PERCEPTIONS OF THE IMPACT OF HIV/AIDS ON THE OPERATIONAL CAPABILITY OF THE INFANTRY SECTION

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Declaration

I the undersigned, hereby declare that the work in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

ABSTRACT

HIV/AIDS is spreading through Africa in epidemic proportions. Hundreds and thousands of people are infected on a daily basis. This pandemic destroys the emotional and physical strength of individuals. In Sub-Saharan Africa there is an estimated 28,1 million people living with HIV/AIDS. The military forces of Africa are not immune to this. Growing concern has shifted the focus of HIV/AIDS to the armed forces because they generally have higher levels of HIV/AIDS than the civilian population. Within the military it is critical that HIV/AIDS be managed in a manner that retards the spread of the virus as well as the negative impact that it has.

The cornerstone of combat efficiency within the SANDF is its infantry section, a group of people forming the basis for the rest of the operational force structure that is deployed within an operational area. The deployment areas are dangerous and unstable and are conducive to the spread of HIV/AIDS. When forces are deployed within the operational area, they forge a bond built on trust, loyalty and a confidence in each other's work capability. HIV/AIDS impacts on this capability and results in an environment characterised by low morals, discrimination and stigma. The important element is to make soldiers aware of the implications of HIV/AIDS, and the perceptions that exist about people living with the disease. The success lies in the correct management in terms of prevention and protection.

A clear understanding of the disease is the most important element in starting an effective prevention programme. People have to understand that HIV/AIDS is not only a medical problem, but also has far-reaching social and security implications. It not only affects the infected but also their families, relatives and friends. The infection has an enormous social impact that should not be underestimated. If left unchecked, HIV/AIDS will cripple the SANDF.

OPSOMMING

MIV/VIGS word tans in Afrika deur duisende mense versprei en bereik epidemiese vlakke. Hierdie virus val die mens se fisiese en geestelike krag aan. In Afrika benede die Sahara is daar omtrent 28,1 miljoen mense wat met MIV/VIGS leef. Die militêre mag van Afrika is nie imuun teen die stryd. Grootskaal se kommer is gefokus op die gewapende magte van Afrika omdat die militêr geneig is om meer MIV/VIGS positiewe mense te hê as die siviele omgewing. Binne die militêr is dit krities dat MIV/VIGS op so 'n manier bestuur word dat die verspreiding van hierdie siekte belemmer word.

Die infanterie seksie is die hoeksteen van vuurkrag effektiwieteit binne die SANW. Hierdie seksie is die fondament van die operasionele mag wat binne operasionele gebiede ontplooi word. Hierdie gebiede word gekenmerk deur gevaar en onstabiliteit wat die verspreiding van MIV/VIGS vergemakilk. Wanneer hierdie mag ontplooi word, is dit op die beginsel van vertroue in mekaar, lojaliteit en in 'n geloofwaardigheid in mekaar se werksvermoë. MIV/VIGS impak direk op hierdie beginsels en veroorsaak 'n omgewing wat deur lae morele waardes, diskriminasie en negatiewe persepsies gekenmerk word. Dit is belangrik dat die soldaat ingelig word oor die persepsies en impak wat MIV/VIGS moontlik kan hê. Die korrekte bestuur sal die mate van sukses bepaal hoe hierdie virus gehanteer kan word.

'n Volle begrip sal die deurslaggewende beginsel wees in die effektiewe beheer van MIV/VIGS word. Mense moet verstaan dat MIV/VIGS nie net 'n mediese probleem is maar dat dit ook 'n verreikende effek het op die sekuriteit en sosiale dele van ons lewens. Dit impak ook op die families van die wat siek is, en die impak moet nie onderskat word nie. Die SANW sal tot sy knie gebring word sou hierdie virus onbepaald voortgaan.

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CHAPTER 1: INTRODUCTION

"We stand nakedly in front of a pandemic as mortal as any pandemic there has ever been." Halfdan Mahler (1987:1).

1.1 Background to HIV/AIDS

"The Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) pandemic and its specific appearance in military forces presents military strategists and tacticians with command responsibility that, if ignored, could be to their professional and personal detriment" (*Department of Defence*, 2000: 28/1). HIV/AIDS affects individuals emotionally and physically: emotionally as such individuals have to come to terms with the fact that they have been infected with a terminal disease as well as with the ever-present fear of victimisation; and physically as their strength weakens, they are unable to fight common viral infections such as colds and influenza and as sores break out in and on their bodies. Only after infected people have dealt with these can they pay attention to their working environment, which has its own set of politics and fears.

HIV/AIDS is an issue of personal security, threatening people's lives, health and family structure, and also the wellbeing of individuals and entire communities, including the defence community. Aids is almost entirely responsible for the fact that life expectancy has dropped by over 20 years in 10 African countries, wiping out the gains of 30 years of development. UNAIDS reports that if a country has an Aids prevalence rate above 15%, which currently includes South Africa and other countries south of the Sahara, it can be expected that between one-third and one-half of boys now aged 15 will inevitably die from Aids (International Crisis Group, 2001: 4).

Sub-Saharan Africa remains the region most severely affected by HIV/AIDS. Approximately 3,4 million new infections occurred in 2001, bringing to 28,1 million the total number of people living with HIV/AIDS (PLWHAs). According

to the South African Ministry of Health, about one in nine South Africans (or 4,7 million people) are living with HIV/AIDS. Furthermore it is estimated that the vast majority of Africans living with HIV are not aware that they are infected with the virus (UNAIDS, 1998: 3). This increases the potential for spreading the virus because if people do not know they have been infected, they will not be concerned about spreading the virus. The growing concern about HIV/AIDS includes a shift in focus onto HIV/AIDS in the armed forces, for a number of reasons (Whiteside, 1996: 12):

- The armed forces generally have higher levels of HIV/AIDS than the civilian population and may play an important role in the spread of the virus.
- In many parts of the developing world, the military are important for national stability, and losing large numbers to HIV/AIDS will affect their ability to perform this role.
- The UN and other multi-national forces increasingly use military forces in peacekeeping operations. This poses a real risk that soldiers might contract and spread HIV/AIDS in the region where they are deployed.

This may imply that the military could play an important role in HIV prevention programmes, not only among the soldiers and their families but also in civil society at large. Educating soldiers means that they can educate others because of the high level of contact soldiers have with civilians in for instance deployment areas.

"Military forces are among the world's most susceptible populations to HIV/AIDS" (Yeager et al., 2000: 87), yet the armed forces are the basis of a country's defence. If the disease debilitates them, it raises important questions about national and international security. The armed forces in Botswana, Uganda, Zimbabwe and Malawi have such high rates of HIV infection that they are unable to deploy a full contingent, or even half of their troops, at short notice. In complex ways, the epidemic plays a role in power struggles, for

example where states are unable to protect state sovereignty or maintain civil order, particularly in cases where the armed forces have become debilitated by the disease (Heinecken, 2000(a): 1). It is obvious that this effect may prevent a defence force from performing its role within its area of responsibility.

In the military environment, the high percentage of young males contributes to risky sexual behaviour. This is most common in the military where troops are deployed far from their homes. In addition, emerging countries such as South Africa typically have high levels of poverty and low levels of education, with the result that people take greater risks and engage in commercial sex or prostitution (Rezelman, 2002: 14). When soldiers are separated from family ties and moral obligations, many of them seek companionship from other sources. The mobilisation and reintegration of infected soldiers threaten their communities when they return home (Forman & Carballo, 2000: 1). Based on these facts, it is clear that the military environment encourages this type of behaviour, leading to an accelerated spread of HIV/AIDS as well as a greater chance of becoming infected.

The South African Civil-Military Alliance is an initiative to combat HIV/AIDS and emphasises the point that armed force personnel are at special risk for a number of reasons (Ingham, 2000:2):

- Military personnel are often away from home for long periods of time, and disruption in the home environment translates into a risk factor.
- Military personnel operate under conditions of high stress and emotional strain. Therefore they often seek recreation to relieve their stress and loneliness.
- Defence force members are at an age when they may have feelings of invulnerability, especially in a profession that condones or even encourages risk taking. This complicates prevention and education strategies; where long-term problems such as chronic disease take

second place to the immediacy of sudden death in operational situations.

- Military personnel, camps and installations are known to attract sex workers because off-duty soldiers generally have cash in their pockets.
- Furthermore, such military camps will always operate in times of conflict, since the defence force is responsible for maintaining stability in regions where there is conflict.

1.2 Statement of the problem

The infantry section is the smallest operational combat unit in the Infantry Corps. Comprising only ten men / women, this is a close-knit unit whose members depend entirely upon one another during deployment. This research project endeavours to assess the perceptions of members of the infantry section and obtain their views on how HIV/AIDS affects the operational capability of this combat entity. During combat or operational conditions, these ten persons will be deployed in close proximity for long periods of time. They may also be deployed independently to execute certain tasks. During such situations these members have to take care of themselves, ranging from protection to preparation of food. Each member in the unit relies on the other to give their best towards executing their mission.

This study examines the perceptions of HIV/AIDS among members of the infantry section and the impact that these perceptions may have on the operational capability of this fighting unit.

The specific objectives are as follows:

- To provide a selected theoretical overview of HIV/AIDS;
- to briefly describe how HIV/AIDS has affected the military; and
- to analyse the responses of members of the various infantry sections of an operational battalion regarding HIV/AIDS.

1.3 Methodology

The methodology used in this study can be viewed as of a quantitative nature. It entails a survey, which Mouton (2001:152) describes as "studies that are usually quantitative in nature and which aim to provide a broad overview of a representative sample of a large population". This survey also employs a case study approach, as it relates to a specific grouping within the South African National Defence Force (SANDF), which executes a specific task. This sample was selected due to the fact that this unit deploys operationally within the borders of the country. Although this sample does not characterise all units throughout the country, certain lessons can be learnt from it.

1.4 Research instrument and sample

The research instrument utilised during the survey was in the form of self-administered questionnaires. The infantry unit used as a sample of soldiers in the Infantry Battalion was based in the Western Cape, however due to the unique deployment responsibility of the unit it cannot be regarded as representative sample of an infantry battalion of the SANDF. In October 2003 the questionnaire was administered in an auditorium to the members of this infantry unit. The respondents were briefed about the rationale of the research project. It was stressed that their participation was voluntary and that their responses would be treated in the strictest confidence. This confidentiality was complemented by the fact that the questionnaires were completed anonymously. The questionnaire was administered to a total of 92 (n=92) respondents. Table 1 presents the group's composition by race, gender and age.

Table 1

Race, age and gender of respondents

Age	M/F	African	Asian	Coloured	Indian	White	Total
<21	M	0	0	0	0	0	0
	F	0	0	0	0	0	0
21-25	M	1	0	2	0	0	3
	F	0	0	0	0	0	0
26-30	M	21	0	5	0	0	26
	F	1	0	0	0	0	1
31-35	M	28	0	10	0	0	38
	F	1	0	0	0	0	1
36-40	M	21	0	0	0	0	21
	F	0	0	0	0	0	0
>40	M	2	0	0	0	0	2
	F	0	0	0	0	0	0
						Total	92

1.5 Questionnaire

As the field work centred on the use of a questionnaire, it was important to design the questionnaire so that the precise information required could be obtained. During this research, a pilot study was preceded by focus group discussions, which assisted the researcher to formulate the questionnaire correctly. The focus group discussions were held with members of a group at two other units in order to obtain various perspectives. The discussions were based on the type of questions that should be asked to obtain the information required. The draft questionnaire was distributed during the discussions during which the group members analysed the various questions for relevance. Mouton (2001: 103) states that it is important to do a pilot study of a questionnaire before it is administered, as the pilot study will assist the researcher to obtain the required results. He adds that bias is a potential weakness in the research, and Brynard and Hanekom (1997: 38) also refer to the disadvantage of bias and distorted answers. A structured questionnaire

was used in order to obtain an objective view, to prevent such bias and to minimise the researcher's bias.

