

# Understanding Prevention A Primary Mission for Military Medical Services

By Stuart Kingma

**A**rmed forces personnel constitute a population group at special risk for exposure to STDs, including HIV. It is known that soldiers are prone to get "VD." This bit of conventional wisdom is rooted in sobering facts; the infection rates of STDs among the military are generally two- to five-times higher than STD infection rates in comparable civilian populations — even in peace times.

In conflict situations, the risk of transmission of these diseases is much higher. STD rates in the United States military have been documented to rise 50 or more times in each period of war engagement. And comparative studies of sexual behavior among military and civilian populations in the U.S., the UK., and France, stratified by age and gender, show that soldiers, in general, have greatly increased risk of HIV infection.

## UNDERSTANDING THE RISKS

The reasons for this heightened susceptibility are not hard to find. It is a normal part of military and peace-keeping service to be away from home for long periods of time. Thus, troops and officers are often in search of recreation to relieve loneliness and stress. Military personnel are employed in a profession which excuses or even encourages risk taking. They are primarily in the age group at greatest risk for HIV infection — the sexually active 15- to 24-year-old age group. Military personnel and camps, including the installations of peace-keeping forces, attract sex workers and those who deal in illicit drugs.

Off-duty times, particularly when alcohol and/or drugs are consumed, are times of greatest risk; off-duty soldiers can be counted on to have cash — but not necessarily condoms — in their pockets. And, even those who remember to take condoms with them are likely to forget them while under the influence of alcohol or drugs.

Soldiers on deployment regularly have sexual contacts with prostitutes and the local population. For example, 45% of Dutch navy and marines personnel on peacekeeping duty in Cambodia had sexual contact with prostitutes or other members of the local population during a five-month tour. In a population-based survey of over 18,000 U.S. soldiers, 35% reported having "one-night-stand" sexual encounters in the previous 12 months.

In another survey in 1995, 42% out of 1,377 US rapid-deployment personnel reported having more than one regular partner and/or at least one casual partner during the preceding year. The risks posed by this type of behavior are confirmed by studies which report that 10% of American naval personnel and marines got a new STD during trips to South America, West Africa and the Mediterranean during 1989-1991.

Partner-related risk of exposure to HIV is high during sexual contacts with partners

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who are “one night stands” or “anonymous”, e.g., “pick-ups”, or commercial sex workers (prostitutes). Having multiple sexual partners multiplies the level of risk. The chances of encountering someone with prior exposure to HIV rise higher as the number of partners goes up. The number of partners is a much more important determinant of risk than the number of contacts per partner.

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. The fact that there are men who have sex with men in the military is a sensitive issue in many countries, particularly for officialdom. It may even be paradoxical, given the “manly” image the military conjures up. Partner-related risk in this type of activity may be seen in the sexual contacts between men who identify themselves as homosexual or bisexual; it may be seen in instances of coerced sex (rape) among men. It may also be seen in experimentation with oral and anal sex among men who identify themselves as heterosexual, but who have sexual contact with other men, for example, during periods of isolation from female companionship.

It is also important to understand the special vulnerability of women in relation to the risk of STD and HIV transmission. Women are at greater risk since they are more likely to acquire any STD from a single sexual exposure than men are. Furthermore, they have more asymptomatic STDs that are more often difficult to diagnose. Women military personnel are also vulnerable in that they are often at a disadvantage in sexual negotiations, or subject to sex under duress and sometimes to outright rape.

## **THE EXTENT OF THE PROBLEM**

Figures from the armed forces in Africa and Asia also report higher levels of HIV prevalence than the corresponding civilian populations. A 1995 estimate of infection rates in Zimbabwe places the HIV infection rate for the armed forces at three to four times higher than that in the civilian population. Cameroon released figures comparing civil and military infection rates for 1993 at 6.2% for soldiers versus 2% for the general population. Thirteen to 14% of men conscripted- since 1991 into the Royal Thai Army from the northern provinces have been seropositive, although there

has been a significant reduction in the proportion of those HIV-positive among new conscripts in the past two years.

The military leadership in a number of countries is concerned that military readiness can be compromised by this particular group of health problems. The loss of training input, the loss of experience and skills, the cost of replacement training — all have their impact on military readiness. Commanders from some high HIV prevalence countries have identified the problem in terms of being able to “field” a full contingent for deployment on relatively short notice. Readiness and smooth team-work are compromised if gaps in the platoon are filled in by those who have not served together previously.

The actual or potential presence of HIV-positive personnel in the ranks becomes important in times of foreign deployment (e.g., on a peacekeeping mission) and in conflict situations. It calls into question the safety of blood supplies in field situations (although newer methods of using blood substitutes, carrying blood supplies to the field and rapid methods of field testing of blood make this less of a problem now than it was previously). Providing first aid and health care in the field may also be viewed as more complicated, though these can be managed by properly observing universal precautions. Interaction with the local population again carries the potential risks of HIV transmission by either infected military personnel or infected civilians.

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The armed forces in a number of countries have discerned several other kinds of impact as direct consequences of HIV infection. 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 brought an economic impact on military/ defense budgets unprepared for this type of burden.

Then, there is the impact on the individuals concerned. A member of the armed forces who has admitted to, or who is known or suspected of being HIV positive, will often be stigmatized and discriminated against in many different ways. This discrimination may be manifest in both official and social settings. It may arise out of fear of close contact with someone who may be viewed as a source of serious disease. It may reflect distaste for contact with

someone assumed to have become infected with HIV through injecting drug use or through sexual transmission of a homosexual nature. It may be a rejection of going on field exercises with someone who is thought may not be able to hold up to the demands, or whose blood — spilled through injury or donated as a member of the “walking blood bank” — is assumed to be contaminated, infected, a hazard.

For those members of the armed forces who are infected with any of the STDs, including HIV, consideration needs to be given to the serious risk of onward transmission of these infections to spouses (and children), partners, commercial sex workers, and other members of the community. A critical point here is the issue of responsibility for partner notification and for adopting SAFER sex practices. If it is known that the person concerned has not informed his or her partner, who is responsible, or has the right, to do something?

### EXPANDING PREVENTION EFFORTS

1. First of all, emphasis is being placed on the collaboration that will be necessary between the military sector and civilian society to assure a harmonious continuum of STD and AIDS prevention and care. Such a program begins with prevention education through the training of medical and nursing staff, and through the regular and repetitive briefing and preparation of the troops themselves. An essential element in this prevention education is regular and explicit instruction in the use of condoms, including demonstrations on how to apply condoms, offering troops and personnel the chance to practice in a non pressure setting. Making a copy of the booklet “Protect Yourself Against HIV/AIDS” available to all peace-keeping personnel is an important part of assuring this prevention education.

2. A prevention measure often overlooked is the avoidance of organized rest and rehabilitation “R&R” visits to resorts with high HIV prevalence in the local sex worker population, visits which can add significantly to the risks of troops bringing STDs and HIV home.

3. The promotion of **STD** care-seeking behavior and the provision of accessible **STD** drugs and services are further key elements in such a program.

4. Another aspect central to a successful program is the

provision of **counseling and voluntary testing services** with regular encouragement to personnel to take advantage of these services. In many cases, troops headed for overseas deployment may be advised to undergo HIV testing.

5. **Universal precautions and blood safety** — the precautions taken in the handling, screening and transfusion of blood products in health facilities and in the field — are essential skills and practices to be taught and reinforced.

6. Not always stressed is the need **to create a non-stigmatizing and nondiscriminating 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 fulfill the tasks for which they have been trained and which they are fit to perform.

7. Finally, the approach to care needs to be paired with 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. It must always be kept in mind that no soldier, sailor, or marine exists in a vacuum. All HIV/AIDS prevention and care efforts must recognize the constant interaction between the military and civilian populations through spouses, partners, and other community contacts.

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One contentious issue exercising military leadership around the world is **testing for HIV — mandatory or voluntary**.

Mandatory testing for the US military was established in 1985 on the premise that protection of individual and public health required early diagnosis of HIV infection. The rationale was based also on certain military-specific concerns: individual safety in the face of multiple live vaccines and potential exposure to “exotic” infections; maintenance of a safe “walking blood bank”; military readiness; and world-wide deployability. Furthermore, making such a diagnosis would allow those who are HIV positive to receive the benefit of targeted behavioral and therapeutic interventions.

Those who defend mandatory pre-recruitment and periodic I-HIV testing also point to the psychological value to

HIV-negative individuals knowing they have been tested and are not infected.

Those who oppose this testing policy present a number of counter-arguments: Some maintain that mandatory testing is a violation of individual rights which cannot be justified by the military-specific demands; there is substantial psychological stress associated with obligatory testing, and the risk of suicide for asymptomatic individuals has been pointed out, although not well studied; in America, the cost per case detected has been in excess of U.S.\$5,000; a positive test in an asymptomatic individual does not bear on that person's right to work or "fitness for work" (points which are part of the UN personnel policies); one also must be concerned about the rate of false negatives and false positives, as well as the pre-seroconversion "window"; and finally, testing is a weak prevention measure, far less effective than good prevention education, and the addition of a voluntary testing program would satisfy all the arguments for testing.

Can one ever justify mandatory testing? There is a moderately elevated risk for subtle neurocognitive impairment in the early asymptomatic stages of HIV infection, especially in reaction time — both simple and choice reaction time. This may justify mandatory HIV testing for pilots where extensive batteries of neurological testing are not available.

What, then, is known about the current policies, practices on HIV testing in the armed forces of countries in the various regions? Over the course of 1995/1996, the Civil-Military Alliance to Combat HIV and AIDS\* and the Joint United Nations Program on HIV/AIDS (UNAIDS) carried out a 120-country survey on HIV/AIDS Prevention, Testing and Care in Current Military Medical Practice." Sixty-three countries returned completed questionnaires. The following data reflects the position in the 63 countries which replied (in each case, noting the number of valid and clear replies to the relevant question).

In one manner or another, HIV testing is carried out by 93% of reporting militaries (58 of 62), though only 55% (33 of 60 countries) have a declared, written testing policy. Forty-three of the reporting countries stated they impose mandatory HIV testing in some situations. Among these 43 countries, the most frequently mentioned mandatory test settings are pre-recruitment (25 countries, or 58% of the 43), prior to foreign deployment (24 countries), before separation from active duty (12 countries), periodically (9 countries), and before new assignment (8 countries). Rejection of candidates for recruitment based on a positive HIV test is the rule in 83% of responses (45 of 54 respondents — here it may be noted that the denominator is a larger group than those countries which declare that they do mandatory recruit testing), and 79% of countries (44 out of 56 responding) impose restriction of duties for those who are HIV positive (for example, banning them from piloting aircraft and from combat), and 90% (37 of 41) practice exclusion of the HIV-positive from overseas deployment.

Key words: HIV, AIDS, STDs (sexually transmitted diseases), military, police, mandatory testing, discrimination, peace-keeping

\*The Civil-Military Alliance to Combat HIV and AIDS, a non-governmental organization created in 1994, works closely with the Joint United Nations Program on HIV/AIDS (UNAIDS) in developing an expanded response to the epidemic in the civil-military sector.

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The Civil-Military Alliance to Combat HIV and AIDS Newsletter, *The Alliance*, is a worldwide nongovernmental organization representing both civilian and military organizations concerned with HIV/AIDS. Prof. Norman Miller, Director, 4 West Wheelock St., Hanover, NH 03755 USA

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