Combat AIDS

HIV AND THE WORLD’S ARMED FORCES
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SUMMARY

Over 22 million people serve in the armed forces across the world. The vast majority are men in their twenties and thirties. Soldiers (including members of other services) are highly mobile and in many communities are better paid than their civilian counterparts and have considerable power and influence.

Soldiers contract HIV in the same ways that civilians do: through unprotected sex, sharing of equipment in drug use, receiving infected blood transfusions, etc. However, the conditions in which they live and work often mean that they are significantly more likely to contract HIV than civilians. Soldiers live in an enclosed society where masculine values predominate and where stress, boredom, alcohol use and sexual activity may be high. Accustomed to taking risks in their profession, they may be more inclined to take part in risky sexual behaviour as well. During peacetime, war and peacekeeping operations they both seek and attract sexual partners. Sex, including commercial sex work, is usually consensual, but in times of war it may include rape, on an individual basis or as a mass act of terror.

High rates of sexual activity mean that the armed forces and their partners are highly vulnerable to a wide range of sexually transmitted infections (STIs), including HIV/AIDS. Large numbers of soldiers have contracted such infections, sometimes depleting entire units of command, and in recent years high rates of HIV infection have also been found among civilians living close to military bases.

Although the scale of the problem is huge, getting an accurate picture of how HIV/AIDS is affecting the world's armed forces is extremely difficult. Nor is it easy to gauge the effectiveness with which each military is responding to the pandemic. These are politically sensitive issues. Information on rates of infection often does not exist, and even where it does, the military forces may not be willing to open themselves up to outside inspection. Making information about HIV infection rates within the armed forces public may be seen as a risk to national security.

For much of the 1990s, Ministries of Defence and senior commanders in the armed forces failed to recognise the threat of HIV to soldiers and their civilian partners. There is now increasing recognition that a comprehensive HIV/AIDS policy that addresses all issues of risk, prevention and care is essential for the well being of each individual soldier and of the armed forces as a whole.

Such a policy should address the driving forces behind the spread of HIV/AIDS in the military – particularly relating to gender and masculinity, and should also address the physical and social conditions in which many soldiers live. They should include widespread prevention messages using peer educators and interactive techniques that allow soldiers to fully express their concerns, voluntary and confidential testing and counselling for HIV and other STIs, the open involvement of soldiers living with HIV, access to care, and similar programmes for soldiers’ partners.
Such activities benefit not only soldiers and their immediate partners but also the wider community. When soldiers are discharged or demobilised, many can act as agents of change in the communities they return to.

Many components of an HIV/AIDS programme in the military are uncontroversial, although adequate funding may prevent them being implemented. Some areas of disagreement remain, including whether to discharge or downgrade soldiers known to be living with HIV. Above all, the question as to whether or not to mandatorily test new recruits or serving soldiers for the virus is unresolved, with some militaries making it a point of principle to test, and others a point of principle not to test.

The importance of HIV prevention programmes for the military is now high on the international agenda. It has been discussed by the United Nations Security Council and General Assembly and is a priority for action for an increasing number of international and national governmental and non-governmental organisations.

Primarily, this publication focuses on young male soldiers serving in the armed forces. While we acknowledge that women serve in the armed forces, and that they too are at increased risk of contracting HIV or STIs, there is very little information available about their situation. Where possible, this publication has attempted to examine female and child soldiers in the military, and to explore the particular difficulties that exist for them in what is traditionally and typically a male-dominated industry. However, further research is needed about these minority groups that exist within the military.

This publication has not attempted to address some of the wider issues surrounding conflict and HIV, and instead has concentrated on the particular issues that affect soldiers and peacekeepers. Combat AIDS is intended to provide an overview for those seeking a basic understanding of the issues surrounding HIV prevention and care in the world’s armed forces, in the hope that it will facilitate further understanding and action.
INTRODUCTION

1.1 The Armed Forces and HIV

“I don’t think we’re different. It’s just that the army has taught us to dominate fear and be more decisive, not to be afraid.”

“Provincial girls like us. They treat soldiers as if they’re special.”
Career soldiers, Peru

“Because of our uniforms, we are being sought after by women. It would not be nice to see soldiers running away from women who are advancing to you. If the woman shows the motive and desire, then the soldier will definitely grab the opportunity.”
Officer, Philippines

Many countries, particularly in sub-Saharan Africa, have been severely affected by high rates of HIV infection, which has led to falling life expectancies, shrinking economies, destabilised family structures, reduced educational opportunities, increased malnutrition and many other social, economic and political problems. These epidemics have also had a considerable effect on the armed forces. In many countries, the armed forces are far more likely to contract HIV or other sexually transmitted infections (STIs) than civilians.

The armed forces play a significant role in many societies. In addition to guaranteeing the nation’s security, they are a source of skills and training, providing employment to many inside and outside the ranks. In some countries, high-ranking officers play a significant part in political life and ordinary soldiers are seen as role models in their communities. In countries affected by conflict, the armed forces may represent the civilian population’s only source of security.
"On the way back from mission I decided to rest with a woman. We put up a fire and spent the night there drinking. So I was exposed to a disease. Soldiers’ luck."

Career soldier, Zambia

"I’d never heard about the virus before. I spent most of the last 3 years fighting in the jungle. I only went into towns a few times."

Cambodian soldier after testing positive for HIV

STIs are usually higher in military units far from home. In the 1830s at least 1 in 3 British soldiers stationed in India were hospitalised for an STI, compared to only 1 in 30 Indian soldiers. The Indians were often married and lived with their wives and families while very few British soldiers were allowed to marry. In the early 1890s, British soldiers in India were twice as likely to have an STI than soldiers back home. During the 1960s, rates of infection among US soldiers in Vietnam were 9 times higher than among soldiers in the United States, and in Thailand, where almost half of soldiers contracted an STI, they were 15 times higher than in the US. In the United States in 1998, syphilis incidence was 2 to 3 times higher in the Marines, Army and Navy than in the general population; only the Air Force rate was lower. In 1996 the chlamydia rate among women soldiers in the US was 3 to 6 times that of the general population.

In many countries, HIV infection is much higher in the armed forces than it is in the general population. Statistics are hard to come by, partly because some militaries cannot afford to or do not want to test serving soldiers,
partly because many soldiers do not want to be tested, and partly because of the national security issues involved (see chapter 6). Estimates during the late 1990s for Africa include 40 - 60% of Angolan soldiers (2.8% of adult population), 10 - 25% in Congo (Brazzaville) (6.4% of adult population), 4.6% in Eritrea (2.8% of adult population), 15 - 30% in Tanzania (8.1% of adult population) and 50% in Zimbabwe (25% of adult population).5 In Cambodia in 1999, 12 - 17% of the armed forces were estimated to be HIV positive, compared with 3.7% of the general population.6

In some countries, however, rates of HIV infection in the military remain low or have begun to fall, largely as the result of effective prevention programmes (see box on effective prevention campaigns), but other possible explanations include rejection of recruits who test HIV positive, discharge of serving soldiers with the virus and successful prevention programmes within the military or the general population.

“I was some time in the provinces and there were only 2 girls for 120 soldiers.”

“There are some girls who only go for soldiers. They like the uniform.”

Career soldiers, Peru

High rates of HIV infection are often found in civilian populations living near military installations or are associated with the movements of soldiers. In navy ports and garrisons far from towns, soldiers often have a limited choice of partners. Many men from the same company or ship are likely to have sex with the same women over a period of time; when that company is replaced, the new soldiers have intercourse with the same women. Even if only a small number of soldiers or their partners have HIV at the beginning of the process, unprotected sex and sharing of partners will soon cause HIV to spread (see box below).
As the impact of HIV infection has become more evident, increasing numbers of military hierarchies have developed prevention and care programmes (see chapter 7). However, while some programmes reach most men and women in a nation’s armed forces, others reach only a minority, and some armed forces have no HIV/AIDS programmes at all. Across the world, millions of soldiers are still unaware of the risks of infection or lack the motivation, skills or condoms to protect themselves and their partners. Many who have HIV have no access to counselling and care and face informal or formal discrimination that both affects them as individual soldiers and impairs military readiness by wasting the services of valuable personnel.

The armed forces present an ideal opportunity to instil widespread awareness of HIV/AIDS and encourage safer behaviour among a significant percentage of the sexually active population. Soldiers are a large audience in a disciplined, highly-organised setting and military structure is ideal for dissemination of both ideas and materials such as condoms, therapeutic drugs and facilities for voluntary counselling and testing (see also box on drug trials in chapter 6).

Furthermore, a reduction of rates of infection in the armed forces protects not only soldiers but also their partners and, where the armed forces are held in high regard, can set a standard for the nation as a whole. Even in countries where soldiers have low status, a well-managed HIV programme can help thousands of men and women reduce the risk of infection to themselves and their partners, both in the military and when they return to civilian life.

Although unprotected sex is the primary means of transmission, HIV can also be transmitted through other situations or activities that can occur in the armed forces: transfusions of contaminated blood, and sharing unsterilised sharp or skin-piercing instruments, such as medical equipment, syringes in drug injection, needles in tattooing, and razors (see box below).