The questionnaire was divided into two sections containing 32 questions that were coded, captured and analysed. The questions in Section A obtain biographical information about the respondents. This information was required to distinguish between the various subgroups taking part in the survey. Section B contains questions dealing with the respondents' perceptions of HIV/AIDS and how they felt it would affect the operational capability of the infantry section. The majority of the questions were structured and required either a yes or no as an answer. Various open-ended questions elicited comments and requested the respondents to give reasons for their answers.

1.6 Structure of the assignment

This research paper is structured in a manner that first addresses the theory and then the practical implications of the theory. Chapter 2 covers a general insight into HIV/AIDS with specific reference to definitions, health conditions, the dangers of HIV/AIDS and the modes for transmitting the infection. Chapter 3 concentrates on HIV/AIDS in the context of the military forces. This enables some important issues to be identified, which should be taken into account when military forces deploy. The findings of the survey are discussed in Chapter 4. Finally Chapter 5 contains some concluding remarks and recommendations.

CHAPTER 2: HIV/AIDS

"HIV/AIDS is a global threat. A threat that calls for global action, national action and individual action. No one should say: "This doesn't affect me" and get away with it. We simply cannot close our eyes to one of the main challenges to human kind." (Sydnes, 2001: 1)

2.1 Introduction

According to the *Health Systems and Trust Update* (1996: 7), about 17 million people worldwide are estimated to be infected with HIV. Two-thirds are from sub-Saharan Africa, and one in five are in Southern Africa. Facilitated by the high prevalence of sexually transmitted diseases (STDs) and population mobility due to political strife, drought, the migrant labour system and transport workers, HIV is rapidly spreading throughout Southern Africa. The epidemic will probably undermine socio-economic development by decreasing productivity, increasing the expenditure on health, disrupting social systems and causing human suffering. The potentially negative impact should not be underestimated, for example if an HIV-positive person infects three other people through unprotected sex without realising that he/she is infected, and each in turn infects three others, it is clear that HIV/AIDS can spread exponentially. HIV/AIDS is spreading rapidly throughout Africa and affecting economies and societies at all levels. Military forces in Africa are also experiencing the results of this spread (*Department of Defence,* 2000: 1).

Military personnel are at special risk of exposure to sexually transmitted diseases (STDs), including HIV/AIDS. Throughout the world, military personnel are among the populations most susceptible to HIV/AIDS, as they are mostly young and sexually active, are often away from home and susceptible to peer pressure, regard themselves as invincible and are surrounded by opportunities for casual sex (Rezelman, 2002: 24). The large sums of money paid in cash to soldiers while they are deployed, compounds the problem by creating opportunities for potential sexual business. This is exacerbated by the non-visibility of HIV (people are infected but do not show initial symptoms of illness). The result is a population that does not physically

feel the impact of the Aids epidemic and also aggravates the problem of gaining the necessary data to assess the epidemic (World Bank, 2001: 6). This epidemic has already taken serious dimensions and received full acknowledgement from the government as a major public health issue. Researchers and scientists have intensified their efforts to develop a vaccine or drug to combat or cure HIV or Aids. The latest technology does not seem to show much progress for a cure, though a sudden breakthrough in the field of medical science, cannot be ruled out.

2.2 HIV and Aids

There is still confusion in some circles about the difference between HIV and Aids. According to Whiteside (1996: 1) the virus that causes Aids is the Human Immunodeficiency Virus (HIV). Once people have become infected, they will remain infected for the rest of their lives. Aids is the term used to describe the disease resulting from the infection. People do not die from HIV infection or even from Aids. They die of the opportunistic infections such as pneumonia and meningitis, or diseases such as tuberculosis, that attack the body because HIV has weakened or destroyed their immune system. The period between infection and death may be as long as 15 years, and the average is estimated to be about eight years. The latent period can be prolonged if a person leads a healthy life and if opportunistic infections are treated early and appropriately. These infections can be as serious as tuberculosis or as mild as the common cold, but the fact remains that the body of an HIV-positive person does not have the capacity to fight these infections.

2.3 Transmission and development of HIV/AIDS

HIV is most commonly spread by sexual contact with an infected partner. The virus may enter the body through the lining of the vagina, vulva, penis, rectum or mouth during sex. It is also spread through contact with contaminated blood prior to the screening of blood or the treatment of blood. The virus is also transmitted through blood transfusions or transfusions of blood components. It

is frequently spread among drug users who inject the drug and share needles or syringes contaminated with minute quantities of the blood of a person infected with the virus. Women may also transmit the disease to their children during pregnancy or birth. The South African Medical Health Services Order (SAMHS Order,1999: 2) states that approximately one-quarter to one-third of all untreated pregnant women infected with HIV will transmit the infection to their babies. Although researchers have detected HIV in the saliva of infected individuals, there is no evidence that the virus is spread by contact with saliva. Laboratory studies reveal that saliva has natural compounds which inhibit infection by the HI virus.

Many people do not develop any symptoms when they first become infected with HIV. Some people, however, have a flu-like illness a month or two after exposure to the virus. They may have a headache, fever, malaise or enlarged lymph nodes. More persistent or severe symptoms may not surface for a decade or more after HIV has first entered the body in adults, but does show up within two years in children born with the HIV infection. Some people may begin to have symptoms within a few months, whereas others may be symptom-free for more than 10 years. Whiteside (1996: 1) agrees that the latent period may be a lengthy and extend to a number of years. One's personal health and resilience can assist in extending this period. However, HIV remains active in the body during this latent period, and infects and kills the cells of the immune system. As the immune system deteriorates, a variety of complications may arise. One of the first such symptoms that many people infected with HIV have, is enlarged lymph nodes which remain enlarged for more than three months. Other symptoms often experienced months to years before the onset of Aids include a lack of energy, weight loss, frequent fevers and sweating, and persistent or frequent oral or vaginal yeast infections. Other symptoms include persistent skin rashes or flaky skin, pelvic inflammatory disease that does not respond to treatment or short-term memory loss (SAMHS Order, 1999: 3).

The SAMHS Order as above (1999: 4) states that the term Aids applies to the most advanced stages of HIV infection. Most Aids-defining conditions are opportunistic infections, which are seldom harmful to healthy individuals. In people with Aids, however, these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses and other microbes. The opportunistic infections common in people with Aids cause symptoms such as coughing, shortness of breath, seizures, dementia, severe and persistent diarrhoea, fever, loss of vision, severe headaches, wasting, extreme fatigue, nausea, vomiting, lack of co-ordination, coma, abdominal cramps or difficult or painful swallowing. Many people are so debilitated by the symptoms of Aids that they are unable to hold steady employment or to do household chores. Other people with Aids experience phases of intense life-threatening illness followed by phases of normal functioning (United Nations, 2001: 2).

The disease is found mainly in two age groups: children under five years, and adults between 20 to 40 years. The prognosis for people infected with HIV is bleak. At the end of the incubation period, an infected person will usually have bouts of sickness increasing in severity, duration and frequency, until he/she dies (World Bank, 2001: 1). The age group, adults between 20 to 40 years is the mainstay of any military force

2.4 HIV/AIDS and the rights of those infected

The Constitution of the Republic of South Africa (Act No. 108 of 1996) grants every person the right to personal privacy and dignity. This principle applies to certain aspects of the personality that are generally considered private, for example, a person's sexual orientation, religious beliefs or health status. The Constitution further states that all people have to be treated equally and that no person may be unfairly prejudiced (*Government Gazette*, 2000: 7). The Employment Equity Act (Act No. 55 of 1998) provides that no person may unfairly discriminate against an employee, or an applicant for employment on the basis of his/her HIV status. Unfortunately, it is a principle that is frequently

infringed upon when it concerns a person's HIV status. Although a person's right to medical confidentiality, including his/her HIV status, is guaranteed by the South African Medical and Dental Council and the Medical Association of SA, most breaches of confidentiality occur in hospitals or clinics. Heywood (2000: 2) states that although the official policy of the SANDF is not to employ people who test HIV-positive, it is nevertheless giving two-year and five-year contracts to infected people. This in itself is contradictory behaviour and either the contracts or the policy of not allowing HIV-positive people to become members of the SANDF, should be revised.

The above perceptions can be attributed to ignorance or a lack of understanding about HIV/AIDS and its modes of transmission. The law is intended to protect all parties involved: it protects the rights of those infected with HIV/AIDS by means of confidentiality and also protects those not infected by ensuring a risk-free environment. Confidentiality is strictly enforced where the risk of HIV transmission in the workplace is minimal. However, confidentiality may be breached in circumstances where the exchange of bodily fluids may occur, particularly in the health-care professions. The managers of every workplace should ensure that the workplace policy complies with the provisions of the Hazardous Biological Agents Act and the Mine Health and Safety Act (*Government Gazette*, 2000: 10). It has also been proven that the more the various communities become involved in helping those who have been infected, the greater the reduction in the stigma and discrimination towards those infected (UNAids, 2001(b): 7). This is true in the sense that the more people know about a topic the more confident they become in dealing with and talking about it. The benefit for HIV-positive people is that when HIV-negative people feel more comfortable about those infected, treatment will become easier and victimisation will probably be reduced. It is important for all individuals to create an environment that is fair and free to all those working in that particular environment.

"No person with HIV or Aids shall be unfairly discriminated against within the employment relationship or within any employment policies or practices, including with regard to:

- Recruitment procedures, advertising and selection criteria;
- appointments, and the appointment process, including job placement;
- job classification or grading;
- remuneration, employment benefits and terms and conditions of employment;
- employee assistance programmes;
- job assignments;
- the workplace and facilities;
- occupational health and safety;
- training and development;
- the performance evaluation system;
- promotion, transfer and demotion;
- disciplinary measures short of dismissal; and
- termination of service." (*Government Gazette*, 2000: 8)

There are grounds to believe that when people work in such close proximity and in such harsh conditions as military operations, the HIV/AIDS status of all members should be known. If not, the infected person should be shifted to a working environment with less exposure to risk. The emphasis should be on creating a safe working environment for those who are HIV positive as well as for those who are HIV negative. The perceptions of the uninfected are just as detrimental as negative actions. The perception creates an attitude which, is manifested in some type of action. This action can even be avoidance and when this is exacerbated the infected person can find that he/she has been rejected from the circle of friends and colleagues.

Emanating from this close contact in the infantry section, its members ought to be familiar with HIV/AIDS and they have to know how best to treat HIV-

positive members. The emphasis is not just on creating a safe working environment but also on raising and maintaining a level of confidence and trust among the members of the infantry section.

