

## **International Military Human Immunodeficiency Virus / Acquired Immunodeficiency Deficiency Syndrome Policies and Programs: Strengths and Limitations in Current Practice**

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**Military Medicine: International Journal of AMSUS** 165, 2:87-92, February 2000.

## Abstract

A survey was conducted to evaluate military HIV/AIDS policies and programs in 119 countries. Ninety-eight percent of the 62 respondents provide prevention education, 95 percent in group settings but only 53 percent individually. Pre-deployment briefings are more common than post-deployment briefings. Condoms are promoted more often than provided. Seventy-eight of respondents report some form of mandatory HIV testing, and 58 percent perform mandatory recruit testing with recruitment denied to HIV-positives in 17 percent. Counseling accompanies mandatory testing less than voluntary testing. In-service care for AIDS patients is universal.

Many military prevention programs can be improved through post-deployment briefings and proactive interventions involving education, condom distribution, and counseling combined with testing. Mandatory testing is often inconsistent with stated goals, and AIDS care policies may strain military budgets. Testing based on benefit-cost assessments may increase efficiency in military HIV control. Military budgets may benefit from greater civil-military cost sharing in AIDS care.

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## Introduction

Military forces are among the world's most susceptible populations to human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). Their personnel are predominately young and sexually active, are often away from home and family, are governed more by peer pressure than by established social norms, are specifically trained in risk-taking and in self-perceptions of invincibility, and are usually surrounded by opportunities for sexual encounters. In addition to shore leaves in the HIV-endemic environments of many of the world's port cities, troop deployments increase risk of acquiring sexually transmitted diseases (STDs) including HIV.<sup>1</sup> Here troops may find themselves in socially and politically disrupted areas where high prevalences of STDs are typically encountered.<sup>2,3</sup>

Militaries form the first and ultimately the last lines of their countries' defense, and therefore HIV/AIDS poses a particular challenge to each country through its armed forces.<sup>4</sup> In this light, the development of effective military HIV/AIDS prevention and care programs assumes considerable importance. In order to maximize their effectiveness, these programs should be based on empirical evaluations of existing military policies and practices. In order to establish such a benchmark, between March 1995 and December 1996 a first-ever global survey was conducted by the Joint United Nations Programme on AIDS (UNAIDS) and the non-governmental Civil-Military Alliance to Combat HIV and AIDS (CMA).

## Methods

The UNAIDS/CMA survey questionnaire focused on self-reported information regarding current military approaches to (1) HIV prevention education, (2) condom promotion and provision, (3) testing and counseling, and (4) HIV/AIDS consequences including medical care. The instrument was mailed to the governments of 119 countries, including all members of the International Committee on Military Medicine and 63 percent of the 190 states and territories recognized by the World Health Organization (WHO), with a request that the questions be answered by senior medical officers responsible for the HIV/AIDS specialty area. Not receiving the survey were non-state WHO members, member states with very small military establishments, and/or member states that were currently or recently involved in disruptive domestic conflicts. Representatives of 62 militaries completed and returned the questionnaire. Responses were not independently verified by other sources. Individual country returns were confidential, although some data were aggregated by regional, demographic, and socio-economic variables.<sup>5,6</sup>

The frequency of dichotomous (usually yes/no) responses was calculated after checking for internal consistency among questions. Countries were split by medians into high and low groups for demographic, socio-economic, and AIDS case-rate variables (provided by UNAIDS) for purposes of correlation with categorical survey response variables. Variables are stated to have an association only if they demonstrated statistically significant relationships (two-tailed test,  $p \leq 0.05$ ), confirmed by Fisher's exact test with Monte Carlo sampling.<sup>7</sup> Monte Carlo

sampling was based on 10,000 sampled tables using 99 percent confidence limits, the upper limit of which was used to test statistical significance. This conservative method was chosen because of the high percentage of cells with expected frequencies of below five in the data set. Regional differences were assessed using standard WHO country groupings; Europe (EURO), Asia (ASIA), Africa (AFRO), Americas (AMRO), and Eastern Mediterranean (EMRO).

