



AIDS BRIEF: MILITARY POPULATIONS

**Rodger Yeager, Ph.D.
Associate Director
Civil-Military Alliance to Combat HIV and AIDS**

Prepared for the Sectoral AIDS Briefs Series

**U.S. Agency for International Development
World Health Organization**

2000

AIDS BRIEF: MILITARY POPULATIONS

The HIV/AIDS epidemic is a global crisis that demands urgent attention and committed, sustained action by alliances of individuals, organisations and sectors. The AIDS Brief series has been developed to support the conceptualisation and implementation of key sectoral responses. Throughout the world, military personnel are among the most susceptible populations to HIV infection and AIDS. They are mostly young and sexually active, are often away from home and family, are governed more by peer pressure than established social convention, are specifically trained in risk-taking and self-perceptions of invincibility and are usually exposed to opportunities for casual sex. This AIDS Brief provides some ideas as to how military populations, which are essential to the security of economies and societies alike, may be affected and what types of response may be required.

Background

Definition of Military Populations

For the purposes of this AIDS Brief, military populations consist of members of national armed forces, including regular army, navy, and air force contingents, militia and reserve units, and paramilitary/guerrilla groups.

Facts about Military Populations

Throughout time, military populations have formed one of the largest and historically most significant sectors of society. Today, the world's armed forces comprise about 25 million men and women in active military service, not including militias and reserve contingents, paramilitary guerrillas and other irregulars, and some women's units. In an increasingly contentious post-Cold War era, national militaries perform an increasingly prominent role. By the late 1990s, 36 countries were actively engaged in armed struggles, eight confronted emerging international conflicts, and 13 were embroiled in internal civil disorders. To a greater degree than in the past, national military personnel are also used in multinational interventions to contain domestic and international disputes. Between 1997 and 1999, 16 United Nations peacekeeping operations were underway in Africa, the Americas, Asia, Europe, and the Middle East. These represented 32 percent of all UN peacekeeping missions undertaken since 1948, and involved a total of over 14,000 troops, police, and observers drawn from 77 countries.

Just as militaries have always figured centrally in human affairs, epidemic disease has presented a perennial problem for military populations and for civilians with whom they come in contact. Troops have found themselves deployed in alien biological environments that are hostile to their immune systems, in adverse physical environments whose climatic and weather conditions are conducive to the spread of infection, and in disrupted social environments that serve as ideal breeding grounds for infectious bacteria and viruses.

During the 12th Century Crusades, bubonic plague and famine reduced one Christian army from 100,000 to 5,000 troops. In 1741, the Austrian army surrendered Prague to the French because 30,000 defenders had fallen victim to typhus. During the Napoleonic wars, four French soldiers died of disease to every one killed in action. In the first month of the Russian campaign alone, dysentery and typhus reduced Napoleon's Grand Armée by an estimated 80,000 men. Between 1853 and 1856, about 2,000 Crimean War combatants died of wounds but more than 50,000 succumbed to disease. Similarly, in the Spanish-American War of 1898, 469 American troops were killed or mortally wounded in action, while

nearly 2,000 fell ill and died. As armies streamed home in post-World War I Europe, a typhus epidemic resulted in 30 million infections and caused at least three million deaths in European Russia. During World War II, the case rate of dysentery in the U.S. armed forces rose from about 20,000 to over 500,000, of dengue infections from fewer than 700 to more than 84,000, and of malaria from about 8,000 to nearly 461,000 (Source: Entomological Society of America).

More recently, U.S. troops in Somalia were attacked by malaria and dengue, multinational forces in Kuwait were beset by sand-fly fever during Operation Desert Storm, and UN peace-keepers continue to be on alert for malaria and typhus in post-war Bosnia. As products of wartime social disintegration in conflict situations, large refugee populations often share the same space and vulnerability to disease with combatants and peace-keepers. By the end of 1997, such conditions had produced almost 12 million refugees, mainly in Africa, Asia, and Eastern Europe, where a total of 10 UN peacekeeping operations were either underway or soon to begin.