2.5 HIV/AIDS and the conflict area

The vacuum left by weakened military and police forces provides fertile ground for conflict and war, or for exploitation by dissident groups. How a nation manages HIV/AIDS and attempts to curtail the spread of the virus within the ranks, are vital to national security. When the infantry section has to deploy in other regions, internally and beyond its borders, the bond among the members of the section has to be strong to withstand the pressures of deployment and the rigours of operational activities. If some of the members in the section are HIV-positive and the other members dislike, disapprove or have no understanding of HIV/AIDS, the bond among these members will weaken and adversely affect their operational capabilities.

The Masibambisane project was instituted in the military to create an awareness of HIV/AIDS amongst individuals so that people are aware how to handle those who are infected. It also serves to help people understand the effects of HIV/AIDS not only on the infected but also on those who are not infected (*Department of Defence, Masibambisane*, 2003: 1).

The fundamental principle followed throughout the Masibambisane Project is that HIV/AIDS is a chronic, progressive and potentially life-threatening disease. As such it has to be addressed no differently from any other similar disease as regards its management, the utilisation of human resources and medical treatment for those infected (*Department of Defence, Masibambisane*, 2003: 1). However, special measures are called for owing to the magnitude of the epidemic in South Africa, the potential impact of HIV/AIDS on the military and the particular risk environment in which the military operates. It is envisaged that the policy of the Department of Defence (DoD) will address all the areas required for effectively managing HIV/AIDS in

the workplace, reducing the transmission of HIV/AIDS, preventing discrimination and providing appropriate care and support. This principle should not only be applied to military camps during training but also to military forces that have been deployed on operations. As this would seriously limit the capability of the force deployed by reducing the productivity of the soldiers, the productivity of the entire military force would also be jeopardised.

The potentially negative impact on military forces poses an immediate threat to the stability of the region where legitimate governments rely on the support of their operational armies. Ingham (cited in Bisseker, 1998: 35) states: "HIV/AIDS impoverishes a country, which leads to instability and war. Democracy, law and order, peace and stability are the most important weapons to fight HIV/AIDS. And if you have the instability, as in the Congo, you cannot conduct HIV/AIDS preventative programs." The rationale is that the increased violence will require additional forces to be deployed, resulting in a situation that may potentially increase the spread of HIV/AIDS.

Loss of personnel as a result of HIV/AIDS compromises an army's combat readiness in general, and in particular its ability to deploy at short notice, as well as upsetting the continuity of command. Soldiers who are weak and ill will be unable to work, which reduces the number of men available to perform the various tasks. It is also demoralising for the other soldiers in the section to see a once fit and healthy colleague become bed-ridden and slowly fading away with no energy or strength to help him / herself.

2.6 Summary

HIV/AIDS is a pandemic with far-reaching consequences for human resources and finances. Africa seems to be at the centre of this problem. The regional conflicts and continuous deployment of troops to conflict areas tend to exacerbate the spread of this pandemic. As a key role player in sub-Saharan Africa, the international community expects South Africa to become involved

in peacekeeping operations to ensure the stability of the countries on the continent.

HIV/AIDS is transmitted through sexual contact (anal, vaginal or oral), by means of infected needles or blood transfusions and by transmission of the virus from mother to child. Blood is particularly contagious as only microscopically small traces of blood, for example the blood remaining in a syringe or injection needle, can cause infection. Large quantities of blood are even more dangerous but are not required for a person to become infected with HIV/AIDS.

The infected person's right to keep his medical status confidential is entrenched in legislation. Although this does pose certain problems, as will be explained in Chapter 3, this right is entrenched in the Constitution; therefore such confidentiality has to be managed. Although a work environment should be free of risk, certain risks are unavoidable, especially in an area where there is unrest. This emphasises the point that all soldiers should be well-informed about HIV/AIDS, and should know how this virus is transmitted.

HIV/AIDS is rife among soldiers and is rapidly destroying their capability of being deployed in various roles to execute and fulfil their mandate. The environments, in which soldiers are deployed, especially in poverty-stricken areas, are conducive to the spread of HIV/AIDS. This problem is compounded by the large sums of money soldiers are paid as allowances. The key principle should be the focus on creating and maintaining the bond among the members of the infantry sections. This bond has to be able to withstand the pressures of deployment and conflict.

CHAPTER 3: HIV/AIDS IN THE MILITARY

"There is no war, simply a disease. The raging war is AIDS. All the statistics are true, but not a single shot has been fired. However, AIDS is taking a toll as profound as any military confrontation around the globe, and it is a security threat to countries it assaults as well as their neighbours, partners and allies" (International Crises Group, 2001:1).

3.1 Introduction

The armed forces are the one sector of society most severely affected by the virus that causes Aids, since the armed forces have infection rates two to five times higher than the national averages. Heinecken (2000(a):1) asserts that the members of the military are at high risk of becoming infected with the virus. Operational deployments take soldiers away from home and during such deployments, soldiers receive various allowances. Depending on the nature and place of their operational deployment they could receive amounts of up to R600,00 a day. This money is often paid in cash to the soldiers while they are deployed. It is safe to assume that when they are off duty, they will spend this money. Such spending attracts various kinds of business opportunities, especially in poverty-stricken areas.

When soldiers are deployed, the area to which they are sent generally has certain security issues. These issues have to be resolved and may appear in the form of faction fighting among civilians or between belligerent forces or even between the armed forces and civilians. This fighting harms the local population's political, social and economic fabric that keeps the community together. Although HIV/AIDS does not in itself cause wars, it becomes a security issue in the following ways (International Crisis Group, 2001: 1):

- HIV/AIDS is a personal security issue because the gains in health, longevity and infant mortality are wiped out as more and more adults become terminally ill.

- HIV/AIDS is an economic security issue because it threatens social and economic progress, worsening the trends that contribute to violent conflict and human catastrophe.
- HIV/AIDS is a communal security issue because it affects police capability and community stability. In 1998 as many as one in seven South African public servants were estimated to be infected with HIV/AIDS.
- HIV/AIDS is a national security issue and in Africa many military forces have infection rates fives times that of the civilian population.
- HIV/AIDS is an international security issue as it has the potential to contribute to conflicts and also to undermine the resolution of conflicts.

It is clear that HIV/AIDS can contribute to an already complex and volatile situation. Resolving HIV/AIDS or more simply merely understanding the profound effects that this disease has on society will not as such halt any conflict but will aid greater understanding and appreciation among those infected and those not infected. Gaining an understanding of the effects of the disease generally leads to compassion and taking a humanitarian approach to those infected.

3.2 Structure of operational forces

The DoD in South Africa has a vision which, in accordance with the Constitution, is intended to ensure an "effective defence for a democratic South Africa, enhancing national, regional and global security, through balanced modern, affordable and technologically advanced defence capabilities" (DoD, 1998). In order to enhance national security, the SANDF is expected (among other responsibilities) to protect the territorial integrity and sovereignty of the country by utilising its capabilities to stabilise areas inside its borders.

To this end, the SANDF is divided into various structures which enhance its control over forces and contribute to the success of achieving its mission. Part

of this structure comprises the various services within the SANDF, namely the Air Force, Navy, SA Medical Health Services and the Army. The Army's units are also subdivided into various corps, for example armour, artillery, air defence and infantry. The infantry units (foot soldiers) are divided into training units responsible for the training and development of the infantry's capability, and operational units or battalions responsible for the execution of missions such as stabilising areas of unrest (DoD, 1998: 26).

The rifle company is a part of the infantry battalion that makes direct contact with the enemy and is therefore viewed as the main element of the battalion. There are normally three rifle companies, namely the A, B and C companies. Each company consists of a company headquarters; three rifle platoons and a 60 mm mortar section. The platoons are numbered from one to nine; i.e. the A company consists of the number 1, 2 and 3 platoons; B company consists of 4, 5 and 6 and so on. There are nine platoons in a battalion. A platoon consists of three sections. Each section can operate in two groups, namely the rifle group and a light machine-gun group. The section is the smallest fighting unit of the infantry and therefore forms the basis of the battalion's fighting structure (DoD, 1998: 27)

The infantry battalion is a self-supporting unit that can operate independently on a limited scale under certain circumstances, but should not be viewed as a single entity. The Infantry Battalion, with its balanced composition (various army corps integrated to form a credible combat force) has an effective and flexible firepower and fighting capability that are indispensable to winning a battle on land. However, the cornerstone of the fighting unit must be in place, namely the infantry section for effective operation (DoD, 1998: 3).

Commanders have to be able to maintain this force and utilise it in the manner for which it was designed. If this cornerstone is threatened by disease or any other threat such as poor leadership or insubordination, so that the infantry

section becomes debilitated, the crippling effects would be disastrous to any armed force.

3.3 Organisation for battle

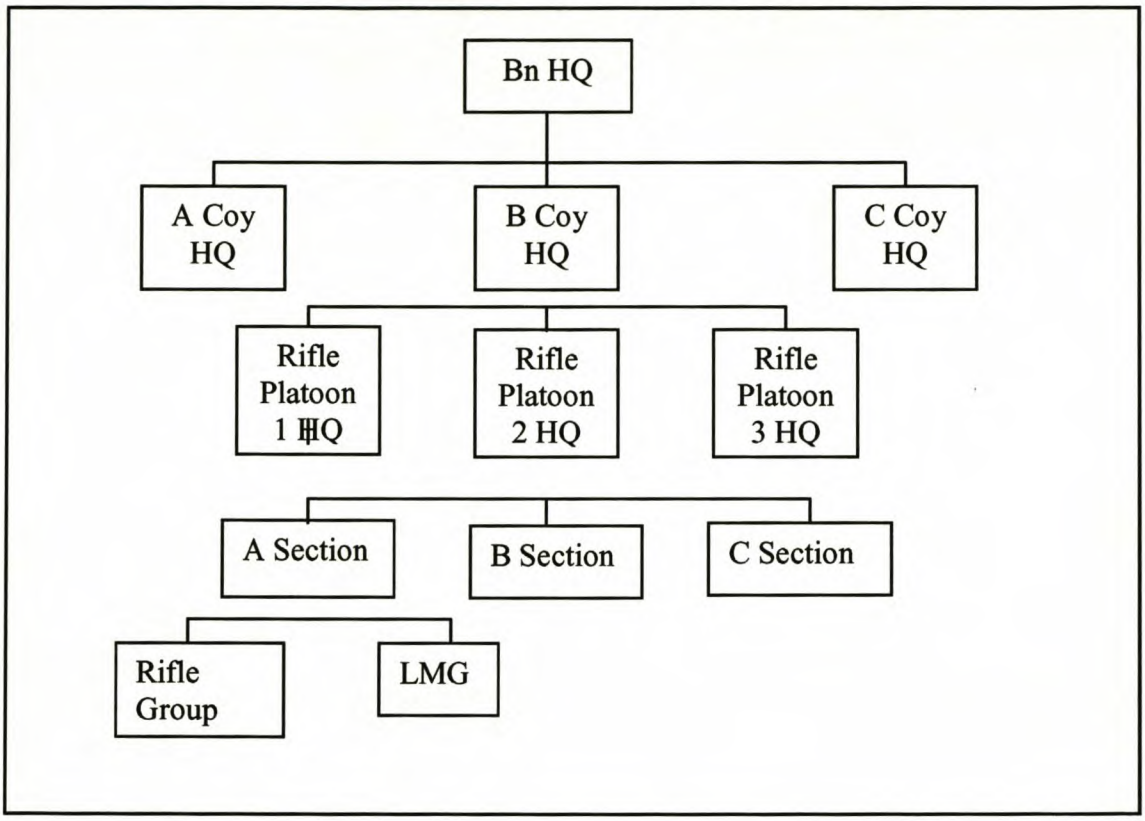
Although the organisation for battle remains fairly standard it may vary for specific tasks. For example, a section from one platoon may be added to another to increase its strength. However, once the adaptations are made the section grouping will not be tampered with. It remains the smallest cohesive element that the Infantry will deploy. The ten men Infantry Section can be broken down as follows (DoD, 1998: 4):

- A section commander with the rank of Corporal (Cpl).
- A section second-in-command with the rank of Lance Corporal (L Cpl).
- A rifle group consisting of six men with the rank of Rifleman (Rfn).
- A light machine-gun (LMG) group consisting of an Operator No 1 and an Operator No 2.

