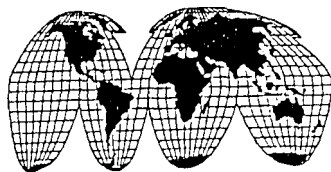


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AIDS Prevention in Military Populations -  
Learning the Lessons of History

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Civil-Military Alliance to  
Combat HIV and AIDS

# AIDS Prevention in military populations – Learning the lessons of history

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In 1984, Brigadier General Andre J. Ognibene (US Marine Corps) addressed a military medical seminar on the subject of infectious diseases in the theater of operations (1):

“Disease is woven intricately into the fabric of war. The story of one cannot be told without the other and yet, each succeeding generation of history, soldier and scholar alike, seems destined to repeat the errors of history and fail to perceive the impact of disease.”

He pointed out the numerous examples of conflicts and field operations in which troops were deployed without taking into account information which was readily available on health risks and disease prevalence in the zone of conflict. The simplest of preparations, which should have been routine, to minimise the risk of febrile disorders diarrhoeal diseases, had regularly been ignored until the impact of those diseases was once again seen in the field.

In the 1990s, we are beginning to see the same kind of disregard for lessons learned in the failure to apply what should be routine prevention interventions for averting the risk of HIV infection.

How serious are those risks? Armed forces personnel seem to constitute a population group at special risk for HIV transmission and infection. WHY?

1. The armed forces employ people precisely in the age group at greatest risk for HIV infection – the 15-24 year old age group in which more than half of all HIV infections occur. This infection liability at that age translates into AIDS as the leading cause of death for males in the 25-44 year old group in many countries.
2. Military personnel are particularly vulnerable since they are often away from home for long periods, and they are often in search of recreation to relieve stress and loneliness. They may have feelings of invulnerability, at an age and in a profession which excuses or even encourages risk-taking, particularly in situations where alcohol or drugs are consumed.
3. Military personnel, camps and installations are known to attract sex workers and those who deal in illicit drugs - and the level of risks goes up. Studies have shown that a large percentage of military personnel engages in casual sex. For example, 35% of U.S. soldiers reported having “one-night-stand” sexual encounters in the previous 12 months (2).
4. Off-duty soldiers can be counted on to have cash - but not necessarily condoms - in their pockets.

5. Dislocation of military personnel on deployment raises the risk of exposure. Studies have shown that military personnel on deployment regularly have sexual contacts with prostitutes and the local population; e.g., 45% of Dutch navy and marines on peace-keeping duty in Cambodia had contacts with prostitutes or local population during a 5-month tour (3).

How do those risks play out in concrete situations?

It is well known that infection rates of sexually transmitted diseases (STDs) among the military are generally 2 to 5 times higher than STD infection rates in comparable civilian populations – even in peace times. In times of foreign deployment and in conflict situations, the risks go higher – much higher.

## Sexually transmitted diseases in the military

- In the Boer War, over 50% of British troops had STDs.
- In World War I, 20% of British troops came down with STDs after leaves in Paris.
- Naval personnel from the Netherlands based in the Dutch East Indies in 1919 showed STD rates of 37%.
- Netherlands army personnel based in the Dutch East Indies in the 1940s had STD prevalence rates of 16%.
- STD rates in the United States military have been well documented to rise sharply - up to 50 or more times higher in each period of war engagement.
- 10% of American naval personnel and marines got a new STD during trips to South America, West Africa and the Mediterranean during 1989-1991.
- Australian troops based in Vietnam reported 27% with STDs.
- 4.9% of French troops based in Cambodia for 6 months in 1992 reported for care of sexually transmitted diseases.

To further complicate the matter, one must remember that it is 5 to 20 times easier to acquire HIV in the presence of other untreated STDs, in one or both partners, than when no other STDs are present.

But we are concerned with one STD in particular - infection with HIV. How can one possibly know where the risks are the greatest? The lessons of the past tell us that the risks are high in certain kinds of circumstances and with certain types of sexual partners.

1. Partner-related exposure risk is high during sexual contacts with partners who are “one night stands” or “anonymous”, e.g., “pick-ups” (2).
2. Exposure risk is high during sexual contacts with prostitutes, since countless surveys have shown that prostitutes have HIV seroprevalence rates between 30% and 90% in all parts of the world.
3. Having multiple sexual partners multiplies the level of risk. The chances of encountering someone with prior exposure to HIV go higher as the number of partners goes up.
4. Having a male sexual partner who had sex with other men also raises the risks, because HIV prevalence is higher among men who have sex with men, as shown by studies in the Americas and in Europe.

### HIV prevalence in the military

- 21% of soldiers from one of the north-west provinces of Cambodia were found to be HIV+ in 1995.
- Cameroon released figures comparing civil and military infection rates for 1993 of 6.2% for soldiers versus 2% for the general population.
- The Central African Republic reported 22% HIV prevalence among recruits entering military service as early as 1991.
- A study of the Congo military covering the period of 1989 to 1993 listed AIDS as the cause of 34% of deaths among serving military, and the probable cause in another 35% of deaths. At the very least, this means AIDS is the cause of death in over 50% of the serving military of all ages in this country.
- Côte d'Ivoire reported 12% of recruits infected in 1994.
- 13 to 14% of men recruited since 1991 from the northern provinces into the Army of Thailand have been seropositive.
- One 1995 estimate of infection rates in Zimbabwe places the HIV infection rate for the armed forces at 3 to 4 times higher than that in the civilian population.
- HIV prevalence among injecting drug users in cities of Eastern and Central Europe, is rising sharply, much as it did in cities like Edinburgh and Bangkok a decade earlier, and this will have its impact on the military population

- The leadership of officers may well be compromised, since they are not spared from infection.
  - The loss of training input, the loss of experience and skills, the cost of replacement training - all have their impact on military readiness.
3. All these factors become all the more important in times of foreign deployment and in conflict situations.
    - HIV infection in the ranks calls into question the safety of blood supplies in field situations (although new methods of using blood substitutes and carrying blood supplies to the field make this less of a problem now than it was previously).
    - Providing first aid and health care in the field is complicated, though it can be managed by simply observing optimum universal precautions.
    - Interaction with the local population is complicated by the potential risks of HIV transmission - - by either infected military personnel or infected civilians.
  4. An additional factor of importance, in virtually all countries, arises from the general lack of coordination between military medical services and their counterparts in the civilian National AIDS Programmes. In many cases, this has meant that HIV prevention, care and counselling services have been slower to develop for military men and women than for civilians.