**NON-SEXUAL TRANSMISSION**

Recipients of blood transfusions have a 90% likelihood of contracting HIV if the blood being used is infected. Tests are able to indicate whether the donor has contracted HIV, but these tests are not always carried out where resources are scarce or in battlefield conditions. Mechanisms for preventing transmission through donated blood include: screening all donated blood for infection, prohibiting the sale of blood, reducing the number of transfusions in regions where medical experts believe there is overuse of the procedure, adhering to sterilisation guidelines, and training staff.

Transmission in health care settings can occur through an injury with an unsterilised needle or sharp instrument, or through splashes of infected blood or body fluids onto open wounds, mucous membranes or eyes. This can happen when medical instruments are used without proper disinfection or sterilisation, and when open wounds are exposed to contaminated blood. Proper medical procedures, including wearing protective gloves and clothing, safe handling of sharp instruments, safe disposal of waste materials and safe handling of corpses, reduce the risk of transmission to almost zero. Although these procedures are relatively simple and uncontroversial, they do have cost implications. It can be time consuming and expensive to guarantee prevention of transmission in battlefield conditions.

Sharing unsterilised instruments for piercing and shaving can also transmit HIV. Scarification is undertaken in some parts of Africa and tattoos are popular in some countries. It is also common practice for soldiers to share razors in the Ukraine, Russia and elsewhere. In comparison with sexual intercourse, however, these forms of HIV transmission are rare.
1.2 National Security

“In the army, you learn to love the institution and your country. When you were a civilian you didn’t sing the national anthem. Now you sing it with greater emotion.”

Career soldiers, Peru

Widespread HIV infection in the ranks threatens the ability of the military to respond to external threat or fulfil its other functions. Illness results in a loss of skills in all ranks and loss of institutional memory among long-serving soldiers and officers, which may contribute to a decline in military performance and breakdown in discipline. Costs are incurred by treatment for those who fall ill and recruitment to replace them. In the worst affected countries, which tend to be poor and have relatively few adults in higher education, the epidemic reduces the pool of potential replacements, particularly for officers. Senior commanders in some African countries privately admit that HIV/AIDS is so widespread that complete well-trained companies are not immediately available for mobilisation.11

There is some debate surrounding the impact of HIV on national security. Some commentators argue that widespread HIV infection in the armed forces of one or more countries may lead to mass regional destabilisation and conflict. It has been suggested that foreign armies have prolonged their stay in the Democratic Republic of the Congo so that some HIV-positive officers, who are involved in smuggling minerals, can earn additional income to buy life-saving antiretroviral drugs that they could not otherwise afford. However, in Southern Africa and the Caribbean, the regions most affected by HIV, there has been no international conflict since the seriousness of the epidemic became apparent. Recent wars and conflicts in Afghanistan, Colombia, Sierra Leone and elsewhere have been enabled by the weakness of all national institutions rather than the military alone.

Furthermore, because it is difficult to distinguish the impact of HIV on the military from the impact on the nation as a whole, it cannot be said that a weakened military in itself is a threat to national security. It is more accurate to characterise HIV as a long-term, rather than immediate, threat to national or international security, and a threat to all of a country’s institutions rather than posing a particular threat to the military.

Maintaining low levels of HIV infection in the ranks, or reducing it from high levels, is a priority for every country, but only one of a series of initiatives that must be taken to reduce the threat of the epidemic to national security.

11 It has also been argued that soldiers with weakened immune systems are more vulnerable to biological and chemical attack, although no proposed biological or chemical mechanism provokes a stronger reaction in people who are HIV-positive than in those who are not.
Sometimes the government itself is seen as weak or as a threat to national interests or to the military itself. In such circumstances the armed forces may take power. In time most countries return to civilian rule, but the military may remain partly or fully autonomous of civil authority. The military may also be key actors in a wide range of issues, such as trade and education, either as an institution, as in China where People’s Liberation Army owns a wide range of companies producing goods such as military hardware and plastic decorations, or as individuals, as in many countries where officers use their status and influence to make money or otherwise influence aspects of national life.
A SOLDIER’S LIFE

“My family is proud of me being a soldier, I can provide them of all their needs as well as education for my children.”
Officer, Philippines

“Training is hard. You leave the life you had. You can’t do what you used to do, even talk to people. You see things differently.”

“They call you a dog, things you hadn’t heard before. The first thing they do is lock you up. From that moment on, you’re deprived of your freedom. You can’t go to the bathroom without permission.”

“But it’s positive. You learn to be disciplined.”
Career soldiers, Peru

Conscripts, for example, may experience army life differently from career soldiers. Some armies have high numbers of conscripts: young men in their late teens and early twenties compelled by law to serve in the military for a limited period of time. Female conscription is rare. Others have only volunteers, who choose the military as a lifelong career, and the average age tends to be late twenties. Whether conscripted or volunteers, soldiers in the ranks tend to come from a poorer background and be less educated than the general population. Officers are almost always career soldiers and are usually better educated, older and living with their families. Career soldiers tend to be more motivated and adapt to military life better than conscripts.

Rates of HIV infection tend to be higher in conscripts than in volunteers. Conscripts are younger, more likely to be unmarried and partake in casual sex, and less likely to be well-informed about risks and prevention. They have little motivation to participate enthusiastically in military life, which reduces their receptivity to prevention messages that come from military
sources and increases the likelihood that they will seek diversions away from military sites.

Young soldiers may also experience army life differently (see box on teenage soldiers) as will men and women (see section 2.1 below).

### TEENAGE SOLDIERS

Until the late twentieth century it was considered acceptable by many armed forces to recruit teenagers as young as 15 into their armies. The United Kingdom, for example, allows 16-year-olds to enrol, while the insurgent FARC (Revolutionary Armed Forces of Colombia) continues to recruit 15-year-old boys and girls. Teenage soldiers face the same problems as their older companions, but more intensely, since they have fewer skills to deal with them.

The United Nations defines all those under 18 as children and encourages member states to recognise that warfare is not appropriate for those who have not reached adulthood. The recently agreed Optional Protocol to the Convention on the Rights of the Child outlaws the direct involvement of children under 18 in hostilities, bars compulsory recruitment below that age, requires governments to raise the minimum age for voluntary recruitment, and bans all recruitment below 18 by non-governmental forces.

Child soldiers (under 15) are a product of warfare and their needs and concerns are covered in Chapter 4.3.

### 2.1 Macho Soldiers

“As soldiers, we are different from civilians.”

“Soldiers are more macho.”

“Soldiers live more meaningful lives because their responsibilities are bigger.”

“Soldiers are quicker and stronger.”

Career soldiers, Philippines

“We’re strong, in the sense that we learn to value what’s right.”

“You have to be morally strong.”

“There are character differences. It’s different from a civilian mentality. A hick my age still isn’t mature enough to do a lot of things.”

“We consider women soldiers as men, whatever they think is what we think as well. We do everything together. We consider them as our sisters, soldier friends.”

Male career soldier, Zambia

Social and physical attributes that are highly valued in military life and warfare include physical strength, aggression, courage, and risk-taking. These are attributes that in many societies are most commonly associated with men, but they are not exclusive to men.
It is increasingly recognised that women also have qualities associated with effective soldiering. However, even though women represent up to 30% of some armies, in most they remain a small minority and only a dozen countries grant women full combat status. Depending on the definition (in some definitions, people holding administrative positions are considered members of the military) the statistics range from under 1%, as in Cambodia, through to 8%, as in the United States, to a third, as in Eritrea. Women tend to be found in higher numbers in insurgent forces or armies involved in civil conflict, as in El Salvador and Nicaragua in the 1980s and Eritrea in the 1990s.

While the physical conditions in which women soldiers live are similar to those of men, they may experience military life very differently. Many are conscious of pressure from male companions and superior officers to be “as good as” men, both physically and emotionally. This is particularly true for women in combat roles, where many male colleagues consider that women’s presence weakens the ability of the armed forces to fight. Colonel Joyce Puta of the Zambian Defence Forces adds that some male soldiers may see female soldiers as a burden from another perspective: rape of women prisoners of war may be used as a tactic to demoralise not only the women, but also their male companions who cannot help them.

“This is my rifle
This is my gun
My rifle’s for killing
My gun is for fun”
US military chant

In the eyes of many, however, to be a soldier is to be a man. For many young men with limited experience and searching for an identity for themselves, military life offers both security and a means of developing that identity.

Both within and outside the military, men’s behaviour is constrained by expectations of masculinity that surround them in childhood and influence them in adulthood. There are also hierarchies of masculinity, which differ from culture to culture and are measured by such indicators as the number of children a man has or how physically powerful he is. The link between masculinity and sexual activity is strong; many people see chastity before marriage and fidelity to one’s wife as less important for men than the ability to have sex. The banter and comments from other soldiers continually reminds male soldiers that to be a man is to be sexually active. The emphasis on promiscuous sex dramatically increases a soldier’s chance of contracting HIV.
Research in Slovakia identified the following situations where young conscripts (18-28) and their partners were at risk of contracting an STI:1

- first visit home after call-up (“sexual intercourse at all costs”)
- the second half of service, when soldiers often go to nightclubs and drink a lot of alcohol
- soldiers who have not yet had sexual intercourse and who have their first intercourse during service in a situation that they do not have under control
- isolated work places with little supervision
- intercourse with younger girls (about 15 years old) and young women from socially weaker strata.

An international meeting in Ghana in early 2001 identified the following risk factors for soldiers:2

- young population perceiving themselves as invulnerable
- duty schedules and periods of deployment resulting in separation from families
- extra money during military operations
- host population dependent on military for food, etc.
- civilian perception of the military as privileged and as people that women want to associate with
- multiple partners
- unprotected sex
- incorrect and/or inconsistent condom use
- mistaken beliefs and ignorance
- alcohol and substance abuse
- sharing of razors and skin-piercing instruments in tattooing and scarification
- handling injured and dead bodies.

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1 “A rapid situation assessment of substance use and sexual risk behaviour in Slovakia”, Department of Social and Biological Communication, Slovak Academy of Sciences, Bratislava, Principal Investigator: Dr. Gabriel Bianchi, CSc, February 2000.

2 Meeting to Develop a Comprehensive Package on HIV/AIDS for Uniformed Services in Africa, Uniformed Services Task Force on HIV/AIDS.

3 Quotes from Slovak conscripts here and below are taken from “A rapid situation assessment of substance use and sexual risk behaviour in Slovakia”, Department of Social and Biological Communication, Slovak Academy of Sciences, Bratislava, Principal Investigator: Dr. Gabriel Bianchi, CSc, February 2000.

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2.2 Home from Home

“I faced complete degradation of human being, simply humiliation. Army officers don’t treat ordinary soldiers as ordinary men.”

“Soldiers have nothing here, no activity, nothing. When you have permission to leave station, you go to a bar. There’s no exercise room; one TV set, that’s all.”

Slovak Conscripts

“My family lives here in Camp Aguinaldo. We have a household help or house maid. We have our own houses here.”

Officer, Philippines

“On the whole, a soldier’s life is difficult. You’re out of touch with so many people, you have to get used to the fact you’re not going to see your family for a long time.”

Career soldier, Peru

The physical and psychological conditions in which soldiers live vary widely. In wealthier countries they live in comparative comfort, while in the poorer countries barracks can be highly congested, housing many more people than originally intended. Sleeping, washing and other facilities may be overstretched and poorly maintained to the point of squalor. Officers and older personnel are more likely to be married and allowed separate...
accommodation, but large families and other dependants may take that space up. Common rooms, including entertainment facilities, may be absent, poorly maintained or their use formally or informally restricted to officers or other privileged soldiers.

Soldiers are frequently stationed away from their base, on exercise elsewhere in the country or abroad, on peacekeeping missions or during conflict. Depending on the posting, such deployment may relieve or compound tensions. Peacekeeping may be welcomed for the increased pay and change of environment, while conflict can lead to more cramped conditions and long periods apart from wives or steady girlfriends. In the mid 1990s Nigerian troops serving as peacekeepers only returned home after 2 years, a period that has now been reduced to less than 12 months. Kenyan peacekeepers stay in East Timor for a year, while their Australian counterparts have leave every 3 months.

2.3 Alcohol and other drugs

“It’s difficult to find anything to do. There are supposed to be cultural events but there are very few. So drinking is the best possible [option], the easiest.”
Slovak conscript

“When we say drink, everything is included in it. It is embarrassing to admit that we womanise. When we say we drink in the beer house, it is a given that there is a woman with us on the table.”
Career soldier, Philippines

“There are incidences of shooting [during drinking]. That is why we are restricted in the bars and gambling areas, even during fiestas and other occasions.”
Officer, Philippines

“It’s not forbidden to drink, but I’ve known cases someone’s come back drunk and immediately been punished.”

“When it’s happened to me, I’ve been put on sentry duty in my free time.”

“Drink’s forbidden in the barracks, but, depending on the guard, it gets in.”
Career soldiers, Peru

Military authorities recognise that barracks life can lead to tedium and tension. Where possible, they provide distractions and entertainment such as sports facilities and films. Where these are not available, soldiers find other ways of spending their time. This may involve games with weapons or “extreme” sports as a means of reasserting autonomy and identity in a
frequently disempowering environment. Alcohol and other stimulants are another way of relieving stress and boredom.

Alcohol abuse is a major problem in the armed forces of many countries, with pressure to drink being both implicit and explicit. In Slovakia one researcher comments: “There is a highly permissive (even though officially prohibited) attitude to alcohol use, which is overshadowed by an exaggerated fear of other illegal substances.” In the Philippines, one group of soldiers estimates that only 10% of men in the army are not regular drinkers.

Who drinks alcohol, where they drink it and how much they drink differs. In barracks, it may be allowed to officers but not the ranks, or allowed in specific sites only. In many countries, military bases sell alcohol at subsidised prices, and in some locals living near barracks sell cheap, home-brewed beer to soldiers. Reasons can easily be found to drink large quantities: someone’s birthday, in memory of a lost companion, or simply because they are on leave. And when sex is desired but not available, alcohol can provide a distraction.

Relatively few soldiers use recreational drugs, partly because prohibitions tend to be more strongly enforced and partly because the drugs are often more expensive. Some soldiers have access to marijuana/cannabis, cocaine or heroin derivatives, or illegally manufactured pills such as ecstasy. In many parts of the world there are local drugs not used elsewhere. In Ukraine, for example, local poppy seeds are prepared in liquid form, “purified” with injection of fresh blood, and injectors all draw from the same pot, a pattern that has led to increased HIV infection among civilians in that country.

Occasionally drugs are made available to soldiers by their commanding officers, although usually only in insurgent forces. In the 1990s the children who fought for the insurgent forces in Sierra Leone commonly used cannabis, while in Somalia, a planeload of miraa, also known as qat (a plant bark chewed as a stimulant), was flown in daily from Kenya to encourage the soldiers of different militia to fight.

Abuse of alcohol and other drugs not only carries significant health risks, but can also indirectly result in HIV transmission. While some drugs reduce sexual desire and performance, others, particularly alcohol, reduce inhibitions, making unprotected sex more likely and placing both partners at risk.

The injection of recreational drugs can be a direct cause of HIV transmission if equipment is shared and not sterilised. However, despite fears in the 1990s that drug injection would become widespread in the armed forces in some countries in Eastern Europe and elsewhere, it still appears to be relatively uncommon.
SEXUAL RELATIONSHIPS

“Soldiers are good in bed.”
Career soldier, Philippines

“Usually you’re worried about promotion, but at the weekend, out in the provinces, with new companions, there’s drink, girls…”
Career soldiers, Peru

“Why do soldiers have sex? That’s a thing that was given from God. God didn’t make woman just for looking.”
Career soldier, Zambia

These different aspects of military life — living conditions, peer pressure, alcohol, boredom, etc. — can not only exaggerate a soldier’s desire for sex, but also increase their opportunities to have it.

Studies from across the world show that most men go through a period in which they have more than 1 sexual partner. Up to a third of men in their late teens and early twenties has more than 1 sexual partner a year. Statistics indicate that this figure is even higher for soldiers in Belgium, Chile, France, the Netherlands, the United Kingdom and the United States. However, soldiers in Slovakia report less sex than in civilian life; and anecdotal evidence suggests the same is true elsewhere in Eastern Europe and in some other countries. Peruvian career soldiers claim that ordinary soldiers work too hard to have sex, while lower ranking officers have more opportunity. Filipino career soldiers in their thirties also believe that soldiers have less sex. “Camp rules are very strict on the matter.” The perception may be true or reflect their relative age, but both Peruvian and Filipino career soldiers were aware of where sex workers can be found and how much they charge, indicating that there is at least some interaction between soldiers and prostitutes. Meanwhile Filipino officers believe there is no difference between civilians and soldiers in the amount of sex they have, though they may have more sexual partners. “If you are away from your family, you tend to look for an outlet or substitute.”

The armed forces may restrict soldiers’ sexual lives, for reasons of discipline, or to reduce conflict with locals, or to reduce the risks of contracting HIV or other STIs. Younger men are often prevented from marrying and troops may be prohibited from visiting sex workers or bars.

1 “Belgian Military Medicine, AIDS: No Cure, but Care”, R Wouters, Civil-Military Alliance Newsletter, vol 1, no 2, April 1995.
3 “HIV/AIDS in the Armed Forces”, A Whiteside, Civil Military Alliance Newsletter, vol 2, no 4, October 1996.
5 “HIV/AIDS in the Armed Forces”, A Whiteside, Civil Military Alliance Newsletter, vol 2, no 4, October 1996.
6 “HIV/AIDS in the Armed Forces”, A Whiteside, Civil Military Alliance Newsletter, vol 2, no 4, October 1996.
7 “A rapid situation assessment of substance use and sexual risk behaviour in Slovakia”, Department of Social and Biological Communication, Slovak Academy of Sciences, Bratislava, Principal Investigator: Dr. Gabriel Bianchi, CSc, February 2000.
The extent to which such measures succeed is disputable. Soldiers across the world, particularly those who are single, report that they regularly look for sex. They do so occasionally on the garrison, with laundry women and other civilians or the wives of other soldiers, but more often off-base, from girlfriends, casual partners and sex workers (prostitutes). Occasionally women may be brought into the barracks, although the opportunity for privacy is rare. Soldiers may vacate a dormitory to allow one of their number to have sex with a regular partner or casual partners may be shared.

For women, the story is different. In almost every society women have less sexual freedom than men. The same is true for women soldiers. The pressure they face is not to be sexually active with many partners, but to be seen to be sexually active with one partner, particularly if they are childless in cultures where motherhood is considered an essential aspect of womanhood. Sexual relations between soldiers are usually strongly restricted, and almost always forbidden between different ranks. In practice, however, such relations sometimes occur. While women soldiers may be able to reject advances from men of the same rank, they may find it more difficult to say “no” to those of a higher rank, who may use bribery, such as promises of promotion, or threats of punishment to persuade them.

3.1 Long-term relationships

“Because of our uniforms, we are being sought after by women. It would not be nice to see soldiers running away from women who are advancing to you. If the woman shows the motive and desire, then the soldier will definitely grab the opportunity. However, I believe this applies more to the single staff.”

Officer, Philippines

“In fiestas nowadays the first thing some girls do is find someone who will buy her a drink.”

Career soldier, Peru

“When you are at home you make sure that your woman reaches climax. When it is [a casual partner], you only want to achieve your own climax.”

Career soldier, Zambia

Long-term sexual relationships where both partners are mutually faithful are an integral aspect of HIV/AIDS prevention. Military life makes such relationships difficult to maintain. Younger soldiers find it difficult to establish long-term relationships, while older soldiers may be married but separated for long periods from their wives. Facilities for married couples may not be provided or may be overcrowded and unsuitable.

In Zambia, younger soldiers are prevented from marrying for 2 years, after which the consent of a superior officer is required. The delay is necessary,
according to Colonel Joyce Puta, partly so that younger soldiers can mature, and partly because they are likely to be sent on long tours of duty that would separate them from their spouses. When a soldier does apply for permission to marry, both partners are advised to take an HIV test in facilities that guarantee confidentiality.

Marriage is no guarantee of protection from HIV. Deployment may separate the couple for long periods of time, during which time not only the man, but also the wife may seek other partners for financial or emotional support. In some countries, particularly in Africa, a man is expected to take another partner if he is separated from his wife for long periods.

Marriage can also disadvantage the wife. A woman recognised as a wife by the Uganda People’s Defence Force is given an identity card which only allows her to leave the barracks at certain times, while her husband is free to leave after working hours and visit areas where there may be bars and other women. In Nigeria, soldiers’ wives often refer to their husbands as oga, a term that implies complete submission. Ogas make all decisions, severely restricting the wives’ ability to negotiate safer sex or to curb their husband’s behaviour with other partners.

### 3.2 Sex as a Commodity

“Men are supposed to provide money and other things. If you don’t have money, why do you take a girlfriend in the first place?”

20-year-old Ghanaian woman

“If they are around 16-20 years old, we pay 2,500 pesos [US$50]. But if they are over 20 years old, we pay around 500 pesos [US$10]. If the price is low, it could mean that she is sick.”

“Bambang Station, near Doroteo Jose, you can just stand there and somebody will approach you for a short-time at 150 pesos [US$3].”

Career soldiers, Philippines

“In the street it’s 15 soles [US$4.30], but if they come to the garrison it’s 7 soles [US$2.00].”

“It depends on the quality, but most soldiers can hardly afford them.”

“As a sergeant, I get 52 soles [US$15] a month. In the Air Force it’s 63 soles [US$18].”

Career soldiers, Peru

How successful soldiers are in meeting partners depends on a number of factors, including pay, military discipline and whether society allows mixing between the sexes. In communities where women have some social independence, but are heavily dependent on men for status and/or income, sex may be seen as a commodity and for many women the only income they
have. In such circumstances many casual and long-term relationships are a form of barter where a woman offers sex in exchange for security, food, gifts or money.

In many parts of sub-Saharan Africa, soldiers are relatively well paid and find it easy to meet women. These may be sex workers, who receive money from many clients, casual girlfriends or long-term partners. Women in casual or long-term relationships do not consider themselves sex workers, but are likely to expect gifts, which may include money.

Where money or gifts are the basis of a relationship, the decision whether or not to practise safer sex depends much more on the man than the woman. A soldier with money can offer more money to a sex worker for sex without a condom and he can withdraw gifts or threaten violence against a girlfriend who does not do as he wants.

Where soldiers have neither money nor prestige, their opportunities for sex can be severely reduced. In Slovakia, conscripts earn US$18 a month, compared to an average of US$700 before enlisting. While some are able to meet their girlfriends regularly, many have no regular partners, or their partners live far from the barracks. Slovak conscripts report that many young women avoid them, partly from reluctance to appear promiscuous. However, women from minority ethnic groups may see them as having prestige.

Generally, however, most soldiers find sexual partners at some point in their careers. In the words of one from Peru: “Usually everyone who’s been to the provinces has had ‘adventures’. Not a prostitute, a girlfriend. You go to a fiesta, get to know one there.”

### 3.3 Sex Between Men

“In our free time they tell us to avoid problems in the street, not to go to brothels and not to go with homosexuals.”

Career soldier, Peru

While emotional bonds among soldiers boost morale, in most armed forces sex between men is seen as incompatible with military life. According to Peruvian soldiers, “A homosexual can’t join the army because he’d solicit other soldiers, or pull rank to get a soldier and give him a disease, even AIDS.” Zambian soldiers claim that there is no sex between male soldiers, partly because it is a strong taboo, and partly because there is never an opportunity for two men to be alone together. Nevertheless, some soldiers have sex with men, either exclusively or in addition to sex with women, and the Peruvian group recalled several cases of officers using their authority to have sex with new recruits.

In some countries sex with men is a means for soldiers to earn extra income. In Chile, one commentator writes: “Low pay makes it difficult for soldiers to visit women sex workers, so they sometimes accept alternatives among local men, which may not only be free but include drinks, food, lodging and even a relationship. Most return to heterosexual lives when they leave the
army.” Similar experiences are reported from Peru, while in Slovakia, conscripts report that half a month’s pay or more can be made from one encounter with a client.

With the exception of a few Western countries where homosexual soldiers are accepted, soldiers who are known to have sex with men are almost always punished and often discharged. That does not mean that such a policy is strictly maintained. In the Slovak Army, for example, homosexuals are theoretically prevented from entering the Army “to reduce potential conflicts”; however there is no formal or legal procedure for identifying homosexuals and no guidelines for commanders on how to proceed if homosexual men or practices are identified in the unit.8

8 “A rapid situation assessment of substance use and sexual risk behaviour in Slovakia”, Department of Social and Biological Communication, Slovak Academy of Sciences, Bratislava, Principal Investigator: Dr. Gabriel Bianchi, CSc, February 2000.
4.1 Sexual opportunities

“I remember the time of conflict, even if we were inside the barracks, there were some girls who come to our camps.”
Officer, Philippines Army

“We wanted to go to brothels but we couldn’t. There were terrorists.”
Career soldier, Peru

“In wartime the immediate aim is your own pleasure and you’re not going to consider the other side. You’re going for two things - one the enemy, two the girl. As you are shagging the girl, your eyes are always looking for the enemy.”
Career soldier, Zambia

During wartime, attitudes towards death and survival and perceptions of risk change. The increased likelihood of death in war means that soldiers and civilians may be more willing to engage in risky sexual activity. Where routine life is disturbed, uncertainty over income forces some women to turn to sex work. Overall, during times of war, rates of consensual sex rise, prostitution increases, the age of sex workers declines and protection against STIs is seen as less important.

During intense fighting there may be limited opportunity for sex, but risks of HIV transmission can increase if unsterilised equipment is used in hastily performed medical procedures. Where stress levels are high, soldiers may inject drugs and needles may be shared. There may be lulls that allow both men and women opportunities for sex, or periods of high tension where women and girls, and sometimes men and boys, are raped. In the aftermath of war, rape remains common, while poverty encourages or forces many women and girls to have sex for financial gain.

During the civil war in Mozambique in the 1980s, Malawi sent troops to protect the railway line that
linked it to the outside world. “I had just finished my cadet officer training when I was selected and you can imagine how excited I was,” recalls one Malawian captain. “With such fat allowances [equivalent to US$0.50 a day] we used to enjoy life.” A woman in Liwonde, on the route to Mozambique, said: “If you had a boyfriend among them you were assured of gifts such as a radio or salt, when they came back from Mozambique.” In Cuamba, in Mozambique, many shops, bars and resthouses were built when the soldiers arrived, with the owners making good money.

In Eritrea, a third of the armed forces are women. During the war of liberation in the 1990s, they served in identical, often extremely hazardous, conditions as men. Consensual sexual relations between the sexes were relatively common.

### 4.2 Rape

“One day we entered a village and axed to death all the old people and invalids, took away the girls and the boys and raped women in front of their own husbands and parents-in-law.”

RENAMO soldier during the Mozambican war

Where troops are engaged on the ground, rape may be common, by soldiers acting alone or as mass acts of terror. When mass rape occurs, it is sometimes difficult to determine whether it results from indiscipline, tacit encouragement from superiors, or explicit orders. Some acts of rape may be by men who would not otherwise commit the crime. When tension is high and men are charged with adrenalin from the urge to fight or to flee, rape may be a means of reducing tension.

Rape in warfare is as old as history. One study reports systematic rape of women and children by soldiers in over 20 countries across the world in the last 30 years. In the early 1990s, over 20,000 women were raped during the Balkans war with the Yugoslav National Army Psychological Operations Department advocating rape to destroy Muslim morale and their will to resist. Rape was also seen as a tool in “ethnic cleansing” by making women pregnant who would later to give birth to “Serbian” children. In Rwanda in early 1993, between 250,000 and 500,000 women were raped during the genocide; a UNICEF report stated that almost a third of Rwandan children had witnessed a rape or sexual assault. Though less common, rape of men and boys also occurs.

Acts of sexual violence in conflict, and orders to commit such acts, are liable to international prosecution. In 1998, the conviction of a defendant at the International Criminal Tribunal for Rwanda defined rape as an act of
genocide when directed at women because of their ethnic origin. In 2001, the International Criminal Tribunal for the Former Yugoslavia convicted Bosnian Serbs of rape as a crime against humanity.

Between December 1998 and December 1999, 3,000 cases of rape by the Congolese military were recorded in Brazzaville. Many soldiers had previously been members of armed groups and had little or no professional training. By early 2000, attempts were being made to restore order, with the chief of staff, General Jacques-Yvon Ndoulo, claiming that “Military tribunals will be set up soon to judge and, if necessary, execute servicemen found guilty of reprehensible acts.”

Rape increases the risk of infection with HIV and other STIs, especially when there is physical trauma. Claims that the virus itself has been used as a weapon of war, with soldiers known to be HIV-positive ordered to rape enemy women, have not been substantiated. Nevertheless, allegations of intentional transmission of HIV have been used as propaganda. In late 2001, Radio-Télévision Nationale Congolaise said that “two thousand HIV-positive Rwandan and Ugandan soldiers [had] been dumped in the Democratic Republic of Congo... Kigali and Kampala’s action demonstrates their inhuman determination to carry out the plan of establishing a Himatutsi empire by infecting the soil of the DRC.”

4.3 Child Soldiers

“I was given to a man who had just killed his woman. Girls who refused to become LRA wives were killed in front of us, as a warning.”

Concy Abana, 14 year old Ugandan abductee

In times of peace, children under the age of 16 seldom serve in the military. In times of war, they may be forced into service by both insurgent and government forces. It is estimated that 300,000 child soldiers are involved in armed conflict worldwide, as fighters, spies, servants, messengers and, particularly in insurgent movements, as sex partners. Children are recruited when few adults remain available and because they are easily manipulated and coerced into violence. Many are recruited by force or simply abducted, while others are driven to join by poverty. In the 1990s, soldiers as young as five years old were reported to be involved in conflicts in Cambodia and Sierra Leone.

The most notorious abuse of children in warfare is carried out by the Lord's Revolutionary Army (LRA) waging guerrilla warfare in North-west Uganda. Over 26,000 cases of child abduction by the LRA have been documented, some as young as eight years old. Many are kidnapped in raids on their homes, while others are taken from camps for the 480,000 people displaced by the war. Up to 90% of LRA soldiers are abducted children. Those caught trying to escape are summarily executed as a warning to others.

Around 20% of abductees are young girls, who are pressed into service as a soldier or soldier's “wife”. Most of the girls and some of the boys are sexually abused, sometimes by more than one man, and many who escape
have contracted HIV and/or other STIs. Similar experiences have been reported from victims of other rebel forces.

Not all children try to escape their abductors. Even when forced into service they may see the insurgent force as the only means of survival as the society breaks down and their families and traditional support systems cannot provide for them. As well as food and shelter, boys may meet their need for more intangible forms of nurturing through a form of father-son relationship with commanding officers, while girls may perceive some security through their status as a soldier’s “wife”.

4.4 Demobilisation

When war ends, reintegration of large numbers of soldiers into civilian society presents an opportunity and a challenge to both the individual soldier and the community. In the 1990s, millions of soldiers were demobilised as the world’s armed forces shrank from over 28 million to 22 million, with mass demobilisation occurring in Bosnia, Cambodia, Ethiopia, Kosovo, Mozambique, Namibia and Uganda. Despite its many obvious benefits, demobilisation presents a number of challenges. The successful reintegration of ex-combatants into civil society is a complex process, requiring that the needs and potential contributions of former combatants are coordinated with the community’s needs and capacity to absorb demobilised personnel.

In Uganda, 50,000 members of the Defence Forces were demobilised in 1996, partly as a result of the improving security situation in that country and partly, it was alleged, because many were living with HIV/AIDS. The Uganda Veterans Assistance Board was established to facilitate the resettlement of ex-combatants, providing soldiers with food, shelter and clothing as well as information on income-generating activities, family planning, HIV/AIDS awareness and other relevant issues. The Board also appointed programme officers to facilitate local administration of the programme. Despite these preparations, the ex-combatants were often received with fear, prejudice and antagonism, requiring community activities to sensitise community leaders to the needs of veterans and the benefits to society of their reintegration.

Not only should all soldiers be made aware of HIV-related risk in civilian life, but many, whatever their HIV status, have a potential role as community educators. With sound training and follow-up supervision, some ex-soldiers could be trained to organise discussion groups, provide counselling, ensure distribution of condoms, and assist in other activities leading to changing attitudes and behaviour. The first challenge therefore is to reach troops with HIV/AIDS prevention and care education and

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information prior to demobilisation. The second challenge is to take advantage of this process to create agents of community change.

In 2002/3, 200,000 Eritrean soldiers, including 60,000 women, will be demobilised as a result of the peace agreement signed with Ethiopia. The government has applied for US$500,000 from the Global Fund for AIDS, Tuberculosis and Malaria and bilateral donors to support an HIV/AIDS programme for this sector of the population, displaced people and peacekeeping personnel. The proposal includes identification of up to 1,000 “change agents”, including people living with HIV/AIDS, from the Defence Forces to foster awareness and build skills to respond to HIV/AIDS challenges within communities across the nation. A similar programme is planned for neighbouring Ethiopia.

A soldier’s life in the Indian Army by Kalpana Jain

Long separation from their families and a difficult life, especially in conflict zones such as Jammu and Kashmir, makes soldiers in the Indian Army vulnerable to HIV infection despite a strict disciplinary code prohibiting casual sex. All are volunteers who serve a minimum of 2 years and only see their families every 3 to 6 months. While some disobey orders, many who are reluctant to leave barracks while on service have frequent sexual contact while on leave, and some have sex with other male soldiers.

Those most at risk are the ordinary soldiers (known as jawans), air force crew and soldiers, who have little education and are often uninformed about the threat of HIV. Rajiv (not his real name), a jawan posted in the northern sector whose wife died of an unknown disease 2 years ago, admits that when he goes home he has sex with his wife’s sister and sometimes sex workers as well.

To reduce the spread of HIV and other STIs, army officers keep jawans busy with a gruelling schedule from morning to evening. Once military duties are over, soldiers can watch television and are offered three movies a week. Sport is also popular, with many reaching world-class status in many disciplines. In the border regions, the terrain provides ideal rugged conditions for adventure training and sports, including mountaineering, hang gliding, hot air ballooning, microlite aircraft flying, rock climbing, white water rafting, skiing and parachuting.

Though most soldiers want to save their earnings to send back home (the monthly salary is 4,000 rupees — US$82), those who enjoy spending, according to officers, can be monitored. For most men, therefore, the highest risk of infection is during their month-long leave. On return, all jawans are given a medical check up, in addition to yearly medical inspections and HIV test. (New recruits are not tested.)

Despite these prohibitions, soldiers do find time for casual sex, particularly in the North-east part of the country, where local customs allow women to mix freely with soldiers. Jawans posted to these areas are often informally told by their seniors to carry condoms.
Living conditions are not always helpful. In some stations accommodation for married men may not meet the demands. “Only about 20% find family accommodation,” says one soldier; the others must wait for their turn. Single soldiers sleep in barracks with up to 20 men sharing a dormitory, depending on their rank. Meanwhile, there are very few women in the armed forces. Women are only appointed at officer level and the process is too recent to confirm the impact.

Ten years ago, soldiers with HIV were treated harshly. Although they were not always dismissed, the results of their test were frequently openly displayed and harsh treatment from their equals and superiors often made life extremely difficult. Today officers are more sensitive about issues of confidentiality and regular awareness programmes have been instituted. Voluntary Counselling and Testing Centres are being opened, an AIDS education programme instituted in 200 Armed Forces schools, and the military system of blood banks is being modernised. Funding for these activities comes from the National AIDS Control Organization, with a budget in 2001 of over 15 million rupees (US$306,000).

In conjunction with these activities, commanding officers are expected to be aware of and respond to any personal problems a jawan might have, as a means of heading off potential high-risk behaviour. Furthermore, regular Sainik Sammelans (soldiers’ conclaves) are intended to get Commanding Officers units to talk with jawans freely about HIV, while the CO’s wife reaches out to the wives of the soldiers. However, such discussions are not always open and frank. Officers say that if they talk about sex with the soldiers they lose the authority to enforce strict discipline. For soldiers there is a lot of hesitation on their part to ask any questions. “It’s like a classroom lecture. You can just sit there and listen.”

Partly as a result of the broader prevention programme, the number of soldiers in the 1.1 million strong Army living with HIV remains low. The most recent figures (1999) show 1,400 army personnel have contracted the virus, with a far smaller number in the Navy and the Armed Forces. Soldiers discovered to be HIV-positive are not dismissed, but are given easier work.
When war ends with an uneasy truce, peacekeeping can prevent a resumption of hostilities. In March 2002, over 46,000 military and police personnel from 87 countries acted as UN peacekeepers in 17 countries. Bangladesh, Pakistan, Nigeria, India and Ghana provided the most personnel. About 5 to 10% of peacekeepers are women. Countries volunteering uniformed personnel to peacekeeping operations are reimbursed by the UN at about US$1,000 per soldier per month. Peacekeeping soldiers are paid by their own governments, and usually receive a bonus in addition to their standard income.

Rotation of peacekeepers every 6 months is strongly encouraged in order to alleviate stress, boredom and loneliness. However, it may cost at least US$2,500 to rotate one person, a sum that many poorer nations — who contribute most troops — cannot regularly afford.

The perceived threat of HIV transmission to civilians and the perception that HIV-positive soldiers compromise the military’s ability to perform at its highest competence, has led to many demands that peacekeepers be tested for the virus before they leave their home country. Such a policy is supported by some governments such as the United States. However, other governments, such as Brazil, and UNAIDS argue that mandatory testing of peacekeepers carries no benefits and engenders a false sense of security among both the military and civilian population. The reality is that as long as peacekeepers have unprotected sex with members of the local population, both partners are at risk of contracting HIV.

AIDS policy officers are now planned for every peacekeeping operation, although they are not all in place. Until a systematic approach to HIV/AIDS is established for peacekeepers, institutional memory on AIDS awareness and training will continue to be lost after each rotation.

5.1 Accusations and Uncertainty
“The position of power, wealth and status enjoyed by peacekeeping personnel gives them the ability to do as they wish.”
UNHCR / Save the Children UK
While peacekeepers are generally welcomed as guarantors of normality, they are sometimes accused of sexually exploiting local women and children and of spreading HIV. In 2001, the Eritrean government expressed concern over an allegation of sexual abuse by a UN peacekeeper of an underage girl. In Mozambique in 1996 and Sierra Leone in early 2002 significant numbers of peacekeepers were accused of having sex with underage girls.

The extent to which peacekeepers spread HIV is uncertain. In 1992, when peacekeepers arrived in Cambodia, the country had no recorded case of HIV/AIDS and little or no commercial sex industry. Within 10 years, prostitution was widespread and Cambodia had the highest incidence of HIV per head of population in Asia. While some attribute the epidemic to peacekeepers, others argue that poverty and the rapid social change that followed the collapse of the Khmer Rouge are more significant factors.

Whether or not they transmit the virus to the civilian population, peacekeepers themselves are at risk. When Indian soldiers returned from peacekeeping duties in Cambodia in the 1990s, the *Times of India* alleged that 45 of them had contracted HIV. Nigerian troops on peacekeeping missions must test HIV-negative before they are deployed and are also tested on return. One study showed that 7% of returning peacekeepers had contracted HIV after one year, 10% after 2 years and 15% after 3 years. While some may have contracted the virus while on home leave, the reality is that during peacekeeping missions there is a much higher probability of contracting HIV than of being killed in action.

*Keeping the Peace in Sierra Leone by Osman Gbla*

Sierra Leone, a small West African country with a land area of 72,000 square kilometres and an estimated population of 4.7 million people, became embroiled in conflict in 1991, when rebel soldiers, aided by insurgents from neighbouring Liberia, attacked a village in the east of the country. By the time a peace agreement was signed, in January 2002, over 20,000 people had been killed and almost half a million displaced. The country’s development was not only stalled, but also reversed.

In 1997, soldiers from the Economic Community of West African States entered the country in an attempt to enforce peace. Two years later, the United Nations took over, and currently 17,500 troops, the largest peacekeeping force in the world, are deployed throughout Sierra Leone. The force is drawn from a wide range of countries, including Zambia, Kenya, Nigeria, Guinea, Ghana, Jordan, Pakistan, Britain, India, and Bangladesh. The largest contingent — about 3,000 troops — come from Nigeria, a country that has contributed to peacekeeping efforts since the beginning.

The war has devastated the social fabric of this small country. There is a significant population of young women, from both Sierra Leone and refugees from neighbouring Liberia, who come from poor backgrounds, have little education and few skills, and are single mothers or have other family members to care for. With few opportunities to earn money, some resort to exchanging sex for money in order to survive.
Such women find natural partners in peacekeepers, who, being paid in dollars and receiving other benefits such as food rations, are wealthier and often more responsive to advances than Sierra Leonean men. In the words of one young woman, Massa: “We look for the UN peacekeepers as you Sierra Leonean men don’t have money and don’t also know how to treat women.”

Opportunities to meet peacekeepers are widespread. UNAMSIL (United Nations Mission in Sierra Leone) headquarters sits close to Lumley Beach, where nightclubs such as Paddy’s offer a convenient meeting place for scantily-clad local women and foreign men with money to spend. In the provinces, the soldiers are housed in makeshift camps near towns and villages, which are easily available to young women.

Sex workers who have peacekeepers as clients are well paid compared to most women. A Liberian woman can charge 20,000-25,000 leones (US$10-$12), or over 30,000 leones (US$15) for sex without a condom. Local women charge less — 10,000+ leones (US$5) for sex with condom and double that amount for no condom.

Some peacekeepers are more likely to respond to offers of sex than others. As anglophones from a similar West African culture, Nigerians find it easier than peacekeepers from other regions to talk to the locals and they have gained a reputation for paying for sex. In comparison, those who do not speak English or the local dialect fluently have problems in communicating with most Sierra Leonians.

While sex work is mostly consensual, there are reports of peacekeepers forcing girls to have sex with them. Some peacekeepers have also established long-term relationships with local women.

A joint report by Save the Children UK and UNHCR found that some peacekeepers are involved in the exploitation of underage girls. “When ma (Mother) asked me to go to the stream to wash plates, a peacekeeper asked me to take my clothes off so that he can take a picture. When I asked him to give me money, he told me, no money for children, only biscuit.” Peacekeepers may pay from US$5 to US$300 to have sex with a child. Some are alleged to pool money to obtain a girl and then all have sex with her. Some reportedly go as far as meeting the parents of the girl and claiming they have good intentions. However, when the time comes to leave, “Some of them leave without even saying goodbye, and some will leave the parents some money to take care of the girl. Others will give the girl some of their personal belongings.”

Certainly not all peacekeeping troops behave this way. One Nigerian soldier says: “The conditions of service are far better than back home. But in spite of these advantages, some of us are really missing our homes and family members. I left my wife and 2 children for over 3 years now and am sure my wife and kids are really missing me.” Meanwhile a Pakistani peacekeeper claims: “As a staunch Muslim, I don’t go around with women as I want to be faithful to my wife back home.”
And many peacekeepers recognise that there are image problems. A Nigerian points out: “The attitude of some Sierra Leoneans towards us as peacekeepers is really not good. Some think that we are enjoying in their country at the expense of their suffering. Some even believe that we exploit their diamonds, other resources and their women.”

HIV infection has been rising in Sierra Leone. By the end of 1999, 3% of adults were believed to have contracted the HIV virus — and the national and international authorities are aware that peacekeepers may play a role in the epidemic. The testing of troops before deployment has little impact, considering that many contract the virus in Sierra Leone and presumably transmit it to other women in the country before returning home. Strict military discipline would be more effective in preventing fraternisation, but this is difficult in situations where troops are free to move around and it may be many months or longer between home leaves.

Following recommendations by UNAIDS, DPKO, UNFPA (United Nations Population Fund) and UNIFEM (United Nations Development Fund for Women), an HIV/AIDS focal point has been established within UNAMSIL (United Nations Mission in Sierra Leone). This initiative is responsible for sensitising military observers and peacekeepers about HIV/AIDS on arrival; this includes distribution of Awareness Cards containing condoms and basic information about safer sex. The focal point is also responsible for ensuring that foreign soldiers are constantly supplied with condoms and tries to ensure that troops are rotated so that they do not stay in one place for a long time. A radio programme on HIV/AIDS is also broadcast regularly on Radio UNAMSIL — Voice of Peace, covering Sierra Leone, Liberia and Guinea, where people call in and ask questions about HIV/AIDS and related issues.

The focal point’s efforts are matched by work undertaken by UNAIDS and the Sierra Leonean government, with funding from the World Bank and others, to raise awareness of HIV among the local population. However, there is still a long way to go. As Hirut Befecadu, the focal point head, points out, “One of the major obstacles to the campaign in Sierra Leone is the prevalence of groups of people who don’t even believe that there is any disease called HIV/AIDS.” Many of the basic aspects of a prevention campaign have not yet been developed: HIV-positive blood donors are not informed of their status, there are few testing and counselling centres, and little community involvement.
Only a blood or saliva test can confirm whether someone has contracted HIV. Testing in the military includes mandatory testing (also known as compulsory testing), where the authorities insist on testing as a condition of recruitment or continuing service, and voluntary counselling and testing, where soldiers choose to be tested to discover their HIV status and where, theoretically at least, the test results are not made available to the military hierarchy.

An increasing number of militaries mandatorily test recruits and/or serving soldiers. New recruits with HIV are almost always denied entry, while serving soldiers with the virus may be downgraded. Some militaries do not use mandatory testing, but soldiers discovered to be HIV-positive may be downgraded or discharged.

Mandatory testing raises practical and ethical issues that have not been resolved. While some armed forces consider mandatory testing to be no different from other medical checks that confirm a soldier’s fitness for duty, others consider it to be a violation of human rights that serves no practical benefit while encouraging discrimination and hampering prevention efforts.

6.1 Practice and Ethics

The primary argument in favour of mandatory HIV testing is that the virus is a medical condition that should be treated no differently from other conditions that compromise a soldier’s competence, such as flat feet or impaired hearing. By excluding those who are HIV-positive or restricting them to non-combat and in-country duties, the armed forces maintain their ability to mobilise, protect their investment in training and maintain the length and quality of life for military personnel and their partners.

This argument sees specific problems arising from HIV, including (a) the health of HIV-positive soldiers may be affected in the harsh psychological and physical conditions of military life, (b) the health of HIV-negative soldiers is at risk in battle conditions, when protective measures may not be available to prevent accidental transmission, and (c) military personnel with HIV may suffer HIV-related cognitive impairment while performing highly
skilled operations such as piloting. Additional arguments in favour of excluding HIV-positive personnel include the risk posed to civilians by sexual intercourse with soldiers with HIV and prohibitively high costs of care and treatment.

Opposition to mandatory testing is based on both ethics and practice. It is argued that mandatory testing violates various human rights, including privacy (because the results of the test are given to others, irrespective of the individual’s wishes) and protection from discrimination. Furthermore, mandatory testing is by definition performed through coercion, sometimes without the individual’s knowledge (when blood is drawn but HIV testing is not given as a reason) and often without appropriate counselling.

However, the counter argument to this is that soldiers forfeit many rights when they enter the military, including freedom of movement and free speech. Some of these rights may be explicitly limited by law: for example, Slovak law limits the rights of soldiers to establish trade unions, strike and participate in political activity, and exempts the military from articles in the constitution that permit freedom of movement and outlaw convict labour; the South African National Defence Force is excluded from labour legislation that protects employees from discrimination on grounds of HIV infection; in Argentina a presidential decree allows the armed forces to test soldiers for HIV without prior consent.

Opposition to mandatory testing on practical grounds is based on the fact that HIV infection can lie dormant for many years without affecting an individual’s physical or mental ability. Rejecting those who have the virus or restricting their military role reduces the military’s capacity and often causes psychological, social and economic harm to the person concerned. Furthermore, testing does not identify all of those who have contracted HIV in the previous 3 months, which means that in high-risk areas, a number of recruits and serving soldiers with the virus will not be identified.

Testing raises other issues that intersect both practice and ethics. Although the initial test is relatively cheap, there are significant costs in administering it, including maintaining premises, training and employing personnel, and confirmatory tests on positive results. Furthermore, testing should be accompanied by counselling, which incurs further costs in time and personnel.

UNAIDS argues that mandatory HIV testing has not demonstrated individual or public health benefits and it can result in significant negative outcomes for those testing positive.

Mandatory testing
a) does not in itself help people to change their behaviour to prevent infecting others.
b) can lead to stigma, discrimination and, where there is no counselling, to depression and suicide among those who test HIV-positive.
c) discourages people from accessing health care services.
d) may involve false negatives for those in the window period prior to manifestation of antibodies detectable by a HIV test; such people then do not realize they need to seek care and to protect others from infection.
e) may lead to a false sense of security that an “HIV-free” environment has been created and thus there is no need to take precautions.


According to UNAIDS, the military can only justify mandatory testing if it can (a) demonstrate compelling aspects that make it different from other workplaces, (b) show that mandatory testing and its consequences (rejection, limitation on employment options, dismissal, etc.) are the least restrictive means available and will achieve its goals more effectively than voluntary testing, (c) show that HIV/AIDS is not being singled out from other similar diseases that raise comparable issues.

Recognising the health concerns underlying the support for mandatory testing, the Brazilian government proposes a combination of approaches that both allow individuals with HIV to serve in the army, and protects those who do not have HIV. Cognitive tests applied on a regular basis to all relevant personnel identify those who are not capable of fulfilling their tasks, irrespective of the cause, while adherence to proper procedures reduces the risk of medical transmission of the virus. Encouraging all soldiers to practise safer sex, (and helping provide them with the resources and skills to do so) protects the partners of soldiers with HIV, while helping to prevent HIV transmission to soldiers who do not have HIV.

\begin{table}[h]
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\begin{tabular}{|c|c|}
\hline
\textbf{DRUG TRIALS IN THE ARMED FORCES} & \\
\hline
The fact that soldiers are a cohesive group that can be monitored over a period of time has led to proposals that they can be used for medical trials — proposals that may be contested if appropriate ethical guidelines are not followed. & \\
In October 2001, the Director General of Tanzania’s National Institute for Medical Research, Andrew Kitua, protested that an alleged new HIV/AIDS treatment developed by South African researchers was being testing on Tanzanian soldiers although trials of the substance had not been approved. The coal-based substance, oxihumate-K, being used in research on HIV-positive soldiers at Lugalo Military hospital, was developed by Enerkom, an affiliate of the South African government’s oil agency, the Central Energy Fund. However, neither South Africa’s Health Department nor Medicines Control Council had authorised Enerkom to conduct trials of the substance on people living with HIV. The previous month, Tanzania expelled backers of Virodene, another discredited treatment for HIV. & \\
In 1996 there was an outcry in Uganda over the apparent proposal to test a potential vaccine on members of the country’s defence forces. It was alleged that the vaccine, if successful, would be more effective against North American than African variations of the virus, and that the soldiers might have been coerced and were not properly counselled. As a consequence of the controversy, Uganda established its own review committee to oversee medical research in the country. & \\
In other situations the military have made a positive, voluntary contribution to HIV/AIDS research. For the last 10 years scientists attached to the United States armed forces have worked on vaccine research and development of diagnostic techniques, both in the US and in military laboratories overseas. In Thailand, the US Army is collaborating with its Thai counterpart to develop a comprehensive prevention programme that includes behavioural interventions and vaccine development. The Royal Thai Army also cooperates with other organisations in studies using army conscripts as samples, including risk behaviour, prevalence and incidence of HIV, risk factors, STIs and the effectiveness of education methods. & \\
\hline
\end{tabular}
\caption{Drug Trials in the Armed Forces}
\end{table}
6.2 New Recruits

In the CMA survey\(^2\), 27 militaries reported mandatory testing of new recruits, although this did not lead to automatic rejection in every country. In Europe only 1 in 23 responding countries tested potential recruits, compared to 7 out of 9 in the Americas and 10 out of 17 in sub-Saharan Africa. To a certain extent, testing policies tend to reflect the severity of the epidemic, with high prevalence countries such as South Africa testing, and low prevalence countries such as the United Kingdom not testing (although the United States, with low prevalence, has a rigorous testing policy).

Furthermore, a policy of testing is not always maintained in practice. For example, in Vietnam in the 1990s every new recruit was tested. Currently, new recruits are asked questions and rejected if they indicate a possible risk for HIV. Only those who pass the verbal test are then tested for the virus.

No similar survey has been taken since the mid-1990s, although the number of armed forces testing has probably risen. Colonel Joyce Puta, who works closely with armed forces across Southern Africa, points out that a policy of testing new recruits is being increasingly adopted across the region. In Brazil, in contrast, government spokesman Paulo Junqueira explains the policy of not testing on the following grounds: “Mandatory HIV testing is an inefficient tool to bring the epidemic under control, for it stimulates the increase in AIDS-related intolerance and stigma and, above all, hinders the access to health services by those groups most affected. Additionally, the use of compulsory screening as a prevention strategy has increasingly led to a misplaced sense of safety in what concerns HIV/AIDS infection, increasing the overall vulnerability of the population.”

6.3 Serving Soldiers

“"This is part of our annual check up. If you are candidate for promotion, you have to undergo HIV testing.""

Officer, Philippines

“"There are almost monthly blood tests. They don’t always tell you when they’re going to do HIV.”"

Career soldier, Peru

Many armed forces also test serving soldiers, although usually only in specific circumstances such as before deployment abroad (including peacekeeping; see chapter 5), if sickness suggests AIDS or before training (in Zambia, for example, soldiers are tested if offered a course financed by a foreign donor or if the course lasts 3 years or more). The United States and India are among the very few armed forces that test all serving personnel on an annual basis. Testing may not be standardised across a country’s armed forces. In Peru, for example, the Air Force tests all candidates for promotion, which is not the case with other services.

The implications of a positive test vary from country to country and within countries. Most that practise mandatory testing do not discharge those found positive. From a financial perspective it may seem illogical for
militaries that deny entry to HIV-positive recruits to keep soldiers who contract the virus after entering service. However, by doing so, they maximise already-invested recruitment and training costs by using soldiers’ skills for as long as possible.

In Peru, where a government spokesman said that they would like to but cannot afford to test all personnel every year, the only restrictions on personnel with HIV are that pilots with the virus are not allowed to fly. In Nigeria, as in many other countries, serving soldiers who test positive are denied permission to serve abroad (see box below), while in Bangladesh and the Philippines, soldiers with HIV are automatically discharged. In Israel, where soldiers who are HIV-positive are discharged immediately, it has been agreed that men and women with the virus may serve, although their role has not yet been clarified.

Compulsory testing is not universally accepted in the countries where it is practised. In Australia, Canada, India, Namibia and South Africa, lawsuits have been brought by individuals denied entry into the armed forces or by serving soldiers who consider they have suffered unjust discrimination because of a positive test result. While some lawsuits are still pending, the outcome of others do not always set clear precedents.3

6.4 Voluntary Counselling and Testing

“I went with my girlfriend. I was counselled, I was asked, are you ready for this test? I said yes. Are you sure you are ready? I said yes. They took my blood and I waited about 2 days for my results. They counselled me before and even when collecting the results. I saw it was negative. This doesn’t mean you are HIV-free. You have to come again after 3 months, abstain from any ladies, anything like that.”

Career soldier, Zambia

Voluntary Counselling and Testing (VCT) is founded on the principle that because an HIV-positive diagnosis can lead to significant psychological problems which may be compounded by rejection and discrimination if others learn of the diagnosis, it is essential that testing is accompanied by
pre-test counselling to enable people to make an informed choice about whether or not to take the test.

- post-test counselling to help those whose result is positive to cope and live positively and advise those whose result is negative how to prevent infection in future.

Also essential are:

- informed consent, which means that the person agrees to be tested and has a clear understanding of what the test involves, the advantages and disadvantages of testing and the implications of a positive and negative result

- confidentiality, which means that the information about a person is not passed on to anyone else without that person’s permission.

Many armed forces do not include counselling as part of the testing process, particularly when new recruits are tested. According to the CMA survey, a policy of pre-test counselling was reported by only 62% of surveyed militaries practising mandatory testing, and 87% of those offering voluntary testing.

Countries where VCT has recently been reported as available in the armed forces include Honduras, where the level of confidentiality is reported to be high; Peru, where military HIV/AIDS Prevention and Control Committees include professionals trained in counselling; Botswana, where counselling techniques are integral to defence force policy on HIV; and Malawi, where those who take the test can decide not to learn the result. The circumstances in which VCT is made available vary from country to country. In Zambia, for example, it is only available on some military premises and soldiers are referred to civilian facilities where military facilities are not available.

While many militaries theoretically offer VCT, not all can afford to provide such services, particularly the repeat counselling sessions that are recommended to help individuals maintain behaviour change and psychological well being. Furthermore, VCT can only be effectively offered as part of an overall programme that destigmatises testing and offers practical follow-up for those who are HIV-positive, which are further costs to be borne.

Even with best intentions, confidentiality is not always respected. The concepts of informed consent and confidentiality may be compromised or poorly understood in military settings. In small communities, such as a barracks, individuals know each other and the site of an anonymous VCT centre quickly becomes known. Medical files are transferred. Careless talk or abuse of rank can lead to confidentiality being broken. These and other breaches can be prevented, but it requires clear guidelines and commitment by all personnel involved to respect those guidelines.

**To Test Or Not To Test**

“I was tested for HIV last August. I was supposed to go to East Timor. In the Airbase Hospital they do not have any reagent for the..."
HIV test. I had myself tested in a private clinic. The results were negative. I don’t think there was any counselling done. They just said that they would be testing me for HIV.”

Career soldier, Philippines

The risk of sexual transmission is only one reason for considering testing peacekeepers for HIV infection. Performance is equally important in the minds of many who propose testing. The arguments are similar to those for the military in general: performance may be limited if the health of soldiers with HIV is compromised by the vaccinations necessary or the harsh psychological and physical conditions of peacekeeping; HIV-positive peacekeepers pose a threat of transmission to others through medical procedures or because of possible HIV-related cognitive impairment while performing highly skilled operations such as piloting; the health-care costs related to the deployment of HIV-positive peacekeepers are high; and repeated mandatory testing for HIV-negative peacekeepers creates an incentive to engage in safer sexual behaviour.

UNAIDS’ position on testing for peacekeepers was confirmed at a meeting in November 2001, when the Expert Panel convened to review the issue and unanimously endorsed voluntary HIV counselling and testing for UN peacekeeping operations. Having considered the above arguments, the Panel concluded that voluntary counselling and testing is the most effective means of preventing HIV transmission among peacekeepers, host populations, and the partners of peacekeepers. VCT should be provided to peacekeeping personnel within a comprehensive and integrated package of HIV prevention and care services. While fitness to perform duties should be the standard for recruitment, deployment and retention of peacekeepers, fitness should be determined through individualised medical assessment, which does not require an HIV test. “HIV status is not an appropriate indicator of whether a person is fit, or can or cannot perform certain duties. This consideration applies to the duties involved in physically demanding activities such as the armed and uniformed services, including peacekeeping.”

Other recommendations, including the ensuring of the supply of HIV-negative blood and the use of cognitive tests for higher-performance tasks, were also made.

The Medical Services Division of the UN Office of Human Resources Management recommends that personnel with HIV or another STI should not be deployed on foreign missions on the grounds that they cannot be assured of proper medical care. However, UN Department of Peacekeeping Operations policy is that HIV testing is not requested. Some countries test troops before sending them abroad and only deploy those who are HIV-negative; others, including some that have high rates of infection, do not test. The reasons for this may vary and include unwillingness to confront suspected high rates of HIV and lack of resources to pay for testing. In East Timor in 1999-2002, many contingents in the 24-nation military force were not screened for HIV before deployment and the extent of HIV prevalence was not known. Theoretically, all peacekeepers were briefed on HIV prevention before arrival and had a supply of condoms available; in reality the extent of preparedness varied widely.
Initially, many armed forces did not respond to the threat of HIV/AIDS, while the response of others was limited to testing measures intended to keep the military “AIDS-free”. Increasingly, however, militaries recognise that an effective response must be based on prevention and care: helping individuals to avoid infection and providing psychological and medical care for those who contract the virus.

Not surprisingly, approaches to prevention and care in the military are similar to those in civilian life, and civil-military collaboration enables the considerable experience gained by civilian groups to be applied in a military setting. However, some practical and thematic issues are either unique to the military or require the military’s particular attention.

One of the most potentially sensitive areas for the military is the active involvement of soldiers openly living with HIV/AIDS. In civilian life men and women with the virus can play key roles in prevention and care programmes and the ability of the military hierarchy to include HIV-positive soldiers in prevention, care and policy development is critical to an open and effective response. While civilians may face discrimination in their workplace or community if their HIV status becomes known, in many armed forces soldiers with the virus face some form of official discrimination in being downgraded or discharged. This official discrimination discourages soldiers from testing for HIV, discussing issues around prevention and policy, and participating or initiating programmes.

(This chapter examines prevention approaches to preventing HIV/AIDS through promoting safer sex. Prevention in a medical setting was covered in the Introduction.)

7.1 Issues

All prevention programmes face the same challenges. Those at risk must first understand how the virus is transmitted and how to prevent transmission, then move from understanding to a change in behaviour. Many people are aware of the virus, but that does not mean that they understand how to protect themselves, while many of those who know how to protect themselves and their partners are prevented from doing so by
such social, economic and psychological factors, such as concepts of masculinity that encourage men to take risks and poverty which obliges women to sell sex. Understanding the different meanings around sexual risk is crucial to designing prevention programmes. Delivering prevention messages through existing systems of military rank and authority can be counter-productive if soldiers start to associate safer sex with the restrictive control and discipline they experience in their professional life. Each rank needs to take ownership of these issues and be allowed to develop prevention programmes in a language and style that best fits with that group’s outlook.

Prevention programmes in the military must recognise that the needs of soldiers can vary widely, depending on such factors as their age, marital status, rank, and education level. Specific concerns that apply to the military include the relative power and authority over civilians that soldiers often have, particularly during conflict, times of tension and peacekeeping missions, and, for women soldiers, the power that senior male officers have over junior ranks. The different needs and concerns of volunteers and conscripts must also be recognised, with the former, for example, being more likely to accept programmes that link HIV prevention with military readiness.

Each programme must start by working closely with the group of soldiers that are to be involved. Trends in their behaviour need to be identified by the actual group – rather than arrived at through assumptions. Similarly, the forces underlying risky behaviour will be unique to each setting and to each group, and also need to be identified before programmes are developed. A balance always needs to be struck between approaches that use military discipline and control, and approaches that create spaces in which the soldiers from different ranks can take ownership of the issues and determine the best solutions to the problems.

Other issues also pose sensitivities, such as the extent of infection in one or more branches of the armed forces, or the extent to which soldiers with HIV can influence military policy towards the disease.

### 7.2 First Steps

The Civil-Military Alliance describes mobilising against HIV as a four-step process:

1. **Making a commitment**, which implies the personal involvement of the Minister of Defence and senior commanding officers.
2. **Conducting a situation analysis**, to determine the extent of infection in the military, risk factors and existing policies.
3. **Preparing an action plan**, including major objectives, programmes and activities, for presentation to the senior command and Ministry of Defence.
4. **Adopting the action plan**, with the involvement of the senior command and Ministry of Defence, who are responsible for ensuring the programmes are implemented.

The Uniformed Services Task Force, formed by Family Health International and including the CMA and other international and US-based agencies, 1

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1. Taken from *Winning the War against AIