the post-Cold War era, these armies are also increasingly called upon to contribute to keeping, building and maintaining peace on the African continent and beyond. In 2007,

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about 70 percent of UN peacekeepers were deployed in Africa, with six of the organisation’s eighteen current peacekeeping missions operating on the continent. Furthermore, African governments expect to bear the burden of troop deployment for future operations. Africa’s regional armies are, thus, confronted with deployment to multidimensional peacekeeping operations, managing humanitarian crises, and serving police functions in newly democratic and post-conflict states. The institutional reflection of this trend is evidenced by the AU’s peacekeeping engagements in Burundi, Sudan’s Darfur region, and Somalia. Moreover, the AU is also in the process of establishing an African Standby Force by 2010.

The African Standby Force - consisting of standby brigades in Central, Southern, Eastern, North, and West Africa - will undertake traditional peacekeeping operations, as well as observer missions, and peacebuilding activities. In North Africa, the regional brigade is being organised through regional cooperation of member states as well as through the Arab Maghreb Union (AMU). Similarly in Eastern Africa, the Intergovernmental Authority on Development (IGAD) is largely implementing the doctrinal development and planning of the region’s brigade while non-IGAD members such as Seychelles and Rwanda, are also participating in the process. In other regions, the brigades are being organised by the RECs – the building blocks of the AU – which include:

- The Economic Community of Central African States (ECCAS);
- The Economic Community of West African States; and
- The Southern African Development Community (SADC).

These RECs, however, have not yet implemented strategies for their own coordinated sub-regional responses to HIV/AIDS. While many of Africa’s defence forces have developed widely varying policies on issues such as HIV awareness-raising and the provision of antiretroviral treatment (ARVs), these national policies are largely un-coordinated at the sub-regional and regional levels, and HIV/AIDS has not been integrated into defence and security plans for Africa’s future peacekeeping operations.

The Risk of HIV/AIDS in Military Populations

It has been widely speculated that HIV/AIDS poses a significant challenge for African militaries. Along with injecting drug-users, long distance truck drivers and sex workers, soldiers have been identified as a high-risk population for contracting HIV. For much of the last decade, commentators have agreed on several features of military life that place regular soldiers at particular risk of infection. These include:

- **Demographics**: most militaries are comprised predominantly of young, single men, who may have more sex partners than their older, married counterparts;

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6 The UN’s peacekeeping operations in January 2007 were in Western Sahara; Liberia; Côte d’Ivoire; the Democratic Republic of the Congo (DRC); Ethiopia/Eritrea; and Sudan.


8 The members of 1) the North Africa Brigade (NASBRIG) are Algeria, Libya, Tunisia, Egypt, Western Sahara and Mauritania; 2) the West Africa Brigade (ECOWASBRIG) are Ghana, Nigeria, Benin, Togo, Côte d’Ivoire, Guinea Bissau, Liberia, Sierra Leone, Mali, Senegal, Niger, Burkina Faso, Gambia, and Cape Verde; 3) the Southern Africa Brigade (SADCBRIGADE) are Tanzania, Malawi, Zambia, Zimbabwe, Namibia, Swaziland, Lesotho, Botswana, South Africa, Madagascar, Mauritius, Angola, and Mozambique; 4) the Eastern Africa Brigade (IGAD EASTBRIG) are Somalia, Djibouti, Eritrea, Ethiopia, Sudan, Kenya, Uganda and Rwanda, and Seychelles; and 5) the Central Brigade (ECCAS CENTRAL BRIGADE) are Sao Tome Principe, Cameroon, Central African Republic, Gabon, Chad, Equatorial Guinea, Congo (Brazzaville), Angola, Burundi, and the DRC.
- **Deployment patterns**: personnel may be posted away from home, where loneliness, boredom and, sometimes, peer pressure may encourage casual or commercial sex;

- **Work environment**: many soldiers also often operate in a high-stress environments, where the need to unwind not only can result in risky sexual behaviour, but also the use of alcohol and drugs. A culture of machismo, aggression and risk-taking in many militaries may also encourage such behaviour;

- **Status and power**: in many settings, military personnel are considerably better off financially than others in the communities in which they live and work. The status and power of soldiers may also attract opportunities for sex, as personnel are seen as “a good catch”, or are able to pay for, or demand sex; and

- **Occupational exposure**: military personnel may be exposed to infected bodily fluids during the course of their duties.

Experts have also argued that involvement in conflict and post-conflict settings contributes to soldiers’ risk of infection. They maintain that features of these environments, including the large-scale loss of livelihoods, population movements, separation of families, collapse of health services, and dramatically increased instances of rape and prostitution, create the ideal conditions for the spread of HIV and other infectious diseases.\(^9\)

Nevertheless, militaries are highly diverse, and, contrary to earlier arguments, some aspects of the military environment may in fact reduce the risk of contracting HIV. For instance, most of the young men recruited into militaries are in the 17 to 22 age range which (again contrary to popular wisdom), is a demographic group that has low levels of HIV prevalence.\(^10\) Many African militaries on the continent also conduct pre-employment HIV testing and do not recruit those found to have the virus.\(^11\) Many units are immobile for long periods of time, are located in personnel’s home communities, and are poorly and irregularly paid, while a focus on discipline in the military setting may discourage risky behaviour. Several African militaries have also put in place comprehensive HIV/AIDS awareness and prevention programmes that may encourage safer sexual behaviour. Ultimately, the demographic structure of an army, its conditions of service and manner of deployment, as well as its HIV/AIDS programmes, are all critical factors in determining the level of HIV in its ranks.\(^12\)

- **Evidence for Increased Exposure Among Serving Personnel**

There is evidence both for, and against, the proposition that serving soldiers are at greater risk of infection. A comparison between rates of HIV infection among Ethiopian soldiers demobilized after Ethiopia’s war with Eritrea and civilian men in the same age cohort finds no evidence of increased HIV susceptibility as a result of military service. However, there is also evidence that soldiers are exceptionally vulnerable to HIV in certain contexts. The chief medical officer in the Nigerian military, for example, estimates that in 1989/90, the prevalence of HIV among Nigerian army troops was less than

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\(^12\) Whiteside et al, “AIDS, Security and the Military in Africa”.
one percent; by 1997, the figure had increased to five percent; and by 1999, to ten percent. This increase coincided with a return of troops from the ECOWAS Ceasefire Monitoring Group (ECOMOG) operation in Liberia.  

The same study found that levels of prevalence among Nigerian peacekeepers in Sierra Leone increased from seven percent after one year of deployment, to ten percent after two years, to more than 15 percent after three years of duty in the operational area. Finally, the Civil Military Alliance (CMA) investigated HIV levels among peacekeepers returning from Liberia and Sierra Leone and found that infection rates were more than double those of personnel not involved in peacekeeping. This research also showed that a soldier’s risk of infection doubled for each year spent on deployment in conflict regions, suggesting a direct link between HIV prevalence rates and the length of uninterrupted duty in war zones.  

### The Gender Dimension

The debates about risk factors and HIV/AIDS prevalence levels seldom include gender issues, but as in non-military populations, the spread of the epidemic within military populations has important gender dimensions. As already discussed, norms of male aggressiveness and risk taking may facilitate the spread of HIV/AIDS among military populations, as may sexual violence against women in many conflict and post-conflict settings. The position of women in military establishments may also leave many of them particularly vulnerable to infection. While most African governments have adopted policy instruments to promote and protect the equal rights of women, lingering cultural and societal norms have entrenched the subordination of women in many militaries. The Zimbabwe Army Wives and Women Association (ZAWWA), for instance, has noted several problems encountered by women in the Zimbabwe Defence Forces (ZDF), including insensitive targeting of HIV/AIDS programmes and the rank subordination of women, which exacerbates the fear of reprisal if women report cases of sexual harassment.

### The Implications of HIV/AIDS for Peace and Security in Africa

Data on the impact of HIV/AIDS on militaries is hard to come by, and a great deal of the information that is available to the public is either anecdotal or speculative. However, this literature - combined with data from non-military institutions - suggests that in the absence of effective programmes to mitigate the impact of the epidemic, HIV/AIDS could impact negatively on the institutional integrity of militaries. This clearly has implications for both nation-building in African states and peacekeeping.

As in other modern institutions, the effectiveness of militaries depends on staff who not only have professional skills but also many years of experience and, often, extensive networks of personal contacts. By causing the illness and eventual death of large numbers of men and women, it is argued that HIV/AIDS may compromise the operational capacity and capability of the armed forces and, particularly in high prevalence countries, have significant budgetary consequences.

While the mandate of the uniformed services has traditionally been confined to defence, the last few decades have seen the emergence of a “new soldier”, as militaries in countries such as Angola, Mozambique, Zimbabwe and South Africa, have sought to introduce a more humane and human rights-
These and other militaries have not only become powerful symbols of their respective states, they have also taken on important additional roles, from auxiliary policing to emergency management and response. Such expanded mandates, together with the greater peacekeeping responsibilities envisaged by the African Standby Force, are likely to see military personnel deployed more consistently than if tasked only with their traditional defensive role. These new demands could also place a premium on soldiers with specific, acquired skills. In the absence of comprehensive programmes to prevent and manage HIV/AIDS in the ranks, militaries faced with ongoing demands on their capacity may find it increasingly difficult to fulfil their mandate in the face of even moderate levels of HIV/AIDS-related illness and death.

There is some still largely unsubstantiated, evidence that HIV/AIDS may already be impacting on peacekeeping, both in Africa and internationally. The experience of the Ethiopian army suggests that even relatively low levels of prevalence may interfere with military duties. Despite estimated prevalence rates of only six percent, HIV/AIDS “has had a devastating effect in terms of the personnel it has claimed and the resources it has consumed”. While diseases like malaria remain more of a priority in international peacekeeping operations than HIV/AIDS, requests like the one made by Indonesia to the UN Security Council in 2000 for HIV/AIDS mapping in countries where peacekeepers are going to be deployed, suggest that HIV/AIDS could become more of an issue in the future. This may also become a key issue in whether host countries accept troops from particular troop contributing countries. Eritrea, for example, requested in 2001 that the UN Security Council test all UN troops serving with the United Nations Mission in Ethiopia/Eritrea (UNMEE). This request was ultimately declined, but could perhaps be indicative of future trends to come.

- The Counter Arguments

Yet, several features may make military institutions more resistant to the effects of the HIV/AIDS epidemic. First, according to analysts, there is a certain level of redundancy in military establishments that may buffer them against the effects of staff losses. By their very nature, militaries are expected to lose some personnel, be it in battle or due to other causes, and there is generally duplication of essential tasks. Linked to this, defence forces usually have a number of available candidates for any given position or promotion, which may again enable these institutions to cope with higher levels of staff attrition. Third, armies often adopt proactive personnel management strategies that help them protect their strategic advantages, and have both the technical capacity and the institutional authority to institute the necessary measures to mitigate the effects of the epidemic. The increasingly common practice of pre-employment HIV/AIDS testing, and in some cases, the discharge of HIV-positive personnel, provide examples of such behaviour, which although highly controversial, may enable armies to reduce the costs of the epidemic. Finally, armies tend to be strictly hierarchical; senior personnel have the authority to make and enforce life-and-death decisions – even if these are unpopular.

These arguments raise important questions about assuming that militaries are excessively – and equally – vulnerable to epidemic. Yet, they do not adequately address the costs of HIV/AIDS to post-Cold War

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armies now confronted with deployment to peacekeeping operations, managing humanitarian crises, or serving policing functions in newly democratic and post-conflict states. Despite areas of resilience, it is also not clear how HIV/AIDS will affect the process of institutionalising peacekeeping in Africa.

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

**Military Responses to HIV/AIDS in Africa**

African militaries are increasingly acknowledging the threat posed by HIV/AIDS, and in several cases, are ahead of their governments in establishing policies and programmes to combat the spread and effects of the virus. While there are significant variations among the diverse defence forces on the continent, the armies of Ethiopia, Kenya, Tanzania, Ghana, Nigeria, Rwanda, Senegal, Sierra Leone, Côte d’Ivoire, Namibia, Botswana, Swaziland and South Africa have all undertaken concrete activities to address HIV/AIDS. Many of these initiatives focus on prevention activities, such as education, condom distribution and counselling, but some have moved into care and support, and even treatment.

In Sierra Leone, the army has put in place the first HIV/AIDS workplace policy in the war-torn country. This policy protects military personnel from being fired because of their HIV status, and calls for ARVs to be provided at no cost to soldiers through grants from the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Centres have also been established to provide free voluntary HIV testing and counselling to military personnel as well as their families and civilians in the surrounding community. The military has also involved soldiers’ wives in raising awareness among women in the barracks about HIV/AIDS and how to promote condom use.

The Moroccan Royal Armed Forces (MRAF) implemented a prevention program for its soldiers as far back as 1996. By 2001, peer advocacy programs had reached more than 60,000 military personnel through prevention efforts and focus groups. Prevalence data and risk-behaviour information were also collected. These were used to improve and refine the military’s prevention efforts. Programming efforts were suspended in 2001 due to a lack of funding, but the United States’ Department of Defence has

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recently agreed to partner with the MRAF to implement the HIV prevention programme. Goals for restarting the programme include train-the-trainer and peer education sessions; activities to improve the analytical and epidemiological skills of military health personnel; and the provision of materials such as post-exposure prophylaxis kits and condoms in order to expand existing efforts.27

Outside West and North Africa, Namibia, Ethiopia and Uganda provide important comparative lessons. The Namibian Defence Force’s (NDF) Strategic Plan on HIV/AIDS for the period of 2004 – 2009, for example, focuses heavily on prevention while seeking progressively to increase the military’s capacity to provide care, support and treatment services to its members and their families.28 By February 2006, nearly 40 unit coordinators had been trained in HIV prevention, and voluntary counseling and testing (VCT) facilities were established in all NDF sites. The Namibian Defence Ministry has identified a number of resource challenges to its capacity to enhance its HIV/AIDS services. First, the ministry faces a shortage of human resources at the management level. Second, basic tools for carrying out its activities are limited. For example, there is a lack of transportation for home-based care, which severely limits the number of visits by HIV/AIDS unit co-ordinators to members. Third, inadequate budgetary allocations impede the sustainability and scope of the government’s efforts to control HIV/AIDS in the Namibian military. The ministry tried to address some of these challenges through a comprehensive workplace HIV/AIDS policy unveiled in June 2006, but new policies may continue to face implementation challenges without adequate human and financial resources.29

Similarly, the Ethiopian army has put in place a thorough prevention programme. In 2001, the Ethiopian National Defence Force (ENDF), in conjunction with the United Nations Mission in Ethiopia/Eritrea, launched a five-year strategic plan for HIV/AIDS control in its armed forces. The plan was launched with a two-week training course for 26 HIV/AIDS educators who were tasked with developing an action plan on HIV/AIDS education.30 HIV testing forms the cornerstone of the strategy. The military’s civic and political department (a department entrusted with the responsibilities of political affairs in the army) uses the results of the screening for sensitization activities to encourage officers and soldiers to remain HIV negative. The information has also been incorporated into the manuals and procedures of promotion and training opportunities for soldiers and officers - the principle being that those who stay negative over periodic tests would be regularly promoted and given the opportunity for training, while those who become HIV-positive would not have these opportunities.31 While this policy is an innovative example of emerging practices, it also raises important questions about stigma, discrimination and the human rights of People Living with HIV/AIDS (PLWHA) in the defence forces. Indeed, the issue of balancing individual rights and the protection of groups from HIV, is an emerging dilemma for many state institutions.

The Uganda People’s Defence Force (UPDF) has been running HIV/AIDS awareness programmes since 1989. These have focused on preventing transmission of disease through health education; voluntary counselling and testing; mitigating the effects of HIV/AIDS on those who have contracted the virus through pre- and post-test; ongoing counselling and home care; and strengthening the military’s capacity to run and monitor HIV/AIDS programmes. While medical facilities provide treatment for opportunistic infections, ARVs have yet to be widely provided – although the military is sourcing funding for a more comprehensive treatment programme. Health educators are attached to each battalion, and condoms are

29 Ibid.

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provided on request. The UPDF is also considering whether to follow the lead of countries like Ghana, Eritrea, Ethiopia and Indonesia, in making a condom pouch part of the standard military equipment for every soldier.  

Business As Usual

As noted above, such programmes have experienced a range of specific problems, including insufficient human and financial resources, as well as a lack of equipment and physical infrastructure such as counselling rooms; resistance within communities; and reconciling scientific knowledge and ostensibly “Western” mitigation approaches with local beliefs and understandings. Through their varying approaches to both testing and dealing with those found to be HIV-positive, African militaries have also taken diverse - and often divergent - stances on the human rights of soldiers. These issues need to be addressed in the short-term, in order to ensure sustained (and sustainable) action against the epidemic. In the long-term, however, effectively responding to the HIV/AIDS epidemic will require new ways of thinking about and mitigating the effects of the disease.

- The Absence of an Organisational Perspective

While the widespread acknowledgment of HIV/AIDS by African militaries is extremely positive, most of these institutions have yet to adopt truly adaptive approaches to managing its potential effects. Promising policies and programmes have been put in place, but these deal with the disease primarily as a health issue. Although some African militaries have made statements recognising the institutional implications of the epidemic, HIV/AIDS has yet to be treated as a potentially important strategic issue that could compromise military effectiveness. The focus has been on preventing, and to some extent managing, HIV/AIDS among soldiers, their families and the communities with which they interact. However, strategic responses will also need to address the prospect of increasing staff losses as a result of the epidemic.

A long-term, more adaptive approach would require acknowledging that, despite the implementation of awareness raising, prevention and care and support activities, some people will still contract, become sick and die of HIV/AIDS, thus requiring measures that address the discontinuity and loss of knowledge that results from losing military personnel. Such a perspective further recognises that, given both the diminished human and financial resources associated with attrition and the potential long-term effects of HIV/AIDS on the size and quality of the available recruitment pool, replacement of personnel may often be neither possible nor preferable. Continuity is, therefore, best preserved by developing and protecting the skills, experience and institutional memory within institutions. This can be done by more effectively managing non-AIDS-related training, attrition, and putting in place policies that preserve available capacity and resources and ensure that enough people are equipped to take over key positions within organisations should they become vacant.

- A Lack of Coordination

A second challenge is the apparent lack of consistency and coordination between militaries on HIV/AIDS issues. While most of the militaries comprising the North, West, Central, Eastern and Southern African brigades of the ASF have developed policies and programmes both to prevent and manage HIV/AIDS in

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the ranks, these vary widely. There is little uniformity among troop-contributing countries on prevention and management, and HIV/AIDS prevention and care standards have not been integrated into the guidelines for Africa’s joint peacekeeping operations. This is not unique to Africa. As noted in a recent report on HIV/AIDS in the military by the U.S.-based Family Health International (FHI):

That the uniformed services in so many countries are advancing HIV/AIDS programmes with their government, donor and [non-governmental organisation] NGO allies is encouraging. But that in itself creates new obstacles. There is occasionally duplication of effort, and lessons learned are not always shared across countries and regions.35

Such coordination failures become particularly relevant in the context of peacekeeping, where highly diverse – and in some cases inadequate – responses to HIV/AIDS could make it not only extremely difficult for Africa to furnish peacekeepers, but also compromise the integrity and effectiveness of the units that are provided. Greater coherence across countries and regions will be necessary in order to ensure that Africa achieves its security objectives.

Regional Responses to HIV/AIDS

The continent’s regional actors are increasingly putting in place measures to address HIV/AIDS, but these have yet to be strongly linked to the epidemic’s effects on the armed forces. In 2001, the AU adopted the Abuja Declaration and Plan of Action for HIV/AIDS, Malaria and Tuberculosis. In May 2006, the AU reaffirmed the Abuja commitments through an African common position, which was submitted to the June 2006 UN General Assembly Special Session on AIDS.36 But while the Abuja plan of action commits African governments to devoting at least 15 percent of national budgets to the health sector,37 the initiative does not explicitly address HIV/AIDS in the continent’s defence forces. The Addis Ababa-based AU Commission, which is mandated to implement the declarations and commitments made by member governments, has developed an HIV/AIDS Continental Strategic Plan. Its 2007 implementation activities seek to strengthen existing national, sub-regional and continental responses to HIV/AIDS in Africa, and to mainstream HIV/AIDS into all the Commission’s departments - including the Peace and Security department. The Peace and Security department has already taken steps to address HIV/AIDS issues for the AU’s 7,000 peacekeepers in Sudan’s Darfur region, and is in the process of designing military health guidelines, including HIV/AIDS policies, for the ASF. It nevertheless remains uncertain exactly how the AU will integrate HIV/AIDS into its peace and security agenda.

The continent’s RECs have made greater progress on these issues. The SADC peace and security plan - encapsulated in it’s Strategic Indicative Plan for the Organ on Politics, Security and Defence Cooperation (SIPO) of 2004 - acknowledges the impact of HIV/AIDS in the sub-region, and the challenges the pandemic poses for the achievement of the organ’s objectives.38 SADC’s Inter-State Defence Committee has established a Military Health Services Work Group which began talks with UNAIDS on developing a regional approach to HIV/AIDS and militaries programme in early 2005. SADC’s Executive Secretary,

Tomaz Augusto Salomão, has also asserted the need for an HIV/AIDS framework for the sub-region’s ASF brigade, SADCBRIG. ECOWAS already has a Plan of Action for 2004 – 2006 for the control of sexually transmitted infections and HIV/AIDS within the armed forces sector. The organisation has also sought to establish a peer education programme for young recruits for the Liberia Armed Forces. However, ECOWAS has yet to incorporate HIV/AIDS into training or doctrine for the West Africa brigade (ECOWASBRIG) of the ASF. It is not clear how HIV/AIDS will be reflected in the establishment of the ASF’s East African Brigade (EASBRIG). However, IGAD has begun to explore the possibility of integrating HIV/AIDS policies into its security programmes. It remains to be seen, however, how existing regional plans will be implemented and how they will relate to the strategies pursued by individual militaries.

Central and Northern Africa have yet to engage significantly around HIV/AIDS on a regional basis. With some exceptions, the countries in these regions have generally been slower to appreciate the potential threat posed by the epidemic for its armed forces, and many countries are only just beginning to confront the issue.

4. Conclusion

The HIV/AIDS epidemic poses significant challenges for African militaries. Armed forces vary widely in terms of their institutional capacity and deployment patterns, and it is likely that the extent and implications of the epidemic will differ between countries. Some of the more recent analyses suggest a need to re-examine many of the assumptions about how HIV/AIDS could potentially impact on African militaries, and there is a need for a great deal more research on precisely how HIV/AIDS will play out in different settings. What is clear is that HIV/AIDS is, and where not already, will become, a major variable in African peace support operations. The pandemic is much more than just a health problem; it has important organisational implications that make it a potentially important strategic issue. Moreover, there are no concrete policy tools, designed by African stakeholders, which can help generate solutions to daily challenges related to HIV/AIDS and security issues. How the epidemic impacts Africa’s militaries, and how they and regional defence structures respond to these challenges will affect future peace and security on the continent and beyond.

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