## Results

Comparisons of responding (62) and non-responding (57) nations reveal potentially important differences among demographic and economic variables, suggesting a systematic bias in the character of responding countries. Reporting countries average more than three-fold greater financial resources than non-reporting countries (higher national budget expenditures and revenues,  $p < 0.02$ ), longer average life expectancies (72 versus 64 years,  $p < 0.003$ ), and lower average population growth rates (1.2 versus 2.4 annual percent,  $p < 0.004$ ). Response rates also varied by region; AFRO, 17/35 (49 percent), AMRO, 9/21 (43 percent), ASIA, 8/14 (57 percent), EMRO, 5/18 (28 percent), and EURO, 23/31 (74 percent).

### HIV Prevention Education

Militaries generally recognize the importance of HIV prevention education for their personnel and dependents. Ninety-eight percent of responding countries reported efforts to provide such education and 84 percent have developed formal policies along these lines (Table I). Group briefings (95 percent) and the distribution of printed materials (77 percent) are the most commonly employed methods of prevention education. Eighty-eight percent of militaries conduct regular group briefings, and 79 percent treat them as mandatory. However, only 57 percent conduct educational sessions more often than annually, and only 53 percent use individual educational techniques. Of the 45 percent which cited "other educational methods" in free-text responses, 50 percent mentioned audio-visual techniques, and 19 percent interactive sessions. Only one military listed peer educators. Ninety percent of reporting militaries conduct pre-deployment prevention briefings, but only 57 percent provide post-deployment briefings. Regularly scheduled briefings of either type occur less often in Africa (75 percent) and Asia (57 percent) than in all other regions (100 percent,  $p = 0.01$ ). On the other hand, 82 percent of reporting militaries have special training programs for HIV prevention educators. Seventy-six percent of those with instructor training activities provide trainer-training programs at least annually. Forty-eight percent offer instructor training more often, in courses that typically last from two to six days. These programs tend to appear most often in militaries that have condom provision policies ( $p = 0.005$ ), and that assess baseline need through knowledge-attitude-belief-practice (KABP) surveys of military personnel ( $p < 0.05$ ). Militaries in countries with higher national AIDS case rates more frequently report having instructor training programs ( $p = 0.04$ ).

### Condom Promotion and Provision

While 82 percent of responding militaries have policies to promote condom use, only 55 percent report written plans to operationalize these policies (Table II). Forty-seven percent of these conducted KABP surveys before adopting their plans. Condom promotion methods are similar to standard HIV education approaches, with 88 percent of responses mentioning written materials and 84 percent group briefings.

Condom provision policies are reported by 65 percent of responding militaries, and of this group 56 percent have developed written plans for disbursement. Eighty-three percent of surveyed militaries reported designated personnel at various command levels as responsible for condom procurement and distribution. Ninety percent of condom provision policies include free distribution to military personnel, but militaries are evenly divided between those that routinely issue condoms (49 percent) and those that make them available only on request (51 percent). Thirty percent of militaries with condom provision policies also sell condoms to their personnel, but only 69 percent offer specific instructions on condom use.

Differences in military condom policies appear to coincide with magnitude of threat posed by HIV/AIDS. Written policies and plans for the promotion of condoms are positively associated with higher AIDS case rates in responding countries ( $p = 0.004$  for policies and  $p = 0.04$  for plans). Militaries in high-incidence countries are also

more likely to have KABP surveys before plan implementation ( $p=0.01$ ) and instructions, upon distribution, for condom use ( $p=0.003$ ).

### **Testing and Counseling**

HIV antibody testing is conducted in 94 percent of reporting militaries, although only 55 percent have developed declared testing policies (Table III). Some form of mandatory HIV testing is conducted by fully 78 percent of countries that are testing, of which 71 percent is not anonymous. In the 33 percent with non-anonymous mandatory testing, results are reported to persons (commanders and personnel officers) other than military medical personnel. The most frequent mandatory test settings are at recruitment and prior to deployment. Other mandatory testing situations include before separation from active duty, before new assignments, and periodically (21 percent, Table 3). In addition, 51 percent of responding militaries advise recruits to receive HIV testing, and 75 percent of those who provided descriptive responses indicated rejection of recruits who refuse to be tested.