Since World War II, advances in medicine have rendered many infectious diseases less dangerous to military and civilian populations alike. Especially in technologically advanced societies, reduced threat of epidemics has also turned public health concerns away from disease prevention and toward curative medicine. This trend is perhaps most pronounced with regard to a type of disease that has always been part of the military lifestyle - the sexually transmitted infection (STI). In the past two decades, however, one STI has emerged for which medicine has no cure. This, of course, is the Human Immunodeficiency Virus (HIV), which results in the Acquired Immunodeficiency Syndrome (AIDS). In many parts of the world, HIV and AIDS pose a far more serious threat to military populations than the inherently hazardous nature of their occupation.

AIDS and Military Populations

All militaries are threatened by HIV/AIDS, but, like the societies of which they are part, militaries in less-developed world regions are especially vulnerable. At the end of 1998, 22.5 million Africans were estimated to be living with HIV/AIDS in sub-Saharan Africa, 68 percent of the world total. Several years earlier, some African Defence Ministries were already reporting averages of 20 to 40 percent HIV-seropositivity within their armed services, with rates of 50 to 60 percent in a few countries where the virus had been present for more than 10 years. A 1995 estimate of HIV in Zimbabwe placed the military infection rate at 3 to 4 times that of the civilian population.

South and South-East Asia may soon surpass sub-Saharan Africa in new HIV infections. In 1995, 21 percent of Cambodian soldiers from one of the country's northwestern provinces were found to be HIV-positive. Similarly, 13 to 14 percent of Royal Thai Army personnel, recruited from Thailand's northern provinces between 1991 and 1995, were infected with HIV.

The attrition created by these magnitudes of infection and eventual debilitation must inevitably cause loss of continuity at command level and within the ranks, increase costs for the recruitment and training of replacements, and reduce military preparedness, internal stability and external security. In this sense, HIV/AIDS can become a regional destabiliser and a potential war-starter.

Unlike quickly developing diseases such as malaria and dysentery, HIV/AIDS is not a war-stopper. For this reason many militaries were initially slow to initiate HIV/AIDS programmes of their own and remained essentially disassociated from civilian programmes. As the impact of the disease has become more apparent, most senior medical officers and

line officers now recognize an urgent need to provide information on how servicemen and women can avoid HIV infection, to promote condom use within their units, to ensure that strict blood-safety procedures are followed and to pay greater attention to the prevention and treatment of STIs in general. These leaders also increasingly agree that the campaign against HIV/AIDS cannot be successfully waged in isolation but requires close cooperation with domestic civilian agencies in the public and private sectors, combined with civil-military collaboration. As a result of such efforts, significant reductions in new HIV infections have recently been reported in the militaries of Uganda, Thailand, and other countries.

HIV transmission is 5 to 20 times more likely to occur in the presence of other STIs. STI infection rates among non-deployed military personnel appear generally similar to those experienced in the wider civil society, although in some countries military STI infection rates may be 2 to 5 times higher than in comparable civilian populations. Deployment may increase the risk of acquiring HIV, especially when sailors and soldiers are exposed to the HIV-endemic environments of many port cities and to socially and politically unstable zones of conflict where sexually transmitted infections (STIs) may abound. Under conditions of foreign deployment, military STI infection rates may equal or exceed those of the local populations with whom they interact

Especially in the growing number of post-Cold War conflict situations, the HIV/AIDS pandemic poses a direct threat not only to public health, socio-economic integration and political stability, but also to national and international peace and security. In this light, the development of effective military HIV/AIDS prevention and care programmes assumes vital and immediate importance.