Critically important is to develop an effective programme that addresses these prevention issues in the military. AIDS prevention in the military is, in one sense, a quintessential “AIDS in the Workplace” issue. After all, the military represents

- a critical and often large target population (in many countries, the military may be one of the largest of all employers);
- a disciplined and regulated community, one in which effective prevention programmes can be readily instituted, implemented and monitored; and
- a segment of the population often outside the stream of the AIDS prevention, care and research programmes in the civilian sector.

What are the essential elements of an effective and comprehensive programme?

What kind of impact can be discerned on the armed forces as its personnel succumb to infection with HIV?

1. First, the armed forces must deal with HIV-related morbidity and mortality in active-duty personnel. Health care costs and the financial burden of maintaining costly facilities to deliver that care, as well as providing social security benefits for families directly affected, all have depleted budgets unprepared for this type of burden. This has been a particular problem for militaries in the African region.
2. Military and security readiness can be seriously compromised by this particular group of health problems.

1. Prevention education through the training of medical and nursing staff and other health care staff, and through the regular and repetitive briefing and preparation of the troops themselves. Pre-deployment briefing and prevention education sessions on STDs and HIV are particularly important, and should not only include condom promotion, but should extend to instruction demonstrations on how to apply condoms and avoid their breakage or failure during sexual contacts. The messages on prevention should emphasise both avoiding situations with high risk of exposure to STDs and HIV infection, as well as being aware of the potential of transmitting HIV.

2. The rigorous and repeated promotion of condom use, and the establishment of procurement procedures that assure the full and unfailing availability of condoms (free) for all troops at all times in all situations.

The experience of the Netherlands contingent of peace-keeping personnel in Cambodia has provided a number of very valuable lessons (3). First, a culture of consistent condom use, reinforced by pre-deployment briefing on sexual risk behaviour and STDs, in particular the risk of HIV transmission, can keep the STD infection rate to under 2%. Second, actual demonstrations on applying condoms are needed to minimise condom failure. Third, this mission and those of other countries demonstrate that rest and recreation ("R&R") visits to resorts with high HIV prevalence in the local sex worker population adds significantly to the risks of troops bringing STDs and HIV home with them. It must be realized that R&R can no longer be overlooked as a significant risk situation for military personnel.

3. The promotion of STD care-seeking behaviour, and the provision of accessible STD drugs and services. All health care staff should be especially trained in this area to provide rapid diagnosis, good case management and counselling.
4. The provision of counselling and voluntary testing services, with regular encouragement to the personnel to take advantage of these services. In many cases, troops headed for overseas deployment may be advised to undergo such testing.
5. Creation of a NON-STIGMATIZING AND NON-DISCRIMINATING ENVIRONMENT within the military population for those who are HIV positive. This begins with full respect for confidentiality of the outcome of any HIV testing. HIV positive individuals should be given every opportunity to fulfil the tasks for which they have been trained and which they are fit to perform. The creation of such an environment requires programmed education of officers as well as the rank and file. It also calls for establishing a system of remedies for cases of discrimination or stigmatization for those who are living with HIV.
6. A well-ordered continuum of care and support for those who live with HIV and AIDS – including continuity of care for them and their families as they return to civilian life.
7. Blood Safety -precautions taken in the handling, screening and transfusion of blood and blood products in health facilities and in the field.
8. Reinforcement of links with national AIDS control efforts and programmes. Enhanced collaboration will enable the military to contribute in meaningful ways to the national mobilisation against this epidemic. A major reason to do this is a recognition of the constant interaction between the military and the civilian population through spouses, partners and other community contacts.

## There is a great deal of work remaining for all of us.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is committed to being a partner and resource for national armed forces and for the United Nations Department of Peace-Keeping Operations in this effort.

The Civil-Military Alliance to Combat HIV and AIDS (4) is another key partner in developing an expanded response to the epidemic. The comparative advantage of the Alliance can be found in its programme of activity:

- pursuing studies which can offer a more complete picture of the HIV situation in the armed forces in all parts of the world;
- fostering an open dialogue on policies that may be needed for expanding the military response to HIV and for developing a "culture of HIV prevention" in military life;
- strengthening national capacities to deal with the impact of the epidemic in both civil and military spheres of life; and
- providing support for the training needed to prepare the military to play its full role in the national AIDS programme.

**CONCLUSION:** The armed forces that do not deal with HIV prevention will be condemned to deal with AIDS. One can paraphrase the military leader quoted at the outset of this paper by saying that the armed forces that ignore the mission of HIV prevention will be "destined to repeat the errors of history by failing to perceive the impact of [this] disease."

The armed forces of all countries must face the increasing risk of HIV infection in their ranks, and address the prevention of AIDS as a priority mission.

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- 4 Civil-Military Alliance to Combat HIV and AIDS - a worldwide interest group representing both civilian and military organizations. Address: Prof Norman Miller, Director, 4 West Wheelock St., Hanover, NH 03755 USA