A periodic test rate of only 21 percent casts doubt on the ability of testing programs in 44 of 56 responding militaries (79 percent) to achieve their stated objective of restricting duties for HIV-positive personnel in high-performance assignments, including commando units and aircraft crews. Additional testing goals include rejection of recruits (9 of 54 countries, 17 percent) and exclusion from overseas service (37 of 41 countries, 90 percent). Ninety-five percent of responding militaries offer voluntary tests for HIV, of which 47 percent are conducted anonymously. Of the 53 percent of respondents with non-anonymous voluntary testing, 27 percent disclose results to non-medical personnel.

Although the issue is not yet closed, pre- and post-test counseling is generally considered to be the standard of public health practice for HIV testing (see Discussion). However, counseling may be logistically and financially more difficult with mandatory testing. Among surveyed militaries practicing mandatory testing, pre-test counseling is reported by 62 percent of respondents. Pre-test counseling is more common (87 percent) when the test is voluntary. In the 97 percent of cases in which tested individuals are informed of the results, post-test counseling is provided in 98 percent and notification of sex partners is advised in 93 percent.

With the notable exception of universal testing in the United States military, distinctions in testing policies appear between militaries in the world's richer and poorer countries. Some form of mandatory testing was reported by most reporting militaries in Africa, the Americas, Asia, and the Eastern Mediterranean. In Europe, by contrast, only 61 percent of reporting countries (11 of 18) require any type of mandatory test (Table III).

### **Care for Persons with AIDS**

Survey results suggest that virtually all armed forces in all world regions provide care and support for military AIDS patients and their families. Eighty-five percent of respondents care for AIDS patients in their military hospitals, and 88 percent specifically train medical officers to treat the disease (Table IV). In 55 percent of surveyed militaries, AIDS-related diagnoses also bear military-status consequences, which include discharge from service in 93 percent. Of the 21 respondents stating reasons for AIDS-related discharge, 67 percent indicated medical criteria and the remaining 33 percent specified only an HIV test or risk factor. Forty-five percent offer additional home care, while 71 percent provide counseling and support to the families of military AIDS patients.

## **Discussion**

Generalizing from the data requires caution because of the limited number of country requests (119 of 190 states and territories recognized by WHO, 63 percent) and returns (62 of 119, 52 percent). Notwithstanding these constraints, several regional and global trends emerge from the data in the areas of HIV prevention education, condom promotion and provision, testing and counseling, and AIDS consequences including policies on care. Moreover, several inferences can be drawn from the survey data that might help in the further development of military HIV/AIDS policy around the world. Limitations in current military medical practice may reduce the

effectiveness of HIV prevention and control efforts. Current military practice should therefore be reevaluated in light of proven interventions that appear in the general literature on HIV/AIDS prevention and control.

### **Prevention Education**

Given the established importance of continuing, individualized STD and HIV prevention education aimed at behavior modification and skills-building in human sexual relations,<sup>8</sup> survey results suggest considerable room for improvement. In fact, recent U.S. military research into STD control suggests that individual health risk assessments and situational prevention practice sessions are even more effective and produce longer lasting results than standard individual counseling.<sup>9</sup>

The potential for spread of HIV infection by troops entering and returning from deployment also presents a challenge to prevention. At least one STD study has shown that the immediate post-deployment period carries even greater risk of further transmission than the period of deployment.<sup>10</sup> By not conducting post-deployment briefings, possibly combined with HIV testing and counseling, an opportunity is missed to limit the spread of the disease at home and also to estimate the magnitude of threat in theater operations to which troops may again be assigned. In short, both pre- and post-deployment education campaigns are critically important to militaries dispatching troops within and beyond their own borders.<sup>11</sup>

### **Condom Promotion and Provision**

Consistent condom use remains a powerful weapon in the global war against HIV and AIDS,<sup>12</sup> and this will continue to be true in an era of only modestly effective and narrowly available drug therapies. As hierarchically structured organizations with well-developed command and control mechanisms, militaries are unique in their capacity for sustained, habit-creating condom promotion. Most surveyed militaries appreciate this advantage, but not all seem fully committed to making use of it.

Condom provision policies vary widely among regions, and are most common in Africa (94 percent) followed by the Americas (67 percent), Europe (52 Percent), Asia (50 percent), and the Eastern Mediterranean (40 percent). In general, available military resources and policy appear to coincide with magnitude of need. In Asia, however, which has recently suffered some of the world's highest HIV incidence rates, there is a disproportionately low frequency of military condom promotion/provision policies and of condom use instructions.

### **Testing and Counseling**

No other sexually related health issue is more controversial than the issue of testing for HIV infection. Several medical, economic, legal, and human-rights issues enter into testing decisions, including who is to be tested, how often, with what expected dispositions, and with what consequences for those tested. Further, is testing intended to yield surveillance data for future efforts at HIV prevention, to further behavioral deterrence, to exclude HIV cases from military entry and career advancement, to help determine in-service job classifications, to identify cases for counseling and later care? Each of these objectives may demand different testing protocols, not all of which having to be mandatory and/or periodic.

In addition to protecting blood supplies, military HIV testing is chiefly implemented to meet health-related staffing goals, for compliance with host-country deployment and foreign-training requirements, and for mission fulfillment in certain military specialties requiring high performance standards. It was also observed that a majority of responding militaries fail to test their personnel periodically, which raises the question, for them, of whether any of these purposes can be adequately served through testing.

The efficacy of testing and counseling in combination is also well established as an effective HIV prevention mechanism, although the effect of testing alone is less clear.<sup>13</sup> Twenty-five percent fewer survey respondents reported counseling before mandatory testing than before voluntary testing. These results may imply that there is a substantial economic cost associated with universal HIV testing, although probably less so than with other prevention interventions including mass-media campaigns, peer-education programs, STD treatment, condom

social marketing, safe-blood provision, and needle-exchange/bleach-provision programs.<sup>14</sup> In the U.S. Army, for example, it is estimated that the average cost per screened soldier is only US\$2.52, because of the low prevalence of HIV in the U.S. military and the resulting infrequent need for confirmatory testing.<sup>15</sup> As HIV prevalences in military organizations rise, however, costs also rise as confirmatory testing increases, especially since many countries continue to rely on the expensive Western Blot test for this purpose. In addition, even the U.S. Army estimate does not account for additional costs in terms of time away from duty while being tested and time spent by medical, laboratory, and administrative personnel in conducting tests, determining their results, contacting and counseling patients about these results, partner notification and follow-up testing of those who may have had contact with HIV-infected personnel, and managing the epidemiological data base thus created.

Non-economic costs might likewise appear. In countries with high HIV rates, testing leading to negative consequences for asymptomatic HIV-positive personnel and/or recruits could compromise staffing and military readiness, already complicated by personnel losses due to AIDS deaths. All of these factors could also be consistent with a reduction in the number of personnel and recruits interested in undergoing voluntary HIV testing.

### **Care for Persons with AIDS**

As in the case of HIV testing and counseling, care for AIDS patients presents a set of issues with discrete implications for militaries in industrial and non-industrial societies. Few would question the value of preserving military readiness while providing effective care for military AIDS patients and their dependents. Because of limited resources in relation to military-readiness needs, this balancing of interests may not be so easily achieved in poorer as opposed to richer countries.

The costs of AIDS care (including counseling and material support) in militaries with high prevalences of HIV could severely distort their defense budgets. Since the foremost military priority is readiness for deployment, these militaries might be especially inclined to discharge AIDS patients and thus to transfer the costs of care to the civilian sector. However, in answer to the survey question: "When a diagnosis of AIDS or other HIV-related illness is made, are there consequences in relation to the person's status?" responding African militaries reported far fewer  yes  responses (6 percent) than non-African regions (average 71 percent, Table IV); and those responding  yes  reported no discharges based solely on an AIDS-related diagnosis. Like their counterparts, African militaries appear reluctant to prevent HIV-positive recruits from entering service (Table III); but militaries in this, the poorest, high-incidence region also appear unwilling to dismiss those in service once they present evidence of AIDS. These observations seem consistent with a strategy of maximizing already-invested recruiting and training costs by using soldiers' skills for as long as possible regardless of health status, even though by doing so African militaries lessen their ability to defer medical and other care costs to civil society.

### **Conclusion**

In each of the policy areas examined by the UNAIDS/CMA survey, success in combating military HIV and AIDS might only be achieved in the context of similar and related advances in civilian society. In addition, when planning and implementing military AIDS care programs in less-developed countries, care should be taken that essential defense spending is not jeopardized. This danger too may be mitigated through a greater integration of military and civilian AIDS care. Civil-military cooperation can make available to civilian practitioners relatively sophisticated military epidemiological data bases. It can also ease the financial burden placed on military resources and broaden the ability of militaries to offer long-term care through referral to civilian medical facilities.<sup>16</sup> In all countries, the most effective overall goal may very well be the adoption of long-term, multi-sectoral approaches to the control of HIV/AIDS, which treat the disease not only as an immediate threat to public health, but also as a challenge to social, economic, and political stability and thus to national security in the broadest possible sense.

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### **Acknowledgments**

The authors thank the following colleagues for their contributions to the survey that provided the data for this paper: Brigadier General Raffaele D'Amelio, M.D., Italian Air Force; Lieutenant Colonel Raymond Wouters, M.D., Belgian Army (Retired); and Dr. Norman Miller, Civil-Military Alliance to Combat HIV and AIDS. We also thank Captain Frederic Daniell, M.D., U.S. Navy (Retired), for his comments on an earlier draft of the manuscript.

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**TABLE I**  
REGIONAL DISTRIBUTIONS OF SURVEY RESPONSES FOR HIV PREVENTION EDUCATION

Survey Question Description*	Militaries Responding	Percent Eligible **	Percent Responding AYes≡						p value***
			Total (N=62)	AFRO (N=17)	AMRO (N=9)	ASIA (N=8)	EMRO (N=5)	EURO (N=23)	
Policy for prevention education / information	61	98	84	71	100	88	100	83	
Provision of prevention education / information	62	100	98	100	100	100	100	96	
: Group briefing	60	98	95	94	100	88	100	95	
::: Regular group briefing	57	92	88	75	100	57	100	100	0.01
::: Mandatory group briefing	57	92	79	53	89	100	100	85	0.04
: Individual briefing	60	98	53	65	67	50	60	38	
Pre-deployment education / information	62	100	90	94	67	100	100	91	
Post-deployment education / information	60	97	57	59	50	88	80	41	
Instructor training	61	98	82	94	100	50	100	73	0.03

\* Colon(s) prior to survey question description indicate question to be answered is conditional on a AYes≡ response to the preceding question with fewer colons.

\*\* Some responses are expected only in the subset of respondents who answered AYes≡ to a previous question.

\*\*\* Only p values of less than 0.10 are displayed for differences among regions, based on Fisher's exact test using Monte Carlo sampling.

TABLE II

## REGIONAL DISTRIBUTIONS OF SURVEY RESPONSES FOR CONDOM POLICIES AND PROGRAMS

Survey Question Description*	Militaries Responding	Percent Eligible. **	Percent Responding AYes≡						p value***
			Total (N=62)	AFRO (N=17)	AMRO (N=9)	ASIA (N=8)	EMRO (N=5)	EURO (N=23)	
Policy to promote condom use	62	100	82	88	89	75	60	83	
: Written plan for condom promotion	47	92	55	71	63	17	100	47	
: KABP assessment before plan development	49	96	47	67	63	17	50	33	
Policy to provide condoms	62	100	65	94	67	50	40	52	0.02
: Written plan for condom provision	39	98	56	73	67	25	50	42	
: Responsible authority identified	40	100	83	94	100	100	50	58	0.05
: Condoms distributed free	40	100	90	94	100	100	100	75	
: Instructions provided for condom use	39	98	69	94	83	50	0	46	0.01
Condoms easily available off-base	62	100	94	88	100	100	80	96	

\* Colon(s) prior to survey question description indicate question to be answered is conditional on a Ayes≡ response to the preceding question with fewer colons.