Impact Checklist

Internal Risk Profile

Are military personnel:

- (i) living in single-sex quarters?
- (ii) aged between 18 and 45 years, and sometimes aged under 18 years?
- (iii) mostly single, separated for long periods from spouses, or denied marriage during their enlistment periods?
- (iv) readily accessible to commercial sex workers and vice versa?
- (v) often less than fully literate?
- (vi) frequently deployed away from their home countries and/or communities?
- (vii) well paid in relation to nearby civilian populations?
- (viii) specially trained in risk-taking and aggressive behaviours?
- (ix) exposed to long periods on duty interspersed with short periods of leisure, and to long periods of abstinence from alcohol and/or drugs followed by brief episodes of binge drinking and/or drug use, including injection drug use?
- (x) at risk to physical injury involving loss of blood and need for blood transfusion under non-sterile conditions?
- (xi) when on deployment, often living in close proximity to refugees and displaced persons?
- (xii) susceptible to peer pressures that treat STI acquisition as proof of manhood?

Impact Checklist

Internal Risk Profile (continued)

Are there crucial skills represented at command level and in the ranks?

Are there readily available replacements for:

- (i) enlisted personnel?
- (ii) officers?

Is military health training:

- (i) structured to emphasize STI/HIV/AIDS awareness and prevention education?
- (ii) mostly interactive, as opposed to mostly didactic, and carried out in small groups, as opposed to large assemblies?
- (iii) designed to increase motivation toward STI/HIV preventing behaviours as well as to provide information on this subject?

Are condoms:

- (i) sold on or near base at retail price?
- (ii) freely available on demand?
- (iii) proactively issued free of charge?
- (iv) sold on base at a subsidised price (socially marketed)?
- (v) readily available at all times?

Is STI/HIV testing:

- (i) always voluntary?
- (ii) always mandatory?
- (iii) both voluntary and mandatory, depending on circumstances?

Is individual STI/HIV counselling:

- (i) readily available to all personnel?
- (ii) provided at recruitment and re-enlistment?
- (iii) provided at pre-deployment?
- (iv) provided as a post-deployment de-briefing exercise?
- (v) provided before STI/HIV testing?
- (vi) provided after STI/HIV testing?

Will military provisions for:

- (i) sick leave
- (ii) compassionate leave be adversely affected by HIV/AIDS?

How will military HIV/AIDS affect benefits such as:

- (i) in-service and/or civilian medical services?
- (ii) pensions or other retirement schemes?
- (iii) disability and medical discharge benefits?
- (iv) funeral and survivor benefits?

External Risk Profile

How will HIV/AIDS incidence and prevalence affect:

- (i) total force strength?
- (ii) force strength in high-performance assignments (e.g., pilots, tank commanders, commandos)?
- (iii) deployment strength?
- (iv) recruitment pool for enlisted personnel?
- (v) recruitment pool for officers?

How many dependents (on average) does each military serviceman and servicewoman support?

At home and/or on deployment, are the bulk of HIV infections:

- (i) in the general population?
- (ii) in identifiable risk groups (e.g., commercial sex workers)?

At home and/or on deployment, what are the special hotspots/risk environments in the surrounding community?

How will the HIV/AIDS epidemic affect:

- (i) military and national health budgets?
- (ii) national defence capability?
- (iii) internal security?

Sectoral Response

HIV Prevention Education

Militaries around the world recognise the importance of HIV prevention education for their personnel and their dependents. In 1995/96, a survey of HIV/AIDS prevention and control programmes in 119 regular armed forces was conducted by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Civil-Military Alliance to Combat HIV and AIDS (CMA). Ninety-eight percent of 62 responding militaries reported efforts to provide prevention education and 84 percent had formal policies along these lines. Group briefings and the distribution of printed materials are the most commonly employed educational methods. Eighty-eight percent of reporting militaries conduct regular group briefings and 79 percent make these briefings mandatory. On the other hand, only 57 percent of respondents conduct educational sessions more often than annually and only 53 percent reported the use of individual educational methods. Given the established importance of continuing, individualised education aimed at behaviour modification and skills building in human sexual relations, these results suggest considerable room for improvement. In fact, recent US military research into STI control suggests that individual health risk assessments and situational prevention practice sessions are even more effective and produce longer lasting results than standard individual counselling.

The UNAIDS/CMA study also found that 90 percent of reporting militaries conduct prevention briefings before their troops are deployed to other countries, but only 57 percent provide briefings in the immediate post-deployment period, when troops may be at even greater risk of acquiring and transmitting HIV. In addition, regularly scheduled briefings of any kind appear to be held least often in Africa and Asia. If this finding represents a continuing trend, its consequences are ominous. Sub-Saharan Africa and Asia account for

about 89 percent of all current HIV/AIDS cases and for over 90 percent of new HIV infections.

Condom Promotion and Provision

The effective and regular use of condoms remains a powerful weapon in the global war against HIV and AIDS. As hierarchically structured formal organisations with well-developed command and control over a wide range of activities and behaviours, militaries are unique in their capacity for sustained, habit-creating condom promotion efforts. Most military representatives participating in the 62-country survey recognized this advantage, but some of their organisations seem more able than others to make full use of it. While 82 percent of these militaries have policies to promote condom use, only 55 percent reported written plans to help them implement these policies. Moreover, condom promotion methods are similar to standard HIV education approaches, with 88 percent of responding militaries mentioning written materials and 84 percent group briefings. This heavy reliance on written and group, as opposed to verbal and individual, suggests the same limitation in condom promotion as encountered in prevention education.

Beyond simple promotion policies, condom provision policies were reported by 65 percent of responding militaries and of this group 56 percent had developed written plans for disbursement. Eighty-three percent of surveyed military representatives reported designated personnel at various command levels as responsible for condom procurement and distribution. Ninety percent of respondents' condom provision policies include distribution free of charge to military personnel. Militaries are evenly divided between those that routinely issue condoms and those that make them available on request. Thirty percent of militaries with condom provision policies also sell condoms to their personnel. On the other hand, only 69 percent of respondents with condom provision policies offer specific instructions on proper condom use.

As in the case of prevention education, differences in military policies on condoms appear along regional lines. Perhaps most notably, specific condom provision policies are most common among African militaries followed by the Americas, Europe, Asia and the Eastern Mediterranean. In Africa, available resources and policy appear to coincide with magnitude of need based on total AIDS cases. In the Asian region however, which now suffers some of the world's most explosive HIV incidence rates, there appears to be a disproportionate lack of military condom promotion and provision.

Testing and Counselling

For armed services in all world regions, no other health-related issue is as controversial as the question of universal testing for HIV. Those opposed to mandatory testing argue that this procedure is inconclusive, overly expensive and in direct violation of the human right to privacy and freedom from adverse discrimination. Advocates of comprehensive testing maintain that the statistical data base thus obtained is important in maintaining military readiness, in extending the length and quality of life of military personnel and those with whom they come in contact and in producing evaluations of the disease that suggest sound protocols of preventive intervention.

On medical cost-benefit grounds and also for human rights reasons, UNAIDS officially opposes routine HIV testing without consent and only a few militaries have adopted mass testing policies. The US armed forces lead this group by requiring HIV screening of all recruits, phased serological testing of active-duty and reserve units, screening of blood donors and periodic testing of groups exposed to high risk including STI patients and some

recipients of blood and blood products. On the other hand, the mounting costs, organisational dislocations and threats to mission fulfilment produced by the HIV virus are prompting military leaders in many countries to rethink the merits of universal testing in a variety of possible configurations. One such variant involves the release of test results, with policy options ranging from complete confidentiality to informing commanding officers and the families and/or sexual partners of test results. In addition to economic cost factors, concerns that may also influence decisions on mandatory HIV testing include the requirements of foreign training, peacekeeping participation and military staffing.

Because of personnel losses created by HIV/AIDS, overseas military training of officers and some enlisted classifications has assumed ever-greater importance for many governments in Africa, Asia, and Latin America. Some countries offering this training require that those selected be certified as HIV sero-negative, which prompts commanders either to require screening of candidates or to select host countries which mandate no such tests.

HIV prevention through compulsory testing has likewise gained importance with the increasing deployment of soldiers on UN and other peacekeeping missions. By their very nature, these operations enhance exposure to disease. This risk is compounded by the role now often assigned to peacekeeping contingents, not only to stand between contending forces, but also to separate them and to help effect demobilisation and create institutions to maintain the peace. Short-term peacekeeping assignments can thus be subtly transformed into lengthy peacemaking efforts, often in situations where HIV prevalence rates are already high. The presence of refugees and displaced persons further heightens risk of exposure to HIV and other STIs. At the beginning of 1996 there were about 12 million of these uprooted civilians in Africa, 5 million in Asia and 2 million in Europe. In earlier-times, military STI patients were usually cured before returning home. With HIV, both military and civilian populations must deal with a chronic and incurable disease that has a high efficiency rate of transmission from the field to home and vice versa. In response, the UN Department of Peace-Keeping Operations strongly recommends that training in HIV prevention be required of all militaries supplying peacekeepers, that voluntary or mandatory HIV screening be employed prior to deployment and that troops infected with HIV and/or other STIs should not be deployed.

In spite of the potential benefits of screening and testing for HIV, negative consequences for military staffing can also occur. Social stigmatisation of those who are rejected before or after enlistment may result in serious decreases in the pool of potential candidates who are inclined to seek military careers. More conclusive evidence is needed about human environmental factors that might slow the development of symptoms resulting from HIV infection. If debilitating symptoms can be postponed in certain controllable situations there may be no valid reason to deprive the HIV-positive person of active service and career-enhancing deployment experience and promotion in rank. Highly regulated military environments seem especially conducive to such regimens if they can be developed.

In one manner or another, HIV antibody testing is conducted in 94 percent of militaries responding to the UNAIDS/CMA survey, although only 55 percent have developed declared testing policies. Some form of mandatory HIV testing is conducted by 78 percent of countries that are testing, of which 71 percent is not anonymous. In 33 percent with non-anonymous mandatory testing, results are reported to persons (commanders and personnel officers) other than military medical personnel. The most frequent compulsory test settings are at recruitment and prior to deployment. Only 21 percent of responding militaries test their personnel periodically, which casts doubt on the ability of most testing programmes to screen personnel for overseas training and deployment and for assignments as fighter aircraft pilots and for other positions demanding high performance standards.

The efficacy of testing and counselling in combination is well established as an effective prevention strategy for sexual transmission of HIV, to the point that pre-test and post-test counselling is generally considered to be the standard of public health practice for HIV testing. However, both types of counselling may be logistically and financially more difficult in mandatory testing situations. Pre-test counselling was reported by only 62 percent of militaries participating in the UNAIDS/CMA survey which practice mandatory HIV testing. Pre-test counselling 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 counselling is provided in 98 percent and partner notification is advised in 93 percent.

Suggesting possible distinctions between militaries in the world's richer and poorer countries, mandatory testing is associated with militaries in countries experiencing high population growth rates and short life expectancies. Some compulsory testing is reported by most responding militaries in Africa, the Americas, Asia, and the Eastern Mediterranean. In Europe, by contrast, only 61 percent of reporting countries practice any type of mandatory testing. Militaries in countries with high AIDS prevalences tend also to offer counselling before both mandatory and voluntary testing.

AIDS Care

In that AIDS has become a leading cause of death in many militaries of the less-developed world, questions arise regarding the competing values of military strength and care for military AIDS patients. In light of limited resources in relation to military-readiness requirements, should special AIDS clinics be established for soldiers and their families? At what point should HIV/AIDS patients be discharged and sent home and with what possible consequences for spread of the disease? Should full medical benefits be provided to discharged military AIDS patients and their dependents? Should financial, legal, and other protective benefits be extended to the survivors of deceased military AIDS patients?

Results from the UNAIDS/CMA survey indicate that many of the world's armed forces provide care and support for military AIDS patients and their families. Eighty-five percent of respondents reported care for AIDS patients in their military hospitals and 88 percent specifically train medical officers to treat the disease. In 55 percent of the militaries surveyed, AIDS related diagnoses bear military-status consequences, which include discharge from service in 93 percent of these cases. 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 counselling and support to the families of military AIDS patients.

The costs of AIDS care in militaries with high HIV prevalences could severely distort their defense budgets. Since the highest military priority is readiness for national defense and effective 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 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 than non-African militaries and those responding affirmatively reported no discharges based solely on an AIDS-related diagnosis. Like many other militaries, African militaries appear reluctant to prevent HIV-positive recruits from entering service. Unlike in other regions, 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 recruitment

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 transfer medical and other care costs to civil society.

In both civilian and military settings, of course, the heaviest costs must be borne by less-developed countries. Unless it is brought under control, growth in AIDS-related deaths among young adults in these countries is likely to exert a highly negative impact on economic growth, social integration and political stability. Especially but not exclusively in military administrations, national security may also be seriously undermined by depletions in the ranks of key officials and their potential successors.

Civil-Military Cooperation in HIV Prevention and AIDS Care

However measured in terms of all approaches to military medical practice, success in confronting military HIV and AIDS can only be achieved in the context of similar and related advances in civilian society. In addition, when planning and implementing military HIV/AIDS policies in economically less-developed countries, care should be taken that essential defense spending is not placed in jeopardy. This danger can be mitigated through a greater integration of military and civilian programmes of HIV prevention and AIDS care.

Action Checklist

On the basis of current military practice in combating HIV/AIDS, several policy recommendations can be suggested that might help in the development of future strategies for military HIV/AIDS prevention and control in all world regions.

Education

- Conduct prevention education programmes frequently, to reinforce health promoting behaviours. These programmes should pay attention to individual approaches, such as situational prevention practice sessions based on personal STI health-risk assessments. Prevention education should also develop skills-building capacities, particularly regarding condom use and sexual negotiation between women and men.
- Conduct prevention education in both pre-deployment and post-deployment situations. Increase financial assistance for formal training and support for HIV prevention educators, so that prevention programmes can themselves be rendered increasingly cost-saving and cost-effective.
- Protect and strengthen the military recruitment pool through HIV prevention-related information, education and communication campaigns targeted toward pre-adolescents and adolescents and through military recruitment limited to literate school-leavers.

Condom Promotion and Distribution

- Ensure adequate numbers and quality of appropriately distributed condoms.
- Conduct surveys of recipients' knowledge, attitudes, beliefs, and practices in order to adapt condom promotion activities to local social, economic, and cultural conditions and sensitivities.
- Based on these surveys, develop operational plans to implement existing condom promotion policies through highly individualised training and peer-education programmes.
- Emphasize a wide and proactive, instead of only on a "readily available" and "on request," distribution of condoms, together with education on the correct use of condoms.

Blood Safety

- Establish protocols and procedures to ensure screening of blood supplies.

Testing and Counselling

- Before adopting voluntary and/or mandatory testing policies, carefully consider the goals and anticipated benefit/cost ratios of such policies.
- Whenever testing is practiced, conduct pre- and post-test counselling to induce and reinforce health-promoting behaviours. Given the absolute need for counselling to accompany testing, the financial and training costs of counselling may help to determine whether and under what circumstances HIV testing is voluntary or mandatory.
- Ensure human rights protection by maintaining confidentiality of HIV test results and protecting job security until medical discharge from service becomes necessary.

AIDS-Related Illness and Death

- Ensure confidentiality in care and treatment.
- Provide continuing medical care of HIV-infected personnel, discharges and their dependents.
- Support survivors by:
 - providing emergency assistance to dependents of deceased personnel through continuation of military pension and provision of death benefits including expenditures to cover funeral costs;
 - reintegrating survivors within their communities with assistance in relocation of survivors' households and through the provision of educational benefits for surviving children;
 - assisting in the protection of family property rights.

Civil-Military Cooperation in HIV Prevention and AIDS Care

- Strengthen health and social welfare sectors through increased civil-military collaboration in HIV/AIDS prevention and control.
- Wherever possible and practicable, integrate military and civilian programmes of HIV prevention and AIDS care.
- Improve civil-military institutional linkages and co-operative strategies in HIV/AIDS prevention and control, resulting in a sharing of health care funding and facilities, epidemiological data and HIV prevention materials and techniques.
- Improve regional and global civil-military communication and change perceptions at senior military and civilian levels stressing the importance of defining HIV/AIDS not only as a national medical emergency, but also as a permanent but surmountable challenge to regional and global stability, security and socio-economic development.
- As a first line of defence against the disease, strengthen the availability and accessibility of condoms to all of those at risk, together with the establishment of a global common culture of consistent condom use.

Monitoring and Impact Assessment

- Conduct prevention impact assessments by periodic mandatory and/or voluntary testing for HIV and/or other STIs.
- Conduct HIV impact monitoring and use information to inform increases in numbers of personnel to maintain military strength and command and control capacity.

Summary

Because of the several years that elapse between infection and the appearance of symptoms, HIV is initially hidden but spreads rapidly within affected populations. Because of their occupation and lifestyle, military personnel are among the core groups most at risk to HIV acquisition and transmission. If left unchecked, HIV increases to epidemic proportions and eventually produces widespread illness and inevitable death due to AIDS-related causes. Severe consequences accompany HIV/AIDS in military populations, including loss of support for dependents, depletion of force strength and command capacity, and possible socio-economic and political destabilization, compromised national security and generalized breakdown of public order.

Responses to the threats posed by HIV/AIDS in military populations include measures to slow the spread of the disease, to manage AIDS-related illness and death, to provide for survivors, and to mitigate the immediate and long-term security impact of military HIV/AIDS.

The spread of HIV/AIDS in military and related civilian populations can be limited through:

- behaviour change resulting information, education, and communication programmes that encourage safe sex and especially consistent condom use;
- blood screening for HIV ;
- effective treatment of other STIs;
- voluntary testing for HIV and other STIs, in all cases accompanied by pre-test and post-test counselling, and especially before and after troop deployment;
- human rights protection, involving confidentiality of HIV test results and guarantee of job security until medical discharge becomes necessary.

AIDS-related illness and death can be managed through:

- social and psychological counselling of military personnel living with HIV and of military AIDS patients, including their dependents;
- preservation of employment security and possibility of promotion in rank until medical discharge is required;
- confidentiality in care and treatment;
- provision of continuing medical care of HIV-infected personnel and their dependents in military and civilian facilities;
- protection of the legal rights of surviving military dependents.

The survivors of deceased military personnel can be supported through:

- continuation of military pensions and provision of death benefits including coverage of funeral costs;
- reintegration of military dependents within their home communities by helping in the relocation of their households and by providing educational benefits for surviving children;
- assistance in the protection of family property rights.

The immediate and long-term security impact of HIV/AIDS can be mitigated through:

- epidemiological surveillance and monitoring, together with recruitment of replacement personnel to maintain military force strength and command and control capacity;
- protection and strengthening of military recruitment pool by implementing STI/HIV prevention information, education and communication campaigns targeted toward pre-adolescents and adolescents, and by limiting military recruitment to functionally literate school-leavers;
- strengthening of national health and social welfare sectors by increasing civil-military collaboration in STI/HIV/AIDS prevention and control;
- national and international co-operation to reduce the effects of HIV/AIDS on people and their communities, through greater civil-military information and resource sharing;
- change in perception at senior civilian and military levels, from HIV/AIDS viewed as only an immediate medical crisis to HIV/AIDS recognized as a serious but approachable challenge to national and international security, peace and socio-economic development;
- increased inter-sectoral commitment to HIV/AIDS prevention and control, moving beyond traditional distinctions among and between military and civilian governmental institutions, and between the public and private sectors, in promoting the common welfare.

References

- Brown AE; Brundage JF; Tomlinson JP; Burke DS; *The U.S. Army HIV Testing Program: The First Decade*, Mil. Med., 161 (1996)
- Kane SC; *Prostitution and the Military: Planning AIDS Intervention in Belize*, Soc. Sci. Med., 36 (1993)
- Kingma S; *Report of the Regional Policy Workshop for Eastern and Southern Africa on AIDS Prevention in the Civil-Military Environment*. Geneva and Hanover, NH U.S.A., World Health Organization and Civil-Military Alliance to Combat HIV and AIDS (1996)
- Kingma S; *Winning the War Against HIV and AIDS: A Handbook on Planning, Monitoring and Evaluation of HIV Prevention and Care Programmes in the Uniformed Services*. Geneva and Hanover, NH U.S.A., Joint United Nations Programme on HIV/AIDS (UNAIDS) and Civil-Military Alliance to Combat HIV and AIDS (1999)
- Kingma S; *Technical Reference Library 1999 for Winning the War Against HIV and AIDS*. CD ROM. Geneva: Civil-Military Alliance to Combat HIV and AIDS (1999).
- Smallman-Raynor MR; Cliffe AD; *Civil War and the Spread of AIDS in Central Africa*, Epidemiol. Infect, 107 (1990)
- Soeprapto W; Ertono S; Hudoyo H; *et al.*; *HIV and Peacekeeping Operations in Cambodia*, Lancet, 346 (1995)
- UNAIDS; *AIDS and the Military □ Point of View, Best Practices Collection*. Geneva, Joint United Nations Programme on HIV/AIDS (1998)
- Yeager R (ed); *Proceedings of an Africa Regional Training Seminar on HIV/AIDS Prevention in Military Populations*. Hanover, NH U.S.A., Civil-Military Alliance to Combat HIV and AIDS (1995)
- Yeager R (ed); *Third African Regional Seminar on HIV/AIDS Prevention in Military Populations*, Hanover, NH U.S.A, Civil-Military Alliance to Combat HIV and AIDS (1997)
- Yeager R (ed); *Situation Review and Strategic Planning Report on STI and HIV/AIDS Prevention in West African Armed Forces*. Hanover, NH U.S.A., Civil-Military Alliance to Combat HIV and AIDS (1998).
- Yeager R; Hendrix C; Kingma S; *International Military HIV/AIDS Policies and Programs: Strengths and Limitations in Current Practice*, Mil. Med., 165 (2000): 87-92.

Useful contacts

Stuart J. Kingma, M.D., Director
Civil-Military Alliance to Combat HIV and AIDS
20, route de l'Hôpital
CH-1180 Rolle, Switzerland
Tel: +41 21 825 3529
Fax: +41 21 825 3586
E-mail: kingma@iprolink.ch

Joint United Nations Programme on HIV/AIDS
20, avenue Appia
CH-1211 Geneva 27 Switzerland
Tel: +41 22 791 3666
Fax: +41 22 791 4187

Prepared by Rodger Yeager, Ph.D.
Associate Director
Civil-Military Alliance to Combat HIV and AIDS
369 Horseshoe Road
Morgantown, WV 26508, U.S.A.
Tel: +1 (304) 594-1960
Fax : +1 (304) 594-3686
E-mail : ryeager1@mail.wvnet.edu

Commissioning Editor: Alan Whiteside

Series Editor: Rose Smart