Figure 1 below illustrates the structure of a typical infantry battalion. Although there may be variations, depending on the mission to be executed, the generic composition remains essentially the same. The infantry section at the bottom of the diagram has to report to the next higher headquarters or command structure. In this case, it will be the Platoon Headquarters. The platoon has to report in turn to the Company and the Company to the Battalion. This structure is referred to as the chain of command and all tasks are carried out according to this chain. Each next higher grouping also has a more senior person in rank and years of experience. This confirms that the infantry section is the cornerstone for operational capability and is critical to the missions that the Battalion may be ordered to execute.

Figure 1

The battle organisation of an infantry battalion



3.4 The infantry section

The infantry section may be given individual tasks such as safeguarding a border post or a signals centre. These tasks may entail that the section has to be placed at a post for a lengthy period. During this time the soldiers in the section will have to operate on their own in rural and urban situations. The success of the section depends on its ability to communicate with higher headquarters and on maintaining an efficient and smoothly functioning system.

It is vital to discuss the role of commanders / leaders in the military to highlight the importance of a cohesive and well-disciplined section. Hasenauer (2003: 1) for example states that command is much more than authority. Commanders have to be fighters with the will to win. Commanders have to be leaders with the ability to influence human behaviour in a group or team

context in order to perform a mission. Discipline remains the fundamental tenet underlying anything a soldier does, and largely dictates the soldier's actions. In order to command, military commanders should be examples of fine moral character. Honesty, loyalty and integrity are indispensable values without which no commander can survive for long. These values are regarded as the cornerstones of command: they are not only military values but are also regarded by many as life values applicable to everyone, not just to soldiers.

The relationship between a commander and soldier is critical for the effectiveness and morale of the army. This pivotal relationship invariably develops in the course of time and is tested under a range of peacetime (training exercises) and war conditions, and is therefore not easily replaced by assigning a substitute commander. Consequently, when individuals die the defence force begins to lose part of the accumulated knowledge and relationships on which military values are based. The higher the rank and greater the responsibilities accruing to the commander's rank and position, the greater the adverse impact of his/her death (Gebretsane, 2002: 16). This relationship or bond is invariably unique and strong between the commander and the infantry section. The bond has usually been tempered and forged in the heat of operations and remains strong even after many years have passed. When soldiers are trained for the heat of battle they have an underlying notion that one or more of them may die during an operation. A soldier works with weapons that are designed to kill the enemy, and essentially this is what soldiers are trained to do. Losing comrades during battle is expected but losing a colleague is an emotional blow, even though all soldiers know, understand and accept that the ultimate price may be paid. However, it is understandable that it is difficult for a soldier to cope with losing a friend, especially when death is due to a disease, as grief may be deepened by the feeling that it was so unnecessary. In addition, such death usually takes a soldier unawares as it is usually unexpected.

Soldiers in the infantry section spend most of their time together. Their training is dependent upon one another and success in missions is a team effort. The section will travel together to the deployment area and deploy together in possibly remote or isolated areas. When they are relieved for a period of rest and recreation, they will still be together in the base camp. It is only natural that a unique bond will be created among these soldiers, a bond founded in trust, loyalty and absolute belief in one another's capabilities. These members learn to know one another well, which is why losing a section member has such a severe effect.

3.5 HIV/AIDS and the soldier

Armed force personnel are at higher risk of HIV/AIDS infection than the population at large. Many factors have contributed to the elevated seroprevalence rates of the virus on a global level among members of the military. Nary (1996: 13) and Kingma (cited in Whiteside 1996: 12) both state that:

- a high percentage of the military population is in the 15-24-year age group;
- sexually transmitted disease (STD) infection rates in the military are 2,5 times higher than the norm;
- STD rates are much higher in war and during troop deployment, occasionally as much as 100% higher.

The principle that must be conveyed to soldiers is that even though they might survive contact and combat situations, they are not invincible. The key is to ensure that the military is included in Aids prevention as this would benefit everyone. Military members who tend to be sexually active and engage in risky behaviour are more likely to have contact with commercial sex workers, who are known to have high rates of HIV/AIDS (Heinecken, 2002: 1). Although this author refers to peacekeepers, a parallel can be drawn to operational units which are deployed inside the borders of the country. The

dangers and activities surrounding internal deployments are much alike if not the same as those for external deployments.

Jayakumar (cited in UNAUSA, 2002:10) states that populations ravaged and displaced by war are the most vulnerable to infection, as they seldom have access to adequate medical care and treatment. Considering the environment in which the SANDF has to deploy in South Africa, the same will apply since in both cases the military members work in areas of unrest and poverty. The soldiers deploy in areas where unrest and instability prevail, and are often stationed there for long periods. The severe poverty frequently found in these areas, exacerbates the problem.

3.6 Summary

HIV/AIDS is destroying the labour force of the country and the effect will be felt in the civilian sector as well as in the military. The SANDF has certain responsibilities and without men and women to perform the tasks assigned to them, the SANDF will not be able to fulfil its obligations.

The structure of the SANDF is designed to promote easy command and control especially during times of war. This structure features unique command channels with elements of discipline, respect, honour and belief in the good of the country. In this structure a natural bond is created among soldiers, and a particularly strong bond is forged during operations and training. It is this bond that has to be fostered so that soldiers take care of themselves and others, and they should help to curb rather than assist the spread of the virus.

The deployment areas are dangerous and unstable and are conducive to the spread of the virus. Complicating this are the large allowances paid to the soldiers while being deployed. The infantry section is a cohesive unit and finds its strength in its members trust and ability to depend on one another in times of combat. They learn to know one another intimately, which increases the

impact that the death an infected member will have on the section. Chapter 4 will discuss the findings of the questionnaire completed by the Infantry sections as well as their perceptions regarding the impact of HIV/AIDS.

CHAPTER 4: FINDINGS

"Any good commander would never take his forces anywhere without first doing reconnaissance. In Africa, where we are all vulnerable, we need to reconnaissance of our own bodies by taking HIV tests." Ruranga (cited in Nary, 1996: 14)

4.1 Introduction

This chapter examines the responses of the soldiers in the infantry sections who completed the questionnaire and especially their perceptions of how HIV/AIDS impacts on the operational capability of the section during internal deployments.

4.2 Findings

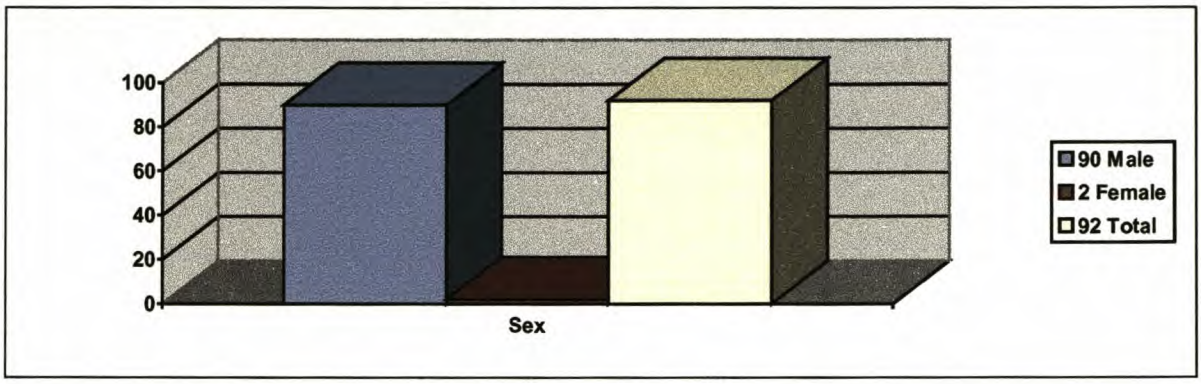
The questionnaire is divided into two sections, namely Section A and Section B. Section A elicits the biographical information of the respondents whereas Section B deals with their responses to the questions and their perceptions. The biographical information helped to classify the research group into the various categories and the responses to Section B were used for deriving the findings of the research. The questionnaire was designed to elicit the respondents' opinions about HIV/AIDS and its impact on the infantry section. As the respondents were assured of the strict confidentiality of their responses to the questionnaire, they could state, without fear of retribution, how they felt about the problem. It is however, accepted that people might be reluctant to express openly their disapproval of those who are HIV-positive and might accordingly give a favourable response to that particular part of the questionnaire

4.2.1 Biographical information

The biographical information of the respondents is detailed below in the same sequence as the questions in the questionnaire, namely gender, population group, age, rank group, years of service and marital status.

Figure 2

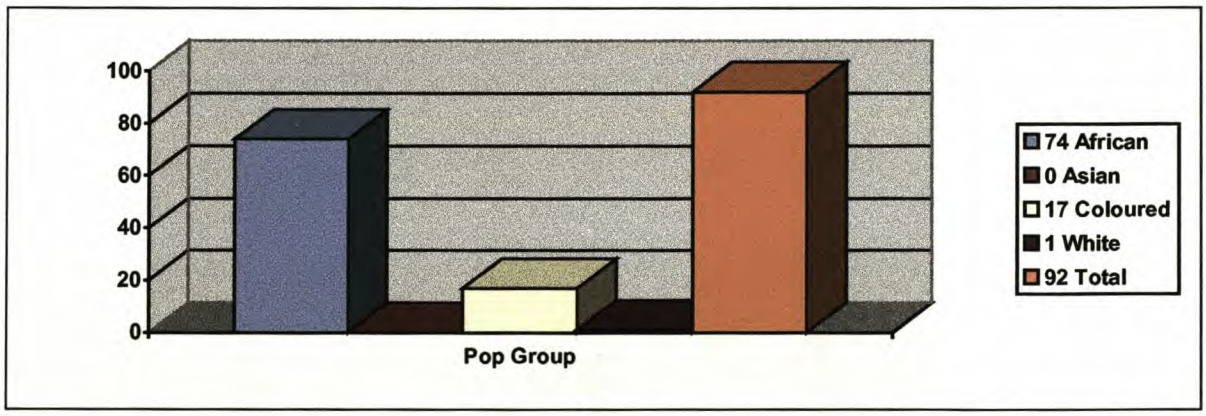
Respondents by gender



The male dominance is not uncommon and reflects the make-up of a typical Infantry Section in most units.

Figure 3

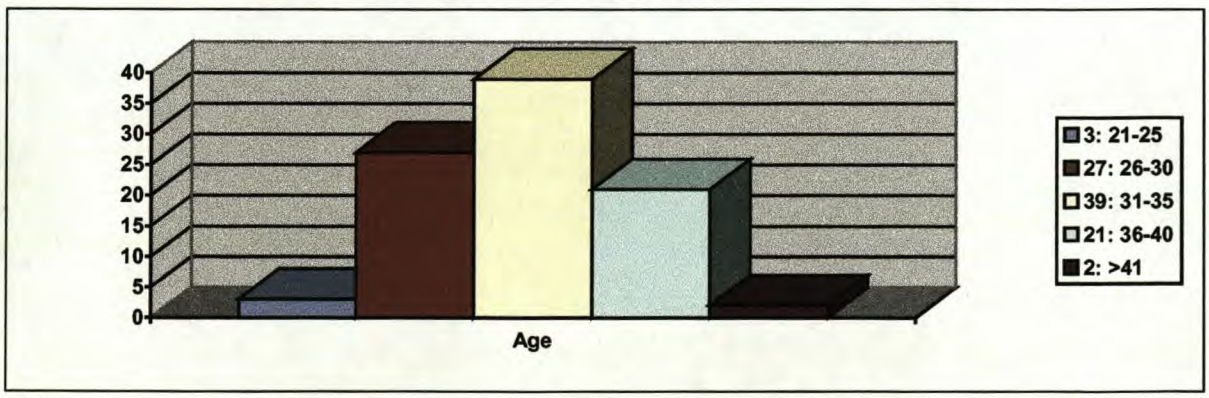
Respondents by population group



The Asian, Coloured and White population groups are more common in the higher ranks and in the other arms of the service.

Figure 4

Age groups of respondents



The majority of the respondents were between the ages of 26-35 years. The SANDF is currently characterised by older personnel in junior ranks and younger personnel in senior ranks.

Figure 5

Respondents by rank

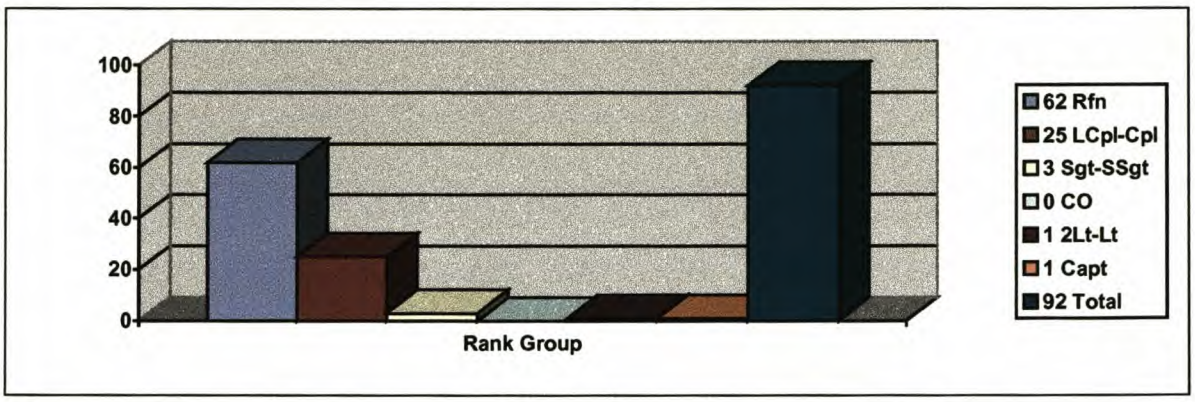
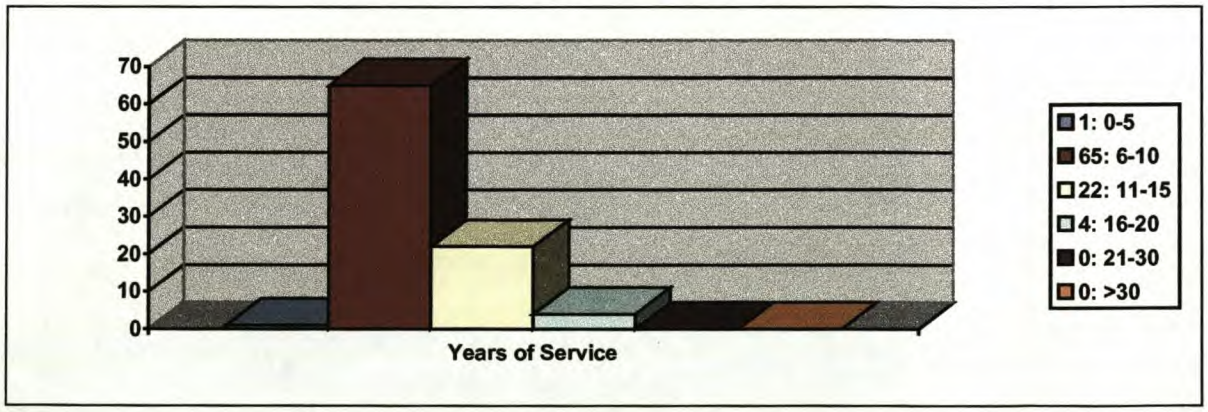


Figure 5 shows the composition of an infantry company that comprises three platoons and nine sections. The high number of riflemen and L/Cpl-Cpl ranks is normal and is what constitutes the company. There are fewer personnel in the other ranks because these ranks constitute the leader group that is typical of a company.

Figure 6

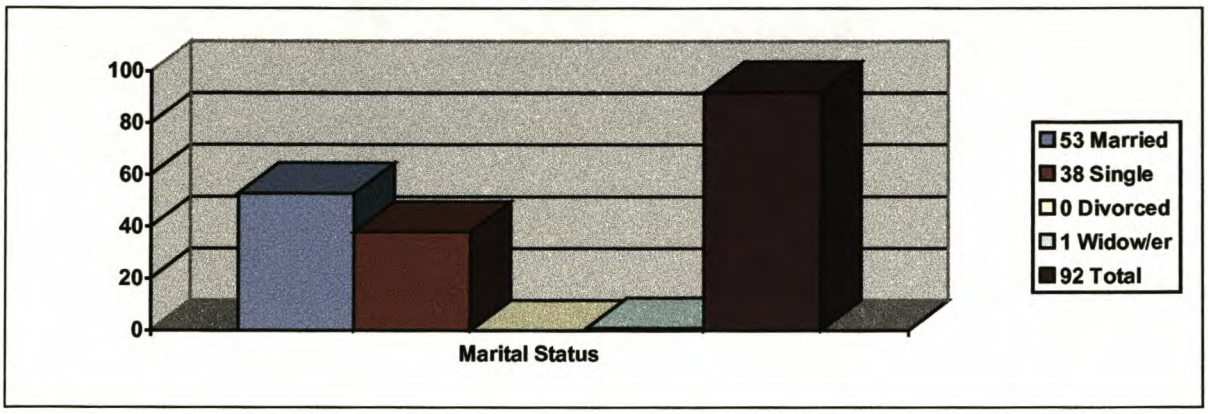
Respondents by years of service



The main group of respondents had between 6-10 years of service. Within an operational unit this member will have been exposed to numerous operations and exercises during this time.

Figure 7

Marital status of respondents



Although little can be deduced from a soldier's marital status, it does assist the analysis by determining that at least 53 of the respondents who would probably be deployed operationally were married, giving a greater understanding of their perceptions of HIV/AIDS and the infantry section's operational capability.

4.2.2 Perceptions of the impact of HIV/AIDS on the operational capability of the Infantry section

The attached questionnaire (Appendix A) was administered to the respondents in October 2003. The graphs below indicate some of the perceptions of soldiers in the infantry sections comprising the operational unit.

Figure 8
Have you heard of HIV/AIDS?

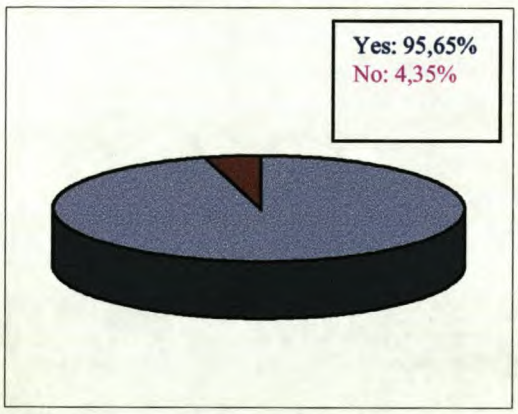


Figure 9
How is Aids contracted?

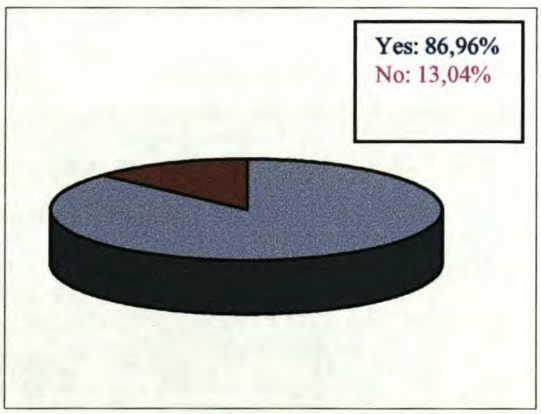


Figure 10
Have you heard of Masibambisane?

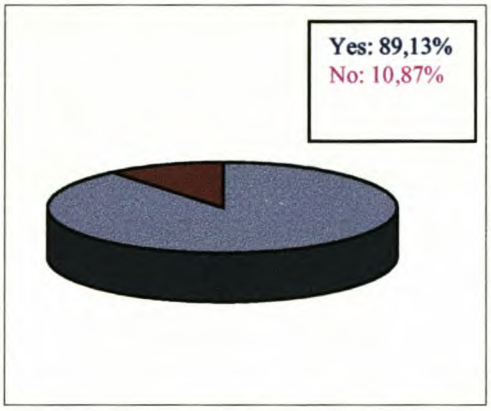
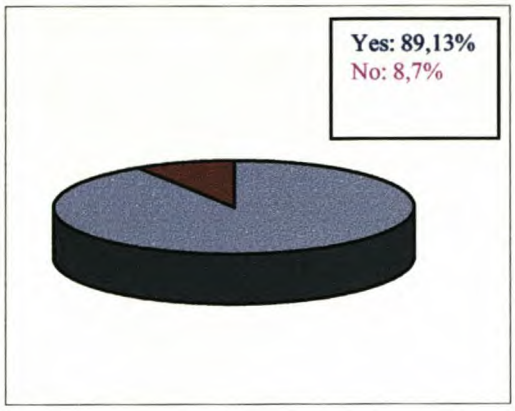


Figure 11
Is this campaign sufficient?



The questionnaire begins with a few general questions to determine the level at which the respondents were informed about HIV/AIDS. Figure 8 relates to Question 1 where 95% (88 respondents) indicated that they had heard about HIV/AIDS. Only four respondents of the total of 92 in the group indicated that they had never heard of HIV/AIDS.

Figure 9 relates to Question 2 where 86% (80 respondents) claimed they knew how HIV/AIDS was contracted. Twelve respondents, in the rank group Rfn to Lt, did not know how HIV/AIDS was contracted. The vast majority (96% or 89 respondents) mentioned that they had received a formal briefing on HIV/AIDS. The SANDF has an official campaign to promote awareness and prevention of HIV/AIDS, called Masibambisane. Figure 10 relates to Question 5 and indicates that 89% (82 respondents) said they had heard of the Masibambisane campaign, with a similar percentage indicating that the campaign was more than sufficient for the SANDF. Ten respondents indicated that they had never heard of the Masibambisane campaign, whereas eight of those who had heard of the campaign stated they felt it was inadequate.

The following questions deal with HIV/AIDS in terms of testing and infection status. Figures 12 and 13 below relate to Questions 8 and 9 and illustrate that 95% (88 respondents) indicated that they had been tested for HIV/AIDS within the last six months and only one respondent had never been tested. Of this grouping 88% (81 respondents) indicated that they were HIV-negative and only two respondents indicated that their status was HIV-positive. These two respondents both indicated that they knew about HIV/AIDS as well as how the

disease was contracted. One of them was married and the other was single. Both also had between 6 – 10 years of military service. The rest of the respondents stated either that their status was private or they did not know.

Figures 14 and 15 relate to Questions 10 and 15 where 85% (79 respondents) indicated that they would like others to know their HIV status. A total of 13 respondents indicated that they would like others to know, 10 of the 13 indicated that they were married: eight of these were African and five Coloured. A total of 17 respondents stated that they did not want to know if others were infected whereas 81% (75 respondents) stated that they would like to be informed about an HIV-positive person working in their close proximity. More than half (69%) believed that they were entitled to be informed about another soldier's HIV/AIDS status, especially if the person was in his/her section.

Figure 12
Last test for HIV/AIDS?

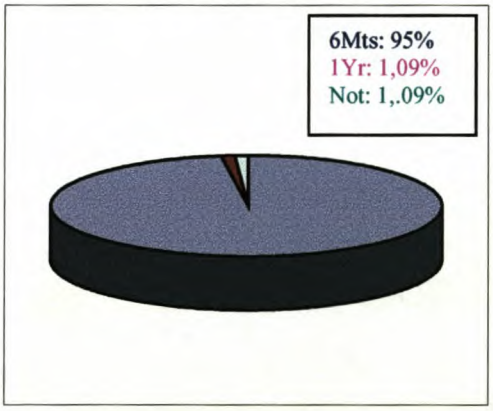


Figure 13
What is your HIV/AIDS status?

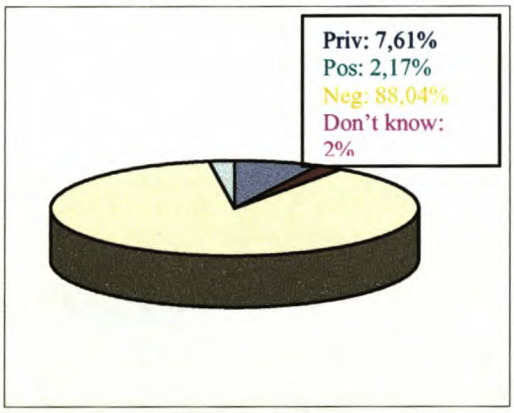


Figure 14
Would you want to inform others?

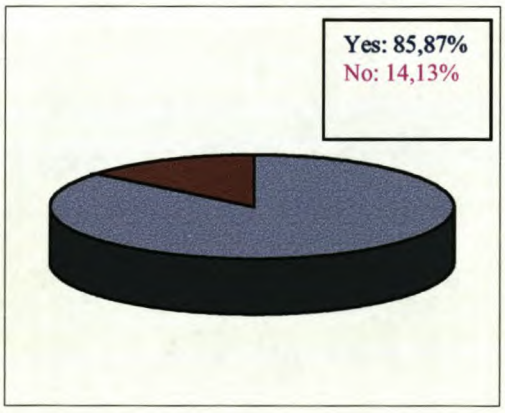
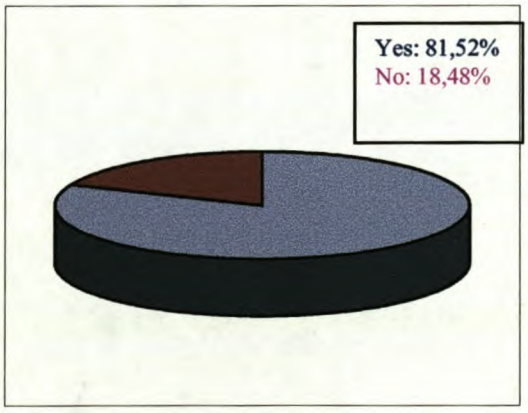


Figure 15
Would you want to be informed of others?



The final questions relate to the respondents' daily operating environment and their perceptions of the possible impact that HIV/AIDS would have on operational capability, i.e. the ability of the infantry section to complete the task at hand. Figure 16 relates to Question 21 where 66% (61 respondents) indicated that HIV/AIDS would affect a person's ability to deploy: of these 61 respondents, 39 were married and 22 were single; 45 were African and 16 were Coloured. Figure 17 represents the responses to Question 22 and indicates that 67% stated that members who were infected with HIV/AIDS should not be allowed to deploy. More than half of the respondents (56%) indicated that they did not want to deploy with a person suffering from HIV/AIDS and 48% stated that they would not feel comfortable about applying buddy aid (a basic level of first aid) to members infected with HIV/AIDS. In addition, 32 respondents indicated that they did not want to deploy with persons who were infected and also stated that they would not want to give them treatment:

Figure 16
Does HIV/AIDS affect a person's ability to deploy?

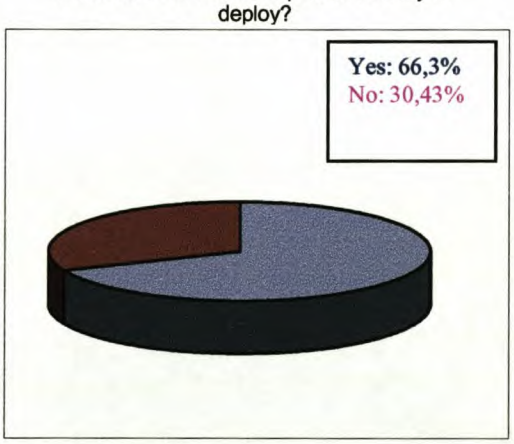


Figure 17
Should HIV/AIDS-infected persons be allowed to deploy?

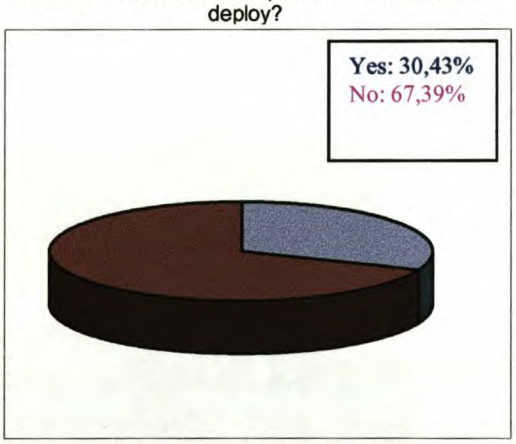


Fig 18
The perception of an infected person on morale?

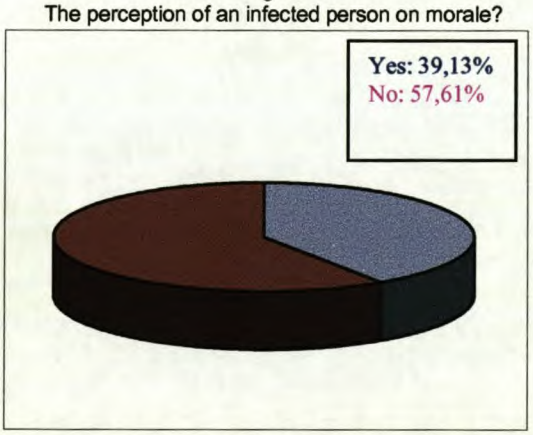


Figure 19
Will an infected person break down the cohesion of the section?

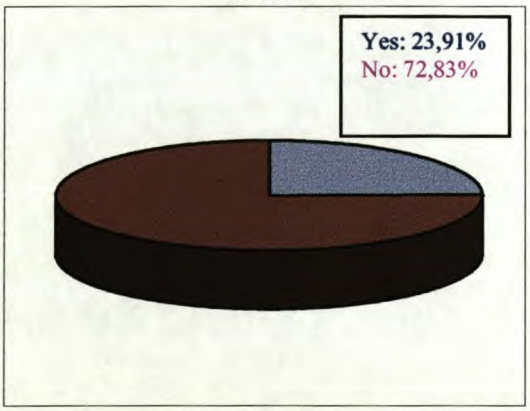


Figure 18 above illustrates the responses to Question 28, indicating that 57% (53 respondents) in the rank group Rfn to SSgt with between 6 – 20 years of service believed that a person infected with HIV/AIDS would not break down the section's morale. The responses to Question 30, represented in Figure 19 indicate that 72% (67 respondents) believed that infected people would not affect the cohesion or unity of the infantry section. A total of 22 respondents with between 6 – 15 years of service believed that infected people would most definitely have a negative effect on the cohesion of the section.

Figures 20 and 21 relate to Questions 31 and 32. Of this operational grouping, 89% (82 respondents) were not aware of anyone infected with the virus in the sections. Most (76%) indicated that an infected person would not affect the ability of the infantry section to complete a mission; and 84% (78 respondents: 63 African and 15 Coloured) believed that the Infantry section was the cornerstone or building block of the operational unit and therefore of combat effectiveness.

Figure 20
Will an infected person affect the ability to complete the mission?

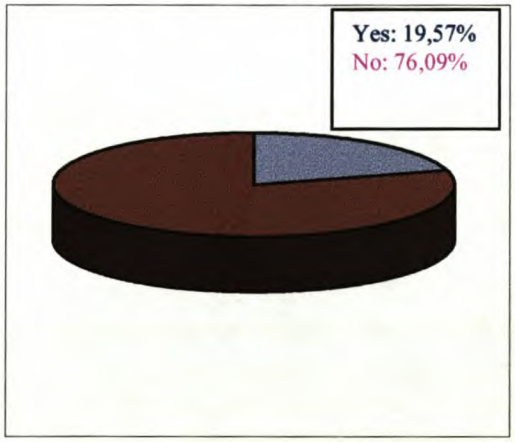
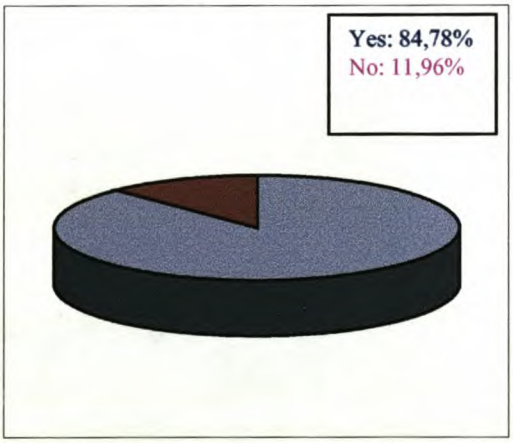


Figure 21
Is the Infantry section the cornerstone for combat effectiveness?



One of the ways in which HIV/AIDS is spread is through sexual contact. When questioned about their sexual activities during deployment, only 8% (eight respondents of whom four were married and four were single) indicated that they would frequent a sex worker while being deployed whereas 16% (six of them married and ten single) indicated that they had already had sexual intercourse with a sex worker.

4.2.3 Responses to open-ended questions

Some of the respondents made the following verbatim comments about an infected person's ability to be deployed. A "yes" response indicates that HIV/AIDS would affect a person's ability and a "no" that HIV/AIDS would have no effect. The questions are grouped according to three major policy issues, namely health, deployment capability and work environment:

(i) Health

- Yes. People living with HIV/AIDS lose their power and are not as effective as healthy people.
- Yes. He can infect his fellow soldiers with injuries.
- Yes. He would not be so fit.
- Yes. People need to be near a clinic.
- Yes. They are not as active as healthy people.
- Yes. The infected person on deployment will not be able to receive treatment as easily.
- Yes. Because one can be infected as easily by other diseases.

(ii) Deployment capability

- Yes. Because you cannot deploy outside the country if you are HIV-positive.
- Yes. It depends on his condition.
- Yes. He may not deploy outside the borders if he is infected.
- Yes. When you deploy you must be healthy so that you can perform your duties correctly.
- Yes. The DoD policy does not allow HIV/AIDS persons to deploy.
- Yes. It has already been decided by policy that they may not deploy in external countries.
- No. It is unfair to infected people not allowing them to deploy.

(iii) Work environment

- "Yes. If it is in full stage, a person cannot be able to do his normal duties and can affect others sometimes in the battlefield".
- Yes. Anything can happen on deployment and you must trust your buddy.
- Yes. Is a threat to his buddies.
- No. They will be careless but not all of them (e.g. like infecting others).

4.3 Summary

The majority of the respondents were African males between the age of 26 – 40 years, married and with 6 – 15 years of service. Over 90% of the respondents had heard of HIV/AIDS and were aware how it could be contracted. This is a strong indication that these members are well-informed. The Masibambisane campaign has clearly been well implemented and can be labelled as a successful awareness campaign. It is highly unlikely that no military person has heard of the campaign let alone HIV/AIDS. This could most probably be accounted for by those who did not focus while filling in the questionnaire, or merely filled the questionnaire in incorrectly.

A strong sense of care for themselves and for others is indicated by the fact that over 80% indicated that they were willing to share their positive status with others as well as wanting to know if someone else was positive. From the comments made in response to the open-ended questions in the questionnaire, this "need to know" seems to be rooted in "knowing how to handle or treat that person properly and not treat them unfairly".

Most of the respondents indicated that they felt a person infected with HIV/AIDS would not be able to deploy to the same extent as an uninfected person. Medical support, possible injuries and reduced physical strength were given as reasons by this high percentage of respondents. The same reasons were also given as a reason for not allowing infected persons to deploy.

However, if an infected person were to deploy with his/her section, the majority of the respondents indicated that it would not break down the section's morale or affect the section's cohesion. The respondents' approach to HIV/AIDS-infected person is very mature and they display a sense of responsibility towards those who are negative and those who are positive. This contributes to their positive attitude to infected members and their willingness to accept them in the working environment.

A minority indicated that an infected person would negatively affect the mission and eventually break down the section's morale and cohesiveness. A total of 61 respondents indicated that HIV/AIDS would affect one's ability to deploy and 18 of the 61 indicated that it would also break down the cohesion of the section. A further 62 respondents indicated that those who were infected should not be allowed to deploy. Although the positive answers throughout the questionnaire indicate a sense of understanding and maturity in handling infected persons and ensuring that their rights would not be restricted. There is cause for concern since such a large percentage seems to contradict themselves by stating they would not want to deploy with infected members?

This attitude could become stronger and more wide-spread, or could be moderated. This will essentially remain a management problem for the senior and middle management in the unit. Another cause for concern, however, is the increased medical attention and cover that infected members will require. This could be an additional burden on an already overextended support system.

CHAPTER 5: DISCUSSION AND CONCLUSION

5.1 Introduction

This chapter discusses the findings derived from the questionnaire and concludes with some recommendations. The aim is to draw conclusions based on the findings and to make recommendations which may assist the SANDF to determine the kind of issues that can be considered in the deployment of Infantry sections internally. Attention is also paid to the perceptions of the infantry section regarding whether or not HIV/AIDS have an impact on the operational capability of an Infantry section.

5.2 Discussion

The indications are that the impact of HIV/AIDS on the SANDF's operational capability is relatively low in terms of the effect that an infected person will have on an infantry section. If an infected person affects one person in a ten-man group by making that person feel unhappy about working with an infected person, how would this affect the working and social bond of the rest of the section? To what lengths would an individual soldier go to disrupt the lives of the rest of the group because he/she feels unhappy about his/her working environment? The SANDF should be concerned about this negative impact, especially during times of deployment. The low percentage of the respondents who indicated that HIV/AIDS members would not have an impact on an infantry section should not be considered as *no impact* but rather as a warning signal of increased prejudice and unfair treatment. It is a fact that deploying with infected members, especially in hostile areas, will increase a soldier's chances of becoming infected owing to accidents, cuts and wounds where bodily fluids are a known hazard for infection (SAMHS Order,1999: 2). It is assumed that no one would intentionally infect himself or herself and that every precaution would be taken to prevent this. Uninfected people should also assume a measure of responsibility for obtaining all relevant information to ensure that they will remain free of HIV/AIDS. However, the SANDF is responsible for ensuring that every member of the armed forces is equipped

with the knowledge and skills so that he or she can safely handle a situation where medical treatment has to be given to an infected person.

5.2.1 Biographical information

The biographical information indicates the typical composition of a section from an Infantry Bn. The dominant percentage of males shown in Figure 2 is due to the expectations about and nature of the work that the infantry section does. The high percentage of Riflemen and Lance Corporals shown in Figure 6 can be attributed to the rank restriction in the infantry section.

5.2.2 Perceptions of the impact of HIV/AIDS on the operational capability of the infantry section

Several issues should be clarified before discussing the respondents' various perceptions of the impact of HIV/AIDS on the operational capability of the infantry section. Firstly, although the questionnaire was completed anonymously and with the assurance that information would be kept confidential, it is accepted that certain questions would probably not be answered as honestly as the researcher could have hoped. This is due to the sensitive nature of HIV/AIDS and the stigma often attached to the disease. Only a few respondents indicated that they were HIV-positive, yet statistically there could have been more. These individuals might consider their status private, be in self-denial or do not want to know.

Secondly, those who indicated that they were in fact HIV-positive and gave unfavourable responses should not be dismissed as a minority. Special attention should be given to the possibility that these responses might in fact be the general feeling of the respondents even though the percentages do not indicate this. This can be attributed to the respondents not wanting to indicate their true feeling. Further research should be done from a psychological or medical perspective in order to ascertain the exact medical status and profiles of such an operational grouping. A note of caution can be applied to all types of deployments, not only to internal deployments within South Africa.

The importance of informing the members of the DoD, especially regarding the way that HIV/AIDS is spread and its prevention, cannot be overemphasised. These perceptions ought to be addressed before too much damage is done.

One of the tests that ought to be completed before deployment is the Comprehensive Health Assessment (CHA), which is a full medical test. This batch of tests includes blood tests to assess, among other things, liver function, STDs and HIV/AIDS. Even though all these tests (see Figure 8) are being done, there is still 4,35% of the grouping that had not heard of HIV/AIDS. This accounts for the high percentage that has been tested within the last six months (see Figure 12).

Even with all the media coverage, the campaigns throughout the country and the SANDF's Masibambisane campaign on increasing HIV/AIDS awareness, some members have not yet been reached. Even more alarming was that 13,04% of the respondents (see Figure 9) had no idea how the virus is contracted and spread. This percentage is very high and although it could be accepted that a few individuals might not be aware of how the virus is spread, it is accepted that the respondents were either not truthful or not concentrating. The high percentage that have indicated that they have been briefed on Masibambisane support this notion. It is clear that although 89% indicated that the Masibambisane campaign is sufficient, it is not fully effective. Despite the fact that 96% of the respondents had in fact received a formal briefing on HIV/AIDS prevention, some of the respondents indicated that they are oblivious to some of the issues surrounding HIV/AIDS. This might be a reflection on the manner in which the formal briefings are conducted: although many people attend them, few really actually understand what is being said. Another possibility is that a certain measure of misunderstanding might have occurred during this research.

Figure 13 shows that only 2,17% of the respondents stated that they were infected with HIV/AIDS. A further 2% did not know their status and 7%

indicated that this was a private matter. It is probably safe to assume that the number of respondents infected is slightly higher than the 2,17% who confirmed they were infected. The members who indicated that they were HIV-positive also stated that they had previously had intercourse with a sex worker. Although this does not prove that they were infected during such sexual intercourse, this still remains one of the major hazards for the transmission of the disease to soldiers. Another factor contributing to this low percentage is that although the unit has focused on internal deployments they are also prepared for external deployments. The current United Nations policy on external deployments is that members who are HIV-positive may not be deployed abroad and are therefore excluded from the operational structure.

Figure 14 illustrates a large percentage of respondents who would like others to know if they have been infected. One respondent stated: "Others must know so that they are careful around me." Figure 15 shows that 81,52% of the respondents indicated that they would like to know if members in their section were infected. This apparently indicates a great deal of understanding and a mature approach to the problem among members of the infantry section. However, 48% indicated that they would not feel comfortable about applying buddy assistance to an infected colleague. This contradicts the high percentage shown in Figure 16 stating that HIV-positive soldiers should be allowed to deploy.

Although there was a positive response regarding members infected with HIV/AIDS, 56,52% of the respondents stated that the SANDF should not recruit members who were already infected with the virus. However, 81,52% indicated that soldiers who were infected should be allowed to pursue their careers in the SANDF, but with some restrictions, for example not in any type of deployment. This indicates a real fear of becoming infected and a concern about whether an infected person can perform his/her job as well as an uninfected person. Almost half (40%) of the respondents stated that an infected person should not be compelled to work the full number of normal working hours and should be allowed to rest. This would not be possible when soldiers have been deployed, as long hours are the order of the day and there

are few rest periods. This finding is illustrated in Figures 16 and 17, showing that 66,43% of the respondents believed that HIV/AIDS could affect a person's ability to deploy. This can probably be attributed to the fear factor (fear of not knowing how to treat or handle an infected person or how HIV/AIDS is spread) prevalent among the uninfected respondents. Only 22,83% stated that infected members were treated unfairly: although this percentage is low it is still cause for concern that this perception occurred at all. Even if one infected person is treated unfairly by transferring that person away from his/her job or creating an atmosphere of intimidation because of the infection, it constitutes an unfair labour practice and should be addressed. The emphasis ought to be on creating an equitable working environment for all, regardless of their HIV/AIDS status.

Though the majority of the group indicated that the infantry section was the cornerstone of combat effectiveness, there was a low response to the question of whether HIV/AIDS-infected people would have a negative impact on the section. Figure 18 shows that 57% of the respondents stated that an infected person would not affect the section's morale and 72,83% indicated that an infected person would not affect the infantry section's unity or cohesion. If there are no infected soldiers in the section, it is clearly quite easy to state that an infected person would have no impact on the section. However, experience has shown that as soon as people are informed, prejudice arises. As these two concepts are related, it is cause for concern that the idea of having an infected person in the section would adversely affect its morale and cohesion. The infected person is not to blame in this case; the perceptions and prejudices among uninfected soldiers are the basis of this contradiction.

Only 19,57% of the respondents stated that an infected person in the section would affect the section's ability to complete the task at hand. This might seem low but 19,57% in a large deployment group could mean a high number of soldiers who could be infected, greatly diminishing the number of members available to perform the task at hand. This would probably be the outcome of

deploying infected people, although these figures might be reduced if there is added emphasis on education and awareness programmes.

5.2.3 Responses to open-ended questions

The responses to the open-ended questions indicate a perception among the respondents that infected members would negatively affect other members while on deployment. Furthermore, 23% indicated an infected person would affect the cohesion of the section which, indicates a sense of bias that would be problematic for deployment situations. The question is whether these members could trust one another if they have been infected with HIV/AIDS and how this would affect their bond as a section.

Generally, the responses were positive and there was apparently a genuine feeling of caring about those who have been infected. Unfortunately there was still an inherent fear and unwillingness to work with infected people in their own working environment. For example 61 of the respondents stated that HIV-positive status would affect such soldiers' ability to deploy and 18 of them indicated that HIV-positive members would negatively affect the cohesion of the section. Half of the respondents mentioned their unwillingness to give assistance to HIV-positive members.

The majority (84%) indicated that they would befriend a person who was HIV-positive, yet more than half the respondents indicated that they did not want to be deployed with them. A possible explanation is that the individuals would not mind befriending an infected person in a situation, which they could control for example, a social gathering. This however is not the case in conflict or operational areas. This attitude leads to unfair treatment, victimisation and labelling an infected person as someone with little or no morals. There is a perception that infected persons will not be able to keep up physically with those uninfected. This is only partly true as it depends on how far the infected person's body has deteriorated. There is also a very real threat involved in being deployed with HIV-infected individuals, partly because of ignorance about how an infected person can be treated safely and partly because the

uninfected do not know how to handle those who are infected. When the responses to Questions 21 and 22 were compared with the responses to Question 30, a total of 61 of the respondents stated that HIV/AIDS would affect a person's ability to deploy and a further 18 of these said that deploying infected people would have a negative effect on the cohesion of the section.

5.3 Conclusion

HIV/AIDS is caused by a virus that is increasingly infecting the personnel of the SANDF. It not only affects the infected but also their families, relatives and friends. The infection has an enormous social impact which should not be underestimated. If left unchecked, HIV/AIDS will cripple the SANDF.

The literature indicates that military personnel are especially susceptible to HIV/AIDS, because the majority of deployed personnel are young and sexually active, are often far from home and subject to peer pressure. Deployment to unsettled areas increases the likelihood that they will contract the virus, not only because of their sexual activity but also because of possible exposure to wounds and contaminated blood.

The findings of this research indicate that certain areas ought to be addressed. There appears to be a sense of dissatisfaction about working and being deployed with infected persons, as 56% of the respondents indicated that they would prefer not to work with colleagues who had been infected with HIV/AIDS. Another concern is the negative impact that an infected person would have on the members of an infantry section and on their ability to complete their mission.

As there is no definite time span for the various stages of HIV/AIDS infection, it is not possible to predict when or how the virus will affect a particular person. This implies that the person might become seriously ill while on a deployment. This would affect the entire section as a replacement soldier would have to be transferred to the section, increasing the strain on the already over-burdened Infantry section.

A large percentage (76%) of the respondents indicated that while they were deployed, an infected person would not affect their ability to complete the task at hand. However, a small number of respondents disagreed with this response and in addition, more than half the respondents stated that, if given the choice, they would not want to be deployed with anyone who was infected with HIV/AIDS. This gives rise to certain concerns about the working environment and the potential prejudice that may prevail, judging by this response. After all, an infected person is quite capable of doing a normal day's work until he or she becomes debilitated and medically unfit.

The soldiers in the sample seemed to be very caring about people infected with HIV/AIDS, as regards promoting their careers and ensuring that they would not suffer discrimination. However, this only appears to be valid in cases where HIV-positive members of the defence force are not personally involved with HIV-negative members. The respondents indicated that HIV-positive members should continue their careers, but not in the presence of HIV-negative members. The personal experience of such fear may be devastating, especially after one has come into contact with an open wound and with possibly infected blood. The effects of such fears and experiences should not be underestimated or ignored.

A clear understanding of the disease is the most important element in starting an effective prevention programme. People have to understand that HIV/AIDS is not only a medical problem, but also has far-reaching social and security implications.

The SANDF is in a unique position and is taking the lead and making a positive contribution by addressing the issue of HIV/AIDS in the working environment. . There are advantages and disadvantages to addressing such issues but critical decisions need to be made now to achieve long-term success. The fear of working with infected people will impede the SANDF's operational capability and the desire of its soldiers to operate. The need to create an environment where infected and uninfected people can operate

without prejudice or fear cannot be overstated. This is critical for the survival of the defence force.

5.4 Recommendations

Based on the findings of this research, the following recommendations can be made:

- Firstly, that the SANDF should address the deployment groups by exercising stringent control over deployed members and introducing safer and more effective extracurricular activities. Although such a step would have far-reaching cost implications, there is no easy solution to the problem of HIV/AIDS infection.

- Secondly, that the Aids awareness campaign should be continued ensuring that the message is spread. This is a critical aspect to the survival of the SANDF and should not be underestimated.

- Thirdly, that awareness of HIV/AIDS should be enhanced by exposing defence force members to practical seminars and discussions that would encourage people to become involved in preventing the spread of the disease to their colleagues, families and community members. Creating such awareness would be a long-term activity, but it is central to changing the behaviour of others and would ultimately link knowledge with practice.

- Fourthly, care should be taken that the SANDF would not suffer from Aids fatigue by resting on its laurels and assuming that the awareness campaign has achieved its goal. It is clear from the research that the Masibambisane campaign, although achieving good results, should be continued.

- Finally, the SANDF should investigate other perceptions from various sources within its organisation, since negative perceptions

about HIV/AIDS in other departments might have serious implications for the SANDF. As there is no cure for HIV/AIDS at present, a strongly disciplined approach should be taken to managing not only those who have become infected but also those who have not yet been infected with the virus.

The aim of the recommendations is to create an understanding about the perceptions of HIV/AIDS and the possible impact that it has on the soldiers. All soldiers ought to be briefed about the impact that HIV/AIDS may have on their lives. Policies should be enforced so those members who are irresponsible and negligent about the risk HIV/AIDS poses to their lives are dealt with severely. The Masibambisane project should be maintained in order to brief people about the impact of HIV/AIDS, as well as how to work with those who are infected. This disease needs to be managed directly without fear of prejudice.

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STELLENBOSCH UNIVERSITY: THESIS QUESTIONNAIRE: CONFIDENTIAL WHEN COMPLETED

THE IMPACT OF HIV / AIDS ON THE OPERATIONAL CAPABILITY OF THE INFANTRY SECTION

This questionnaire will take about 15 –20 minutes of your time. All information is strictly confidential and is used for research purposes ONLY. It deals with the impact of HIV/AIDS in the Infantry Section. The Questionnaire is anonymous; please do not write your name on this questionnaire.

INSTRUCTIONS:

All answers are confidential. There is no right or wrong answer and you are requested to be as honest as possible in answering the questions. If you are unsure of any questions, please raise your hand.

SECTION A: BIOGRAPHICAL INFORMATION

AGE

< 20	21 - 25	26- 30	31 - 35	36 - 40	41 an older

GENDER

MALE	FEMALE

RANK

RFN	L/CPL – CPL	SGT- S/SGT	CO	2LT-LT	CAPT

POPULATION GROUP

ASIAN	BLACK	COLOURED	INDIAN	WHITE

Note: This is purely for statistical purposes.

YEARS OF SERVICE

0 – 5	6 – 10	11 -15	16 -20	21 – 30	> 30

MARITAL STATUS

MARRIED	SINGLE	DIVORCED	WIDOWER / WIDOW

SECTION B: QUESTIONS

1. Have you ever heard of HIV/AIDS?

YES	NO

2. Do you know how HIV/AIDS can be contracted?

YES	NO

3. Have you received a formal briefing on HIV/AIDS?

YES	NO

4. Have you ever received formal training on HIV/AIDS prevention?

YES	NO

5. Are you aware of the AIDS awareness campaign (Masibambisane) in the DoD?

YES	NO

6. Do you believe that this campaign is sufficient? (If not, please state what could be done to enhance this)

YES	NO

_____
_____
_____
_____
_____
_____

7. Do you believe that the SANDF should get involved in the fight against HIV/AIDS?

YES	NO

8. When were you last tested for HIV/AIDS?

Previous 6 months	Previous year	2 – 3 years ago	Never tested

9. What is your HIV/AIDS status?

Private	HIV positive	HIV negative	Do not know

10. If you did have HIV/AIDS would you want others to know? (If no, please state why)

YES	NO

_____
_____
_____
_____
_____
_____

11. Have you ever had casual or unprotected sex?

YES	NO

12. Have you ever engaged in intercourse with a sex worker?

YES	NO

13. Do you know of someone who has HIV/AIDS?

YES	NO

14. Would you befriend a person suffering from HIV/AIDS?

YES	NO

15. Would you want to be informed if someone in your section has HIV/AIDS?

YES	NO

16. Do you believe it is your right to know if a person working with you has contracted HIV/AIDS?

YES	NO

17. Should the SANDF recruit individuals with HIV/AIDS?

YES	NO

18. Should members of the SANDF be allowed to pursue their careers even if they are infected?

YES	NO

19. In your opinion should a person suffering from HIV/AIDS be compelled to work normal working hours?

YES	NO

20. Do you think that person's suffering from HIV/AIDS are treated unfairly? (If so, please state some examples)

YES	NO

_____

_____

_____

_____

_____

_____

21. Do you think that HIV/AIDS affects a person's ability to be deployed? (Please motivate your answer)

YES	NO

_____

_____

_____

_____

_____

_____

22. Do you think people infected with HIV/AIDS should be allowed to deploy? (Please motivate your answer)

YES	NO

_____

_____

_____

_____

_____

_____

23. Should there be a difference between the regulations of internal and foreign deployments with reference to persons infected with HIV/AIDS?

YES	NO

24. Would you want to deploy with a person suffering from HIV/AIDS?

YES	NO

25. Would you feel comfortable applying buddy aid to a person who has HIV/AIDS?

YES	NO

26. Have you received formal buddy aid training to prevent infection while treating the wounded?

YES	NO

27. Would you frequent a sex worker while deployed operationally?

YES	NO

28. Do you believe that a person suffering from HIV/AIDS will break down the sections morale? (Please motivate your answer)

YES	NO

_____
_____
_____
_____
_____
_____

29. Are you aware of any infected person's in your section or platoon? (If so please state how you were informed)

YES	NO

_____
_____
_____
_____
_____
_____

30. In your opinion do you believe an infected person will break down the cohesion (unity) of your section?

YES	NO

31. While being deployed would a person infected with HIV/AIDS in your section affect your ability to complete the task at hand? (If so please state how)

YES	NO

_____
_____
_____
_____
_____
_____

32. Do you believe that the Infantry Section is the foundation for a Unit's combat effectiveness?

YES	NO

Thank you for your time.

*YOUR RESULTS ARE **STRICTLY CONFIDENTIAL**!*