\*\* Some responses are expected only in the subset of respondents who answered Ayes≡ to a previous question.

\*\*\* Only p values of less than 0.10 are displayed for differences among regions, based on Fisher's exact test using Monte Carlo sampling.

TABLE III

## REGIONAL DISTRIBUTIONS OF SURVEY RESPONSES FOR HIV TESTING AND COUNSELING

Survey Question Description*	Militaries Responding	Percent Eligible. **	Percent Responding Ayes≡						P value ***
			Total (N=62)	AFRO (N=17)	AMRO (N=9)	ASIA (N=8)	EMRO (N=5)	EURO (N=23)	
HIV testing policy	60	97	55	38	75	88	80	44	0.06
Any military testing	62	100	94	94	100	100	80	91	
: Any mandatory testing	55	95	78	81	89	88	100	61	
:::: Recruits	43	100	58	69	88	71	75	9	0.00
:::: Periodically	43	100	21	8	63	43	0	0	0.00
:::: Prior to deployment	43	100	56	46	88	86	25	36	0.05
:::: Prior to separation	43	100	28	31	13	14	75	27	
:::: Mandatory testing anonymous	41	95	29	42	25	14	25	30	
::::: Non-medical access to mandatory test results	30	73	33	50	60	17	67	0	0.04
: Voluntary testing available	57	98	95	88	89	100	100	100	
: Counseling before mandatory testing	50	86	62	79	57	71	75	44	
: Counseling before voluntary testing	54	93	87	100	71	88	100	80	
: Subject notified of test result	58	100	97	94	100	88	100	100	
:::: Counseling provided when test results given	56	97	98	100	100	100	100	95	
::::: Partner notification recommended	53	95	93	86	100	100	100	90	
::::: Physician counselor	54	96	94	93	89	100	100	95	
::::: Nurse counselor	54	96	32	57	44	29	0	15	0.05
::::: Other trained counselor	55	98	35	67	22	14	0	30	0.03
: Recruitment denied if positive	54	93	17	14	13	29	0	19	
: Duties excluded if positive	56	97	79	69	100	71	75	80	
:::: Foreign deployment excluded if positive	41	71	90	82	86	100	100	93	

\* Colon(s) prior to survey question description indicate question to be answered is conditional on a Ayes≡ response to the preceding question with fewer colons.

\*\* Some responses are expected only in the subset of respondents who answered Ayes≡ to a previous question.

\*\*\* Only p values of less than 0.10 are displayed for differences among regions, based on Fisher's exact test using Monte Carlo sampling.

**TABLE IV**  
**REGIONAL DISTRIBUTIONS OF SURVEY RESPONSES FOR MEDICAL CARE  
AND HIV CONSEQUENCES**

Survey Question Description*	Militaries Responding	Percent Eligible **	Percent Responding AYes≡						p value***
			Total (N=62)	AFRO (N=17)	AMRO (N=9)	ASIA (N=8)	EMRO (N=5)	EURO (N=23)	
Physician care training	60	97	88	100	100	86	100	73	0.06
Military hospital provides care	59	95	85	88	100	100	100	68	
Civilian hospital provides care	59	95	46	44	22	71	0	59	0.05
Provisions for home care	58	94	45	71	22	57	0	40	0.02
Family support provided	59	95	71	71	78	86	60	67	
Status change with AIDS-related diagnosis	58	94	55	6	89	43	75	77	0.00
: Discharged with AIDS-related diagnosis	30	52	93	0	88	100	100	100	0.05

\* Colon(s) prior to survey question description indicate question to be answered is conditional on a Ayes≡ response to the preceding question with fewer colons.

\*\* Some responses are expected only in the subset of respondents who answered Ayes≡ to a previous question.

\*\*\* Only p values of less than 0.10 are displayed, based on Fisher's exact test using Monte Carlo sampling.