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Assessment Report for the Harmonised Control of HIV and AIDS, Tuberculosis and Malaria in Militaries in the SADC Region

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For more Information

Directorate of Social and Human Development
And Special Programs
SADC Secretariat
Private Bag 0095
Gaborone, Botswana
Tel (267) 395 1863
Fax (267) 397 2848
Email: registry@sadc.int
Website: www.sadc.int

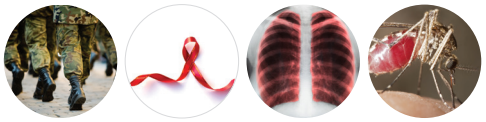
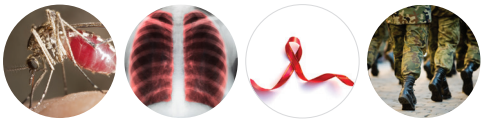
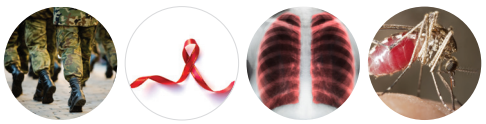


Table of Contents



ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
DDT	Dichlo-Diphenyl-Trichloroethane
DOTS	Directly-observed treatment, short course
HIV	Human immunodeficiency virus
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant Tuberculosis
NMCP	National Malaria Control Programme
NSP	National Strategic Plan
SADC	Southern African Development Community
STI	Sexually transmitted infection
SWOT	Strengths, weaknesses, opportunities and threats
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDSHIV and AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization
XDR-TB	Extensively drug-resistant Tuberculosis

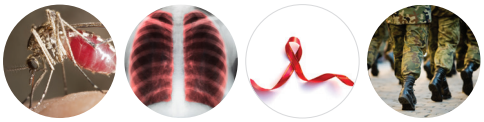


EXECUTIVE SUMMARY

HIV and AIDS, Tuberculosis (TB) and Malaria are the largest causes of morbidity and mortality in the Southern African Development Community (SADC) region. These three communicable diseases often seriously affect militaries, due to the nature of the profession. The relatively high mobility of military personnel means that they are at high risk of becoming infected and of transmitting infections to others. This assessment report details the status of communicable diseases policies for the SADC militaries, as a basis for the development of minimum standards for the harmonised control of HIV and AIDS, Malaria, and Tuberculosis in the SADC region.

Member States have developed widely varying policies on these communicable diseases, with some including specific provisions for the military. While Member States' policies on HIV and AIDS differ, their focus on prevention (including education, condom distribution, treatment of sexually transmitted infections, and voluntary counselling and testing) reflects a similar approach, and demonstrates that a coordinated regional response is possible.

Militaries are usually not involved in formulating national strategic plans and policies. Consequently, their specific needs and requirements (and their increased vulnerabilities) are not always addressed in national policies. Only eight out of the 15 SADC Member States specifically mention the military in their national HIV and AIDS strategic frameworks, for example. It is important for the military to be involved at national level in the formulation of policies in order to ensure that their needs are mainstreamed.



1. INTRODUCTION

One of the aims of SADC is to combat HIV and AIDS and other deadly communicable diseases. Serious HIV and AIDS, TB and Malaria epidemics are underway in the region. These epidemics affect all of society, but certain sub-populations – such as the military – are especially vulnerable, due to the nature of their work.

Military personnel are often deployed away from their homes and families for long periods. They are deployed elsewhere in their countries, in the SADC region (as part of the SADC Standby Brigade), elsewhere in Africa (as part of the African Standby Force), and even elsewhere in the world (as part of the United Nations Peace-Keeping Force). Personnel can encounter a variety of communicable diseases in these different theatres of deployment. They may be in Malaria or TB endemic areas while lacking the requisite immunity. They may also find themselves in circumstances where they could transmit communicable diseases to local populations.

At the same time, the military is a unique group. It tends to be well-disciplined and well-organised, and presents a relatively "captive audience" for interventions aimed at limiting the spread of communicable diseases. It therefore is ideally positioned to assist local communities in controlling communicable and other diseases.

SADC Member States made commitments in Abuja (2001) and at the 2001 United Nations General Assembly Special Session (UNGASS) to combat AIDS, and other communicable diseases such as Malaria and TB. (1) SADC Heads of State and Government affirmed those commitments in the Maseru Declaration (2003). (2) The military and other uniformed services are explicitly mentioned in that Declaration as vulnerable populations that require special targeted interventions and as entities that are in a unique position to strengthen prevention initiatives among communities.

Globally, the UN Security Council's Resolution 1308 of 2000 was a landmark in addressing AIDS as a security risk, and in proposing ways to address HIV and AIDS among peace-keeping personnel. The United Nations Department of Peace-Keeping Operations and UNAIDS have developed a detailed programming guide for the military in peacekeeping missions in the context of the AIDS epidemic, whereby voluntary counselling and testing is encouraged as part of a holistic care and support programme for the military.

Member States have developed different policies for the various communicable diseases. In some cases, those policies include provisions for the military. While the Member States policies on HIV and AIDS differ somewhat, their focus on prevention (including education, condom distribution, treatment of sexually transmitted infections or sexually transmitted infections (STIs) and voluntary counselling and testing) reflects a similar approach and demonstrates that a coordinated regional response is possible and can add value to national responses.

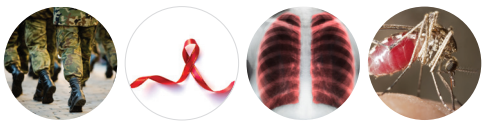
The development of regional minimum standards for controlling communicable diseases in the SADC region is in accordance with existing commitments, notably the Maseru Declaration (2) and the SADC Protocol on Health. (3) The Protocol prioritises the control of communicable diseases and calls for the harmonisation of policies and strategies aimed at disease prevention and control.

This situational and response analysis provides an outline of the rationale for the framework for minimum standards for HIV and AIDS, TB and Malaria for the militaries in the SADC region.

2. PROCESS FOR REVIEWING THE MILITARY POLICIES

The process for reviewing Military policies and programmes for HIV, Tuberculosis and Malaria (communicable diseases) was participatory including Member States, the SADC Secretariat and various stakeholders. The process was also informed by internationally-recognised best practices.

Firstly, a desk review of the current national, regional and global policies relevant to military and communicable diseases was conducted. This was followed by individual country assessments in each Member State by the military coordinator for each of the communicable diseases. During the process, key informants within the respective programs, including development partners, civil society organizations and the private sector were consulted to provide information on the state of programmes and policies. The respondents also shed light on some challenges and best practices. Each visit culminated in a country level assessment report which was reviewed and validated by relevant military officials.



The country reports were then compiled to inform a regional picture of the situation and response analysis. The draft regional assessment report was used as a basis for Regional Minimum Standards. Both the draft Regional assessment report and the draft regional minimum standards were then reviewed by a technical team for technical soundness. The team comprised Member States military health services representative, Technical Partners, Civil society Organizations and the SADC Secretariat. The purpose of the review team was to strengthen the quality of the documents.

Following the technical review and the incorporation of the comments, the documents were then presented to a regional workshop for validation of the situation and response analysis report. All Member States and major stakeholders including regional partners and civil society organisations were invited to the validation and consensus building workshop. The workshop was held on 13-15 May 2009. The meeting made recommendations on the draft report.

The revised reports were reviewed by the SADC National AIDS Authorities in their meeting of October 2009 for technical soundness and recommendation for finalisation.

3. SITUATION ASSESSMENT

The SADC region is experiencing some of the most severe epidemics of HIV and AIDS, TB and Malaria in the world. Although these communicable diseases are prevalent throughout the general population, some sub-populations tend to be affected more than others.

The military are among the most vulnerable and susceptible groups. They are sometimes deployed to areas where their risk of contracting communicable diseases is extremely high. High rates of mobility also mean that military personnel may transmit such diseases to host populations. It is therefore vital to formulate policies that effectively reduce the military's susceptibility and vulnerability to these communicable diseases, and decrease rates of transmission. In addition, the importance of the military for social security and peace means that civil society groups have a stake in ensuring that the military is kept healthy and disease-free.

Several existing global and regional initiatives are aimed at securing the health and well-being of military personnel. They require working with the military to reduce the spread of these three communicable diseases. Although other serious communicable diseases (such as haemorrhagic fever, for example) also affect the military and the general population, the minimum standards set out in this publication specifically address the three most prevalent communicable diseases in the region: HIV and AIDS, TB and Malaria.

3.1 Situational and response analysis for HIV and AIDS

Various studies suggest that the military tend to experiences higher rates of HIV and other STIs than civilian populations. (4,5). This believed to be due partly to the ages at recruitment and deployment of military personnel, subjective perceptions of invincibility, and a tendency toward risk-taking. (6,7) The fact that increasing numbers of women are being recruited into the military highlights a special need for focusing on the gender-based discrepancies women in the military may experience. Women are at higher risk for HIV due to biological predisposition and to other factors (such as the sexual abuse of females as a weapon of war).

Both in their sovereign capacity, as well as in the context of regional and global policies, Member State Governments increasingly recognise the importance of creating awareness among the military and taking steps to combat HIV and AIDS. The 10 countries with the highest adult HIV prevalence in the world are all SADC Member States (see Table 2.1). Each of the 15 SADC Member States currently has a national strategic plan to combat the AIDS epidemic, and at least one of them has promulgated an HIV and AIDS Act as part of its response.

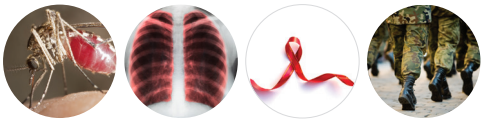


Table 3.1: National adult HIV prevalence (15-49 years) in SADC Member States, 2007

World rank	Country	Percentage
24	Angola	2.1%
2	Botswana	23.9%
46	Democratic Republic of Congo	1.2-1.5%
3	Lesotho	23.2%
44	Madagascar	0.1%
8	Malawi	11.9%
28	Mauritius	1.7%
7	Mozambique	12.5%
5	Namibia	15.3%
50	Seychelles	N/A
4	South Africa	18.1%
1	Swaziland	26.1%
10	Tanzania	6.2%
6	Zambia	15.2%
5	Zimbabwe	15.3%

Source: Adapted from SADC HIV Epidemic update, 2007

Most of the SADC Member States mention the military in their national strategic plans. In some cases, the plans stipulate a number of interventions for addressing the risk factors for the military as a vulnerable group. For example, some strategic frameworks refer to the mobility of military personnel as a risk factor. The risks are thought to be associated with a stronger tendency to have unprotected sex with multiple partners, which boosts the chances of contracting and transmitting HIV and other STIs.

Possible best practices have been identified in some countries where the military is included in national strategic frameworks (especially in the context of behavioural change communication initiatives, treatment of STIs, and the promotion and marketing of condoms).

Other notable practices include specific inclusion of the military in the prevention of HIV infection; provision of treatment, support and care for military personnel; establishment of a monitoring system to monitor the epidemic among military personnel; and a revision of the military's HIV and AIDS policy so that it is harmonised with national HIV and AIDS policies. Harmonising military policy with national policy is an example of putting the "Three Ones Principle" into action – by combining one agreed HIV and AIDS framework, one national HIV and AIDS coordinating authority, and one agreed monitoring and evaluation framework.

In at least one SADC Member State, the military is specifically required to design a budget for HIV and AIDS activities, mainstream HIV and AIDS awareness and education into its activities, and review its existing HIV and AIDS policies. However, in most Member States the military is currently mentioned strictly as a vulnerable group, and as a possible factor in the spread of the disease. Table 2.2 provides a summary of SADC Member States' strategic plans and frameworks, and those that include specific references to the military at national level.

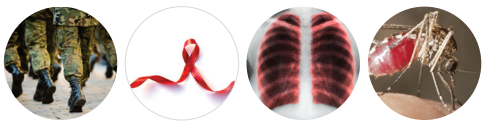


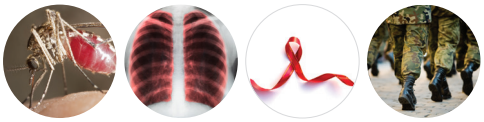
Table 3.2: SADC Member State strategic plans and frameworks that include HIV and AIDS, gender and the military

SADC Member State	HIV and AIDS strategic plan or framework	Military specifically mentioned	Gender sensitivity of plan or framework
Angola	Yes	Yes	Highly gender sensitive
Botswana	Yes	Yes	Highly gender sensitive
Democratic Republic of Congo	Yes	Yes	Moderately gender sensitive
Lesotho	Yes	No	Highly gender sensitive
Madagascar	Yes	Yes	Moderately gender sensitive
Malawi	Yes	Yes	Highly gender sensitive
Mauritius	HIV and AIDS Act	No	Not gender sensitive
Mozambique	Yes	Yes	Moderately gender sensitive
Namibia	Yes	No	Not gender sensitive
Seychelles	Yes	No	Moderately gender sensitive
South Africa	Yes	Yes	Highly gender sensitive
Swaziland	Yes	No	Highly gender sensitive
Tanzania	Yes	No	Moderately gender sensitive
Zambia	Yes	No	Highly gender sensitive
Zimbabwe	Yes	Yes	Highly gender sensitive

Note: Plans and frameworks were deemed "not gender sensitive" if they made no reference to either gender or gender-differentiated needs; "moderately gender sensitive" if they made reference to gender, but did not provide detailed information; and "highly gender sensitive" if they provided extensive detail on issues pertaining to gender and the different needs of men and women.

There are regional efforts to document best practices and standardise the HIV and AIDS response both within the military and in relation to the civil-military interface. SADC Member States have adopted global policies and guidelines. As part of the *Maseru Declaration* on HIV and AIDS (2), all SADC Member States have pledged to combat HIV and AIDS in the region. The *Declaration* specifically mentions the uniformed forces as a vulnerable group. The *SADC HIV and AIDS Strategic Framework and Plan of Action (2003-2007)* also recognised the military as a vulnerable group and prioritised the development of regional minimum standards to ensure that the special case of militaries is addressed. (8)

Globally, the UN Security Council's Resolution 1308 (2000) represents a landmark in recognising HIV and AIDS as a security risk, and in proposing measures for addressing HIV and AIDS among peace-keeping personnel. The United Nations Department of Peace-Keeping Operations and UNAIDS have developed a detailed programming guide for the military in peacekeeping missions in the context of the AIDS epidemic, whereby voluntary counselling and testing is encouraged as part of a holistic care and support programme for the military. They recommend that "fitness to work" (rather than "HIV status") be used to determine the deployment of HIV-positive military personnel. UNAIDS and the United Nations Department of Peace-Keeping Operations have also produced an HIV and AIDS Awareness Card for Peacekeeping Operations as part of their global awareness strategy for the uniformed services. The card contains a condom pocket, and outlines the basic facts about HIV and AIDS and the relevant codes of conduct that peacekeeping personnel should respect. (9)



Multisectoral partnerships are necessary for an effective response to HIV and AIDS. Civil-military alliances are crucial for the success of any potentially effective intervention against the epidemic. Since the military are required to provide security and protection for states, threats (including AIDS) that affect their operational capacity and effectiveness would also have wider detrimental effects. In addition, the military are sometimes perceived as factors in the spread of epidemics. (5, 11) The effects of civil-military interaction in spreading communicable diseases appears to be more evident in less-developed regions such as the SADC Member States than in the more developed regions. (5)

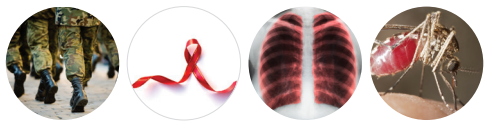
Table 3.3 provides a summary matrix of global and regional policies that apply to the SADC region, and identifies those that explicitly mention the military in the context of the AIDS epidemic.

Table 3.3: Global and regional policies and strategies that specifically deal with HIV and AIDS for the military in the SADC region

Policy name	Regional/global	Key content
UNAIDS, in consultation with United Nations Department of Peace-Keeping Operations, HIV Programming for Peace-Keeping Operations	Global	Advises provision of voluntary counselling and testing as part of an integrated package of HIV care and services, and use of "fitness to work" (rather than HIV status) to determine recruitment and deployment.
Inter-Agency Standing Committee Guidelines for HIV and AIDS Interventions in Emergency Settings	Global	A guideline for interventions in emergency settings; includes special reference to the uniformed services.
SADC Gender Policy	Regional	Guides development and implementation of gender-sensitive policies and programmes that address critical health issues affecting the population, including HIV and AIDS, Malaria, TB and STIs, and other communicable diseases.
Maseru Declaration on HIV and AIDS	Regional	Key HIV and AIDS declaration for the SADC region, signed by all Member States; uniformed services are specifically mentioned.
SADC HIV and AIDS Strategic Framework and Program of Action, 2003-2007	Regional	Specific mention of police and military.

The strongest justification for civil-military alliances in the fight against AIDS is the common goal to drastically reduce the spread and impact of the epidemic across society. It is important that that these sectors are mutually, rather than exclusively, involved in HIV and AIDS prevention, care and education. (11) Military sector-specific data on HIV and AIDS is scarce; few findings of HIV research conducted among the military are publicly available, since the information is typically considered sensitive and is typically classified.

In 1995, a number of Southern African military services conducted surveys to monitor the HIV prevalence rates within the military. Although the results are not available to the public, most of the surveys are understood to have found HIV prevalence rates of 30-40% among military personnel. In some of the countries, prevalence rates were as high as 50-60%. (10) At the "AIDS, Security and Democracy Expert Seminar and Policy Conference" held in the Hague in 2005, evidence was presented showing that in most SADC countries HIV prevalence rates among military personnel was between two and five times higher than in the general population. (12) These high prevalence levels are attributed to high rates of unprotected sex between military personnel and civilians. Yeager (5) found that knowledge of HIV among military personnel was generally low. Interventions aimed at the military must include HIV prevention education capable of countering the "invincibility syndrome" that occurs in the military.



A UNAIDS/Civil Military Alliance survey of the military also found that military education programmes tend to be sporadic and makeshift, and do not follow a systematic format. Condom promotion and provision, HIV testing and counselling for military personnel and their families, AIDS care, and civil-military cooperation around HIV prevention and care were found to be vital initiatives for the military. (5)

In response to such findings, UNAIDS has developed manuals to train peer educators in the response to HIV and AIDS among the military. Some analysts have also suggested using the military as HIV educators in society broadly. (5, 13) Several militaries in the SADC region are training peer educators to increase awareness among their personnel.

Another key concern identified in the situation analysis is the dilemma of HIV testing as part of comprehensive, routine health assessments of military personnel before, during and after their deployment. The debate revolves around the human rights of the personnel. It has been argued that HIV testing is not only crucial for managing the epidemic, but that timely knowledge of personnel's HIV status may increase military readiness for combat and peace-keeping missions, and may lead to better care and support for infected personnel and their dependants. (11)

But it is also sometimes argued that HIV testing and screening (especially at the pre-recruitment stage) is needed because strenuous military training and service may accelerate the progression of infected personnel to AIDS. (10) There is hardly any published evidence on the effect of military training on HIV-positive personnel, however.

Routine HIV testing, with a comprehensive counselling, care and support programme, remains the gold standard to manage HIV and AIDS in a comprehensive manner. This could help keep military personnel healthy and alive for longer. If avoided, it may delay access to life-prolonging treatment.

Discrimination and stigmatisation of HIV-positive military personnel remains an issue. Some stakeholders believe this can be successfully dealt with through proper education and policies that combat discrimination based on HIV status. (11)

It is important to note that post-deployment HIV testing is also important. It could enhance treatment, care and support for military personnel who have become infected (and for their families), and it could inhibit onward transmission of HIV.

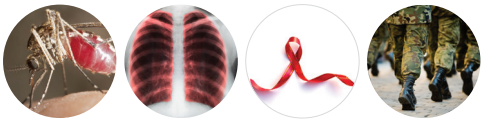
Gender issues are poorly addressed currently in the context of HIV and the military. Generally, women are more vulnerable to HIV infection, and their vulnerability appears to increase in times of conflict. Thus women working in the military appear to face greater risks of HIV infection, compared to men.

UNAIDS proposes that the objective of reducing the vulnerability of female military personnel must feature centrally in HIV and AIDS policies in the military. Policies should emphasise preventive education that includes messages of increased negotiating and communication skills for women, and increased respect for women. Other gender issues, such as sexual harassment, must be included in preventive behavioural change communication initiatives. In times of war and conflict, gender-based violence and rape are often used as weapons of war, placing women at even great risk of infection.

Studies show that male circumcision can considerably reduce the risk of female-to-male HIV transmission. Three randomised clinical trials (in Kenya, South Africa and Uganda) found that the risk of HIV infection in circumcised men was between 51% and 60% less than for their uncircumcised counterparts. (14, 15, 16) Subsequently, WHO and UNAIDS have officially recognised male circumcision as an important part of a strategy for reducing HIV infections.

These findings are of great interest to SADC Member States with high HIV prevalence and low male circumcision rates. The Institute of Security Studies for Africa has been supporting a consultation process to debate the protective effect of male circumcision on HIV infection in the context of militaries. One of the proposed strategies has been to offer male circumcision to a cohort of recruits and then monitor the effectiveness of the intervention. However, militaries are yet to reach consensus on male circumcision as an intervention for HIV reduction.

Unprotected sex between men carries a high risk of HIV infection, especially for the recipient partner. Yet, none of the literature, nor the policies and plans reviewed, addresses this issue in the military context. This presents a number of challenges, which are exacerbated by the stigmatisation of men who have sex with men. There is an absence of evidence-informed studies and policies and programmes for reducing the stigmatisation of sex between men and for dealing with the high risk of HIV transmission associated with this activity.



Monitoring and evaluation of military responses and initiatives, as well as of HIV prevalence and incidence rates among national military forces, are important. Monitoring and evaluation will be part of development and implementation strategies to accelerate prevention and care and campaigns against HIV and AIDS. Kingma, Abramson and Ager-Harris de Soto (1999) have drafted a guiding plan for such monitoring and evaluation. (11) They recommend three objectives that should guide military campaigns against HIV and AIDS, and present a 10-point programme of HIV prevention and care, similar to that of Yeager. (5)

The three objectives are prevention of new HIV infections, female and male condom promotion and provision as an effective barrier method, and efficient treatment, care and support policies. (10, 11)

The 10-point programme provides a minimum standard for military initiatives aimed at combating HIV and AIDS and is outlined below.

Prevention
- HIV and STI prevention education,
- Female and male condom promotion and availability,
- Protection of blood supplies,
- Risk-reduction in health facilities, especially during war times.

Treatment, Care and Support
- Testing and Counselling,
- Continuity of care and support,
- Universal access to all HIV and AIDS and STI interventions.

Impact Mitigation
- HIV surveillance,
- Non-stigmatised environment,
- Civil-military interface policies and practices,
- Gender balance and gender sensitivity.

(Adapted from Kingma, Abramson, & Ager-Harris de Soto, 1999, and SADC Member State national strategic plans, various years)

Member States have formulated national strategic plans and policies to address high AIDS morbidity and mortality rates. A strengths, weaknesses, opportunities and threats (SWOT) analysis was conducted by SADC military health services managers during the inception meeting held in Windhoek, Namibia, in November 2008. Table 2.4 summarises the regional strengths, weaknesses, opportunities and threats identified in relation to HIV and AIDS responses for SADC militaries.

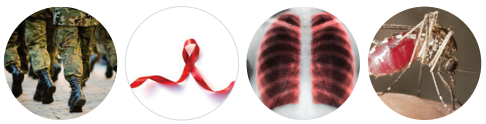
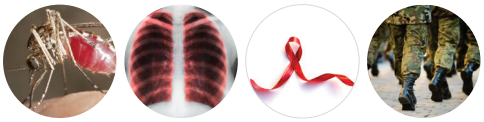


Table 3.4: SWOT analysis of HIV and AIDS responses in militaries in the SADC region

Strengths	Weaknesses
The existence of the Defence chiefs' leadership and political commitment.	Failure to treat health as a command function.
The existence of national HIV and AIDS strategic plans or frameworks facilitates the mainstreaming and harmonisation of the military and national responses to HIV.	National strategic plans of some Member States do not address the military's HIV risk and vulnerability.
National HIV and AIDS policies present foundations for military policies. Military health services work with national AIDS councils and health departments on HIV and AIDS.	There is weak leadership and coordination of policies and plans at military level.
Multisectoral partnerships facilitate the creation and sustainability of civil-military alliances.	Inadequate capacity to implement HIV programmes, especially during deployment and training.
Functional HIV and AIDS programmes in Member State militaries provide a platform for harmonising policies and programmes.	Limited structures for care, treatment and support for military personnel and their families when they are found to be HIV-positive. Policies and strategies are not gender-sensitive, and do not reflect women's vulnerabilities and higher risk of infection.
The military is a disciplined organisation. Guidelines and policies are easily incorporated and adhered to.	High turnover of skilled military personnel complicates effective implementation of HIV policies and programmes.
Military personnel present a "captive audience" for prevention interventions.	In the military, HIV often is not adequately recognised as a security threat. This may increase the HIV risk of soldiers and other military personnel.
Opportunities	**Threats**
Availability of Government, UN, NGO and other funding for policies and strategies, and for monitoring and evaluation. Good working relations with the SADC Health Desk, United Nations agencies, some NGOs and partners.	Current global financial crisis may reduce donor funding for HIV interventions.

3.1.1 Gaps and challenges

- Based on the situational assessment of the military and the SWOT analysis conducted at the inception meeting, the following gaps and challenges have been identified:
- The military is in most cases not involved in the formulation of national strategic plans and policies. Thus, the needs, requirements, and increased vulnerabilities of the military often are not addressed at national level;
- Greater involvement of HIV-positive people and military personnel is needed in the creation of policies and initiatives, including their dependants and civilians that work with the military;
- HIV and AIDS is often not regarded as a security threat that should be addressed with more extensive civil-military alliances;
- The high turnover of skilled personnel may complicate implementing a sustainable and functioning programme to respond to HIV in the military;



- Infrastructure required for implementing policies and programmes for HIV is weak, especially during times of training and deployment; and

- Leadership and coordination of programmes and policies are weak.

3.2 Situational and response analysis for Malaria

Although Malaria has received far less attention than HIV and AIDS and TB, it is one of the leading killers in Africa. In 2007, some 90% of all Malaria deaths occurred in sub-Saharan Africa, according to the Roll Back Malaria Initiative. A few SADC Member States have low numbers of reported Malaria cases. However, military personnel and other mobile populations travelling to Malaria-endemic areas run the risk of infection and, possibly, death due to Malaria. They are also at increased risk of carrying the parasites across SADC frontiers. That threat includes the possible introduction of resistant forms and parasites such as the Plasmodium Vivax, which are not common south of the Zambezi River. Not only are the effects of Malaria debilitating to the military in times of conflict, but the military is often ill-prepared to effectively treat persons who contract Malaria.

The military in SADC therefore faces many challenges in the control, management and elimination of Malaria. Military personnel may be deployed at short notice for combat or peace-keeping. In such instances, it is not always possible to take the requisite, high-level precautionary measures to ensure that military personnel remain Malaria-free.

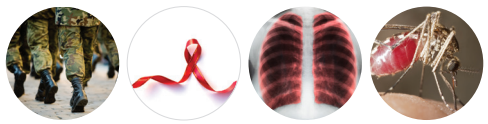
In theory, the strategy is to provide at-risk military personnel with a personal Malaria prevention kit that includes lower-level protectionary intervention methods (steps personnel can take to reduce the chances of being bitten by a mosquito). But personnel from Malaria-free zones (including Lesotho, Mauritius and the Seychelles) do not require pre-deployment screening, which would allow for timely administering of drugs to those who harbour parasites and those who have contracted Malaria. If Malaria is detected prior to deployment, further deterioration of a person's health could be avoided, especially in conflict situations where health facilities and anti-Malarial drugs may not be widely available.

When military personnel do contract Malaria, most SADC Member States attempt to provide universal access to health care facilities and timely provision of effective anti-Malarial drugs in the region. Depending on the security nature of military deployment, however, it is not always possible for the military to carry with them all the required anti-Malarial commodities, especially in conflict and battlefield situations. The emphasis among SADC Member States currently is for the military to ensure under all conditions that all anti-Malarial commodities are available and that there is universal access to Malaria interventions for all military personnel, their dependants and civilians working for the military. Quick evacuation schemes to the nearest healthcare facility must be developed and explained to military personnel during pre-deployment training.

Drug resistance to first-line Malarial treatment is a challenge during military operations. Since the introduction of Artemisin-based Combination Therapy, there is recognition that SADC Member States need to conduct ongoing monitoring of its efficacy by conducting drug resistance studies. However, this requires that the military jointly carries out a review of anti-Malarial and chemoprophylactic drugs, and harmonises policies that apply across borders throughout the SADC region.

All SADC Member States where Malaria is present have developed policies on Malaria. Lesotho, Mauritius and the Seychelles are Malaria-free zones, and have put in place programmes to prevent the re-introduction of Malaria (see the Policy Framework section, below, for details). But none of the SADC Member States Malaria policies and plans specifically mentions the military as a susceptible group (see Table 2.5). On the one hand, it is important that military health policy be set apart from national health policies in order to address the heightened vulnerability of military personnel. On the other hand, due to the comparative advantage of the military in responding to emergency situations, the military should be part of the national response to serious communicable diseases. The military often participate in emergency rapid responses, for example when floods occur. But the aftermath of floods is usually also a high-risk period for Malaria, which points to the need for a wider understanding of the nature of the emergency.

Key practices from SADC Member states in the control and eventual elimination of Malaria include regular campaigns both within the military and in civil society, as well as indoor residual spraying programmes. However, the use of rapid-diagnostic tests has not yet been harmonised in the region, and there is no consensus as to whether rapid diagnostic tests result in the correct diagnosis. Some SADC Member States' military have included educational campaigns on the use of rapid testing, and have reported high levels of accuracy and success. Civil-military alliances and linkages to national Malaria control programmes have been said to be key to the successes of many of these programmes.



3.2.1 HIV and Malaria co-infection

The combined effect of being HIV-positive and having Malaria is not adequately addressed in the strategies and policies of SADC Member States.

Acute Malaria episodes are associated with marked increases in HIV viral load (17), which could facilitate HIV transmission and increase disease progression, especially under battlefield conditions. Co-infection and the negative side-effects that it may cause call for the integration of responses to the three communicable diseases. Additionally, Malaria and HIV and AIDS have a gender dimension, in that women especially pregnant women are more vulnerable to Malaria. Additionally women are biologically, psychologically and socially more vulnerable to infection than are men.

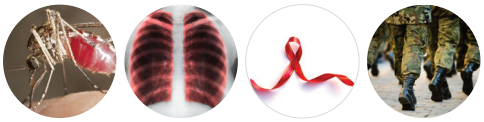
In order to place the policy framework for minimum standards for Malaria in context in the SADC region, national, regional and global responses to Malaria control were examined. Information on the responses was collected through relevant policies, programme documents and from Member States' military health service coordinators.

Table 3.5: SADC Member States strategic plans and frameworks that address Malaria, gender and the military

Country	Malaria policy or strategy	Military specifically mentioned	Gender sensitivity of plan or framework
Angola	Policy	No	Moderately gender sensitive
Botswana	Policy	No	Moderately gender sensitive
Democratic Republic of Congo	Policy	No	Moderately gender sensitive
Lesotho	No policy – Malaria-free zone	No	N/A
Madagascar	Policy	No	Moderately gender sensitive
Malawi	Policy	No	Moderately gender sensitive
Mauritius	No policy – Malaria-free zone	No	N/A
Mozambique	Strategic plan*	No	Moderately gender sensitive
Namibia	Policy	No	Moderately gender sensitive
Seychelles	No policy – Malaria-free zone	No	N/A
South Africa	Policy	No	Moderately gender sensitive
Swaziland	Policy	No	Moderately gender sensitive
Tanzania	Policy	No	Moderately gender sensitive
Zambia	Strategic plan*	No	Moderately gender sensitive
Zimbabwe	Policy	No	Moderately gender sensitive

** The presence of a strategic plan includes the availability of a policy on Malaria control.*

There are a number of regional and global normative documents, which can directly or indirectly assist in the development of minimum standards for Malaria in the military in the SADC region. Table 2.6 provides a summary matrix of global and regional policies and strategic plans that explicitly mention the military as a target population in the context of Malaria. These policies outline key objectives and strategies for the control and eventual elimination of Malaria, and recognise the military as a vulnerable group.



These policies should include three key activities:

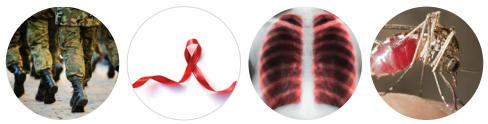
- The control of Malaria;
- The eventual elimination of Malaria; and
- The development of new research approaches to support vector control and elimination.

Specifically, long-lasting nets and indoor residual house spraying are the main vector control methods. Microscopy and rapid diagnostic tests (RDTs) and anti-Malarial treatments (such as ACT) have been identified as key actions that should be introduced in Africa.

In order to implement strategies to control and eventually eliminate Malaria, several core areas that need strengthening have been identified: human resources, monitoring and evaluation systems, and emergency responses.

Table 3.6: Global and regional policy and strategy documents that specifically deal with Malaria within the military

Document	Regional or global	SADC Member States included	Main objectives
WHO Malaria Action Plan	Global and regional	All except Seychelles, Lesotho and Tanzania	Control and eliminate Malaria, develop new research tools and approaches
SADC Military Health Service Working Group and Military Malaria Managers	Regional	All	Facilitate cooperation in times of national and regional disasters and epidemics, joint training, exchange of expertise and participation in regional health programmes
Military Support for SADC and National Programmes from Malaria Control to Elimination (2008-2015) in the SADC Region	Regional	All	Support national and SADC health programmes to reduce the burden of Malaria, reduce and confine the geographical extent of Malaria-endemic areas in southern Africa, and prevent import and export of Malaria by military involved in external deployment missions
SADC Malaria Strategic Plan 2007-2015	Regional	All	Implement harmonised policies, guidelines and protocols for the provision of Malaria control services; mobilise funding for Malaria control programmes; establish a solid partnership and collaboration mechanism for Malaria control in SADC Member States; energise and support SADC Member States to eliminate Malaria nationally
SADC Gender Policy	Regional	All	Develop and implement gender-sensitive policies and programmes that address critical health issues affecting the population, including HIV and AIDS, Malaria, TB, other communicable diseases, and STIs
African Malaria Network Trust Strategic Plan (2007-2011)	Regional	All	Create and foster global awareness of the African Malaria burden; research and development of Malaria intervention tools; promote collaboration with key stakeholders including policymakers, the Multilateral Initiative on Malaria, operational health personnel and national Governments



Regional and global policies of specific interest are the *SADC Malaria Strategic Plan (2007 - 2015)*, the *WHO Global and Regional Action Plans* and the *Military Support for SADC and National Programmes from Malaria Control to Elimination (2008-2015) in the SADC Region* (see Table 7).

The *Military Support for SADC and National Programmes from Malaria Control to Elimination 2008-2015 in the SADC Region* document (also known as the *Military Support Action Plan*) is complemented by the *SADC Malaria Strategic Plan*. (18, 19) Both documents outline programmatic strategic areas that inform the development of the current minimum standards, and policy framework for the military in SADC to contribute to the control and eventual elimination of Malaria.

Additionally, at the SADC Military Health Services' fourth Malaria managers' meeting in Gaborone, Botswana, in 2007, SADC Member State representatives agreed to several action points. These were aimed at reducing the regional Malaria transmission rate, as well as controlling the disease within the military, and were approved by SADC Member States Military Health Services Chiefs. They outlined key minimum standard requirements that should feed into both the *SADC Malaria Strategic Plan* and the *Military Support Action Plan's* objectives and programmatic areas. Included in the Malaria control component of both plans are the various stages of control, Malaria pre-elimination, elimination, certification and prevention of re-introduction.

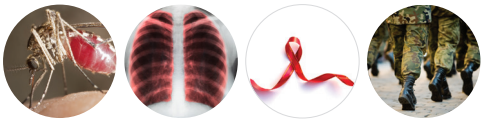
The WHO has also developed regional and global strategies aimed at controlling Malaria. SADC Member States participated in the development of these strategies. The action plan stipulated by SADC and the military health services complement the WHO strategies, which outline key, approved interventions for Malaria control in Malaria-endemic countries.

3.2.2 SWOT analysis of current regional Malaria responses for the military

Military health service managers conducted a SWOT analysis during the inception report meeting held in Windhoek, Namibia, in November 2008. Table 2.7 summarises the regional strengths, weaknesses, opportunities and threats identified for the military in relation to Malaria responses in the SADC region.

Table 3.7: SWOT analysis of policies related to combating Malaria in militaries in the SADC Region

Strengths	Weaknesses
Almost all SADC Member States have national Malaria control policies. In addition, the military can use the SADC Protocol and plans as a basis for Malaria interventions.	National Malaria control programmes are silent on military policy and gender issues. The policy is also inconsistent on various Malaria control issues. Similarly, the SADC Protocol on Gender and Development is silent on gender issues pertaining to Malaria.
The SADC Military Malaria Group exists. The Group can link all SADC Member States' militaries and help harmonise policies and programmes in the region.	No strategies or guidelines have been approved, and structures in the military required for future implementation of approved strategies and guidelines are incomplete.
Similar Malaria interventions are evident among SADC member states, which may make it easier to harmonise policies and minimum standards across the region.	Generally, there has been slow implementation of protocols, lack of standardised strategies, network mechanisms and weak partnerships. Weak infrastructure is exacerbated by a lack of human and financial resources.
There is political support from the Ministries of Health and Defence in all SADC Member States. This can be used for political leverage and can assist the implementation and harmonisation of minimum standards in the region.	
An annual Malaria regional calendar exists. It could be added to a map to make it easier for military personnel to locate Malaria-endemic areas and periods.	



The SADC Protocol on Gender and Development is available to guide gender-sensitive policies and programmes in SADC Member States, and in the region as a whole.	
Opportunities	**Threats**
There is increased capacity at the national level, and this could be an opportunity to strengthen the military's capabilities to respond to Malaria at the regional level.	The integration of programme business plans has been weak.
The military in the SADC region belongs to a number of regional interventional bodies.	

3.2.3 Gaps and challenges

Based on the situational assessment on Malaria in the context of the military, and the SWOT analysis, the following gaps and challenges have been identified:

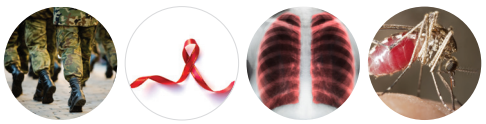
- HIV-seropositivity and co-infection with Malaria has not been adequately addressed at the national and regional level;
- Descriptions and outlines of how programmatic areas are to be accomplished within the military have not been achieved, and these require strong leadership commitment, as well as increased financial and human resources;
- Military personnel's dependants and kin are often not included in strategies and plans;
- None of the SADC Member States includes the military as a high-risk group in its policies or strategies;
- Gender issues, such as Malaria infection on female military personnel who may be pregnant, are not specified in programmes and policies, and gender issues in relation to Malaria are not addressed in regional plans and policies;
- The inability to take high-level precautionary measures when military personnel are deployed quickly in high Malaria endemic areas may increase their risk;
- Often during times of conflict and war, national health systems collapse and the military are then required to provide interim health care services. This may deplete funds and human resources that are already strained.

3.3 Situational and response analysis for Tuberculosis

TB contributes significantly to mortality in sub-Saharan Africa. In 2005, the TB mortality rate in this region was 74 per 100 000 people; by 2007, it had increased to 93 per 100 000. (20, 21) In 2007, almost 1.3 million new TB cases were reported in the SADC Member States.

TB has become increasingly deadly, largely due to the susceptibility of persons with HIV to TB infection and illness. TB is also becoming increasingly drug-resistant, with the numbers of multidrug-resistant (MDR-TB) and extensively drug-resistant TB (XDR-TB) increasing alarmingly.

The burden of TB mortality and morbidity in the SADC region is high. Five of the 15 SADC Member States (Democratic Republic of Congo, Mozambique, South Africa, Tanzania, and Zimbabwe) are included in the WHO's list of the 22 highest-burden countries for TB. (22) This threatens not only those Member States but also the entire region, given the mobility of people and personnel. During peace-keeping or combat missions, military personnel travel between the high-burden and low-burden countries, with obvious implications for the spread of TB.



The general lack of human and financial resources, as well as weak healthcare systems, has exacerbated the burden of TB in the SADC region. The military are often deployed in areas in where healthcare systems are either weak or non-existent, due to conflict or emergencies. Military health services are thus not always able to effectively implement TB control interventions.

Although almost all the SADC Member States have moved to combat or control TB, those efforts are increasingly undermined by the impact of high rates of co-infection of TB and HIV. (23) Table 2.8 shows the TB prevalence in absolute numbers among persons living with HIV in the SADC Member States.

Table 3.8: TB prevalence in persons with HIV, SADC Member States, 2007

Country name	TB prevalence
Angola	4,544
Botswana	4,707
Democratic Republic of Congo	7,216
Lesotho	4,827
Madagascar	598
Malawi	16,396
Mauritius	9
Mozambique	21,838
Namibia	5,347
Seychelles	N/A
South Africa	167,799
Swaziland	5,490
Tanzania	28,116
Zambia	20,977
Zimbabwe	35,980

Sources: WHO, Global Tuberculosis Control: Epidemiology, Strategy, Financing, 2009, available at: http://www.who.int/tb/publications/global_report/en/index.html.

The WHO has been leading TB control in the African region and globally. All SADC Member States have implemented WHO recommendations, and many have set targets based on those recommendations. Some SADC Member States have declared TB an emergency. Regionally, the SADC Secretariat has also provided a strategic plan for TB control in the SADC region. These documents as well as the national programmes, policies and strategies that currently exist, share key concerns and outlooks, and stipulate similar strategies and interventions to control TB.

Since national policy guidelines for TB control are based on WHO norms, standards and guidelines, many of the SADC Member States already pursue similar TB control initiatives. For example, 14 Member States have included the WHO-recommended Directly-Observed Treatment, Short Course (DOTS) strategy for case-detection and treatment in their national policies and plans. The DOTS strategy has become a standard for comparing the performance of countries' TB control efforts. This also provides an environment conducive to the development and implementation of TB control minimum policy standards in the SADC military. The DOTS strategy has had high rates of treatment success in most of the SADC countries (see Table 2.9), although some countries have faired better than others.

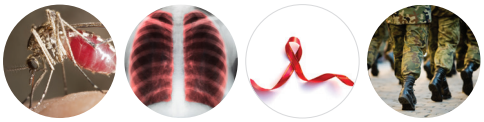


Table 3.9: Percentage of DOTS new smear-positive treatment success in SADC Member States (2007)

Country Name	Number
Angola	18
Botswana	72
Democratic Republic of Congo	86
Lesotho	66
Madagascar	78
Malawi	78
Mauritius	92
Mozambique	83
Namibia	76
Seychelles	--
South Africa	74
Swaziland	43
Tanzania	85
Zambia	85
Zimbabwe	60

Source: Adapted from WHO, Global Tuberculosis Control: Epidemiology, Strategy, Financing, 2009. Available at: http://www.who.int/tb/publications/global_report/en/index.html.

Nutritional programmes and the provision of clean and ventilated accommodation have been implemented as a TB control measure in the military in at least two SADC Member States. Another key control measure is advocacy and mediation of TB control through civil-military alliances. In order for this to be effective, information, education and communication materials (such as booklets, posters, pamphlets, CDs and educational games) have been created and are provided to military personnel and civilians. In addition to printed materials, at least one SADC Member State has extended its efforts to radio, television, the internet and call centres.

Prevention measures among some Member States include active and passive case finding, as well as contact tracing, all of which is synchronised with the use of community health workers and call-in centres. Such measures have been shown not only to raise awareness and increase prevention measures, but are vital for increasing rates of treatment adherence.

Table 2.10 shows which SADC Member States have a policy, strategic plan and programme available for TB control, and whether the military are included: 14 of the 15 SADC Member States have some form of programme, policy or strategic plan for TB.

Three Member States have developed national strategic plans to control TB, while one has a joint HIV and AIDS and TB strategic plan. At least one country has identified “strategic pillars” for controlling and, eventually, eliminating TB. The pillars include the reduction of poverty and improvements in living and working conditions. The latter is pertinent to the military, since military personnel often live in less than optimal barracks and other living quarters, which may facilitate the spread of TB.

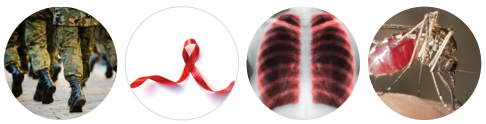


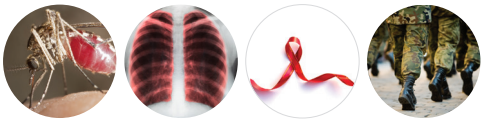
Table 3.10: SADC Member States' strategic plans and frameworks that address TB, gender and the military.

SADC Member State	TB policy or plan	Military specifically mentioned	Gender sensitivity
Angola	National programme	No	Not gender sensitive
Botswana	National TB policy	No	Not gender sensitive
Democratic Republic of Congo	National programme	No	Not gender sensitive
Lesotho	National programme	No	Not gender sensitive
Madagascar	National programme	No	Not gender sensitive
Malawi	National programme	No	Not gender sensitive
Mauritius	No policy	N/A	N/A
Mozambique	National strategic plan, (2008-2012)	No	Moderately gender sensitive
Namibia	National programme	No	Not gender sensitive
Seychelles	National programme	No	Not gender sensitive
South Africa	National strategic plan (2007-2011)	Yes	Moderately gender sensitive
Swaziland	Included in the national HIV strategic plan only	No	Moderately gender sensitive
Tanzania	National TB policy	No	Not gender sensitive
Zambia	Joint HIV and AIDS and TB national strategic plan	No	Moderately gender sensitive
Zimbabwe	Yes	Yes	Highly gender sensitive

Note: Plans and frameworks were deemed "not gender sensitive" if they made no reference to either gender or gender-differentiated needs; "moderately gender sensitive" if they made reference to gender but did not provide detailed information; and "highly gender sensitive" if they provided extensive detail on issues pertaining to gender and the different needs of men and women.

The military does not have a specific TB control programme, but many of them do follow their country's national plans and policies. However, as is the case with Malaria and HIV and AIDS, these policies and plans often do not account for the specific vulnerabilities faced by military personnel. They also do not provide significant and relevant prescriptions that pertain to gender. Only one SADC Member State has included the military in its TB strategic plan and control programme. One of the key objectives is to prevent the spread of infection by implementing infection control measures in barracks and hospitals. Other strategies include ensuring early detection of TB and contact tracing, appropriate treatment and referral of personnel with TB, increased awareness of TB, and reporting of TB cases. The programme also stipulates the provision of care for civilians where military health services facilities are more accessible than Department of Health ones.

MDR-TB and XDR-TB pose huge challenges. All the SADC Member States have scaled up or are busy scaling up efforts to address the increases in MDR- and XDR-TB cases. A lack of resources remains a major difficulty, though. In order to monitor and evaluate whether their control and detection programmes are successful, Member States have implemented the WHO-recommended DOTS strategy. A number of countries have also invested in training healthcare professionals to perform all the required activities (including training in MDR-TB, DOTS surveillance, and the routine screening for TB among HIV patients).



WHO's *Strategic Plan for Tuberculosis Control for the African Region (2006-2010)* outlines a number of interventions to address the challenges associated with TB control in the African region. (23) Even though the military are not specifically mentioned in the WHO plan, it applies broadly to the military, as well. WHO emphasises that there should be a strengthened commitment from political leaders for TB control, and increased training and funding for TB control activities. Furthermore, since poverty reduction and TB control go hand-in-hand, poverty reduction activities need to be included.

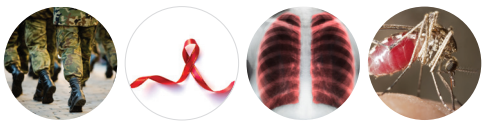
The convergence of the AIDS and TB epidemics makes it vital for countries to roll out TB and AIDS collaborative activities. This requires more trained health personnel, the improvement and expansion of laboratory networks, the strengthening of political will and commitment (nationally and regionally), and the forging of public and private partnerships – such as between civilian and military organisations. (23)

The *SADC Strategic Plan for the Control of Tuberculosis in the SADC Region, 2007-2015* draws conclusions and recommendations similar to those of the WHO, and emphasises the dual TB and AIDS epidemics, and the increase in MDR-TB cases as key challenges. (22) The military in the SADC region largely follow the policy recommendations, objectives and goals set out in the SADC plan, which highlights the following interventions:

- Harmonise of policies, strategies and guidelines for the control of TB;
- Develop a regional laboratory quality-assurance system for TB microscopy, culture and drug susceptibility testing;
- Prevent and manage all forms of MDR-TB and XDR-TB;
- Establish a regional mechanism for TB and HIV and AIDS collaborative activities, private-public mix and community participation in TB care;
- Develop an effective drug supply and management system;
- Support and advocate for research and development for new tools for TB control;
- Achieve consensus on regional policy, strategy, frameworks and guidelines.

(SADC Strategic Plan for the Control of Tuberculosis in the SADC Region, 2007-2015 2007)

The development of the WHO and SADC strategic plans for TB control was informed by the *Regional Committee for Africa Resolution on TB Control* (1994). (24) This led to the incorporation of the WHO-recommended DOTS Strategy in African countries. Similarly, the *Strategic Orientations for WHO Action in the African Region (2005-2009)* outlines activities of support for TB control from the WHO to African countries. (25) Table 2.11 summarises global and regional documents for TB control, which include the SADC region.Table 3.11: Global and regional strategies and plans for TB control



Policy name	Includes SADC region	Main objectives
SADC Strategic Plan for Control of Tuberculosis in the SADC Region, 2007-2015	Yes	Accelerate the reduction of morbidity, mortality and spread of TB by 2015 in the SADC region in line with the MDGs and WHO's Stop TB Partnership targets.
WHO Strategic Plan for Tuberculosis Control for the African Region, 2006-2010	Yes	Accelerate the reduction of TB-related morbidity and mortality towards the achievement of the TB-related MDG targets by 2015.
Regional Committee for Africa Resolution on TB Control (1994)	Yes	Adopt a countrywide implementation of the DOTS strategy by all Member States.
SADC Gender Policy	Yes	Develop and implement gender-sensitive policies and programmes that address critical health issues affecting the population; including HIV and AIDS, Malaria, TB, STIs, and other communicable diseases.
Strategic Orientations for WHO Action in the African Region, 2005-2009	Yes	Establish health policies, technical guidelines, norms and standards; provide technical policy advice; contribute to sustainable capacity building; strengthen management capacity; and provide health leadership.

3.3.1 SWOT analysis of regional TB responses in the military

Senior military health professionals from SADC Member States conducted a Strengths, Weakness, Opportunities and Threats (SWOT) analysis of policies on the three communicable diseases during the inception meeting held in Windhoek, Namibia, in November 2008. Table 12 presents the results of the analysis in relation to TB. The issues identified have been complimented by the findings of the literature review of the national, regional and global strategies and plans for TB control in the context of the military in the SADC region.

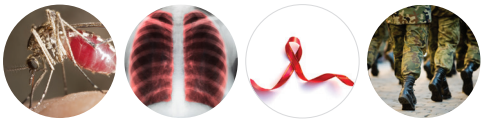


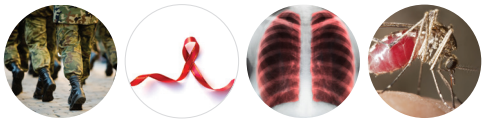
Table 3.12: SWOT analysis of policies for combating TB in SADC militaries

Strengths	Weaknesses
Most SADC Member States have implemented national TB policies, which may facilitate harmonisation of national and regional standards.	Several diagnostic shortfalls exist and capacity is inadequate.
Access to effective treatment (DOTS) throughout the region is good, and may facilitate the implementation of regional minimum standards and access to such treatment for the military, irrespective of deployment areas.	Current policies and guidelines do not permit disciplinary action against defaulters, and there is an overall lack of military-specific policies and guidelines.
Staff are available for training to build capacity for improved TB detection and management.	The long duration of treatment makes it difficult for military personnel to adhere to treatment regimes during deployment. Aggravating this is the generally weak knowledge and awareness of TB as a disease, its consequences, its link to AIDS morbidity and mortality, and available treatment options.
	Currently, there is no capacity to detect MDR-TB timeously, and thus no timely management.
	Health systems in the region are weak and drug supplies are unreliable. This is exacerbated by shortages of financial and human resources for implementing TB control activities for the military, their dependants and civilians that work with them.
	There is a lack of agreement on intermittent preventive treatment, and on which drugs should be used; second line treatment for MDR-TB is absent in some Member States.
Opportunities	**Threats**
TB can be an indicator for HIV testing and if a patient is also HIV-positive, it can inform the timing of antiretroviral therapy initiation.	The emergence and increased incidence of MDR- and XDR-TB.
	Cases have been reported of misconduct by private practitioners who do not refer patients in time for government institutions for provide TB treatment.

3.3.2 Gaps and challenges

Based on the situational assessment on TB in the context of the military and the SWOT analysis, the following gaps and challenges have been identified:

- Adherence to treatment remains a challenge in combat situations and during deployment;
- The increase in MDR- and XDR-TB has boosted the need for universally agreed upon second-line treatments;
- HIV and TB co-infection has increased;
- Stigma and discrimination against persons with TB, and its association with HIV infection, are not adequately dealt with in national policies and plans; and
- There are insufficient trained healthcare professionals and financial resources available to care and support TB-infected military personnel and their dependants.



4. CONCLUSION

The military in the SADC region are highly vulnerable to HIV, TB and Malaria. Yet the distinct vulnerabilities the military encounter have not been addressed appropriately at a regional level. The situation and response analysis has found a number of linkages between the three communicable diseases and the military, and identified ways in which minimum standards can be applied at a regional level to control HIV, TB and Malaria.

These vulnerabilities include the fact that the military are a mobile population that is often deployed away from home and kin for long periods, which can facilitate the spread of infection and complicate adherence to treatment. Increasing interaction with dependants of military personnel, and between the military and civil society are core factors for the success of the proposed minimum standards.

5. RECOMMENDATIONS

The situation and response analysis provides the foundation for the regional minimum standards. The minimum standards are treated as minimum policy requirements for harmonising SADC Member State responses to HIV and AIDS, TB and Malaria in the military.

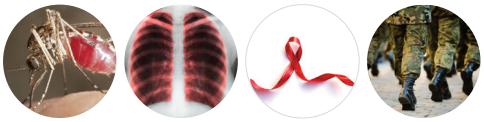
This does not limit the national military to only implement the regional minimum standards; additional policies and interventions may also need to be implemented, depending on the circumstances. In addition to the regional minimum standards (outlined in the Regional Minimum Standards for Communicable Diseases Policies for the Military in the SADC), the following recommendations are made:

5.1 HIV and AIDS

- Health should be regarded as a command function, given the importance of treatment adherence and the large numbers of defaulters in the region, which impedes military and peacekeeping operations.
- Member States should include the military in planning and implementing the various stages of their strategic plans, in order to assure that the particular vulnerabilities and needs of the military are taken into account.
- Political leadership and the coordination of plans and policies should be strengthened.
- Financial and human resources should be mobilised at a national level to ensure that the programmes and minimum standards that are implemented work efficiently and benefit the military, their dependants and the civilians they serve.
- Structural and support programmes for military dependants should be strengthened.
- Multisectoral and military-civil alliances should be created and supported. This will ensure that both the military and the civilian population have goals and programmes that are aligned.
- Policies and guidelines should incorporate a more gender-sensitive perspective, taking into account female military personnel's specific vulnerabilities.
- Member States should attempt to train and retain skilled staff to ensure continuity and high-quality prevention, treatment, and care and support for military personnel and their dependants.

5.2 Malaria

- The military should be involved in formulating and implementing national Malaria control programmes to ensure that their particular vulnerabilities and needs are addressed.
- Special attention to the realities of female military personnel should be assured, in order to formulate gender-sensitive programmes that cater for their particular needs.



- Political will and leadership should be strengthened to ensure the adoption of the relevant protocols, standardised strategies and structures within the military that are required for the full and successful implementation of the minimum standards.

- Requirements to be fulfilled from external donors and funders should be aligned to regional and national requirements, as determined by the military and its national government.

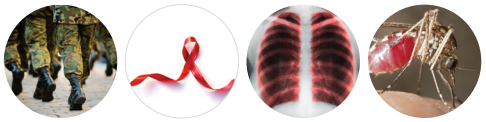
5.3 Tuberculosis

- Capacity should be built to overcome diagnostic shortfalls and increase the rate of detection of TB among military personnel.

- Alternative treatments or ways in which treatment may be shortened should be researched, given the effects of lengthy TB treatment during deployment on treatment adherence.

- Guidelines and protocols for disciplinary measures for malpractices by private doctors who do not refer military patients timeously for proper TB treatment should be formulated and enforced.

- Clinical guidelines should be established in order to harmonise case detection and finding, case tracing and treatment options.



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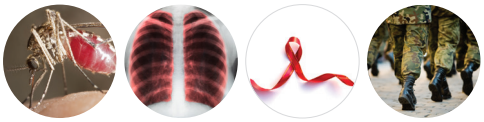

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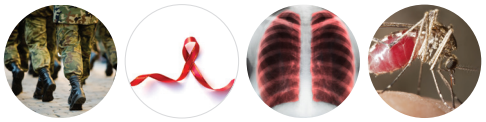

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National Strategic Plans for Malaria Control for: Angola; Mozambique; and Zambia,

Directorate of Social & Human Development & Special Programs SADC Secretariat

Private Bag 0095
Gaborone, Botswana
Tel: (267) 395 1863
Fax: (267) 397 2848
Email: registry@sadc.int
Website: www.sadc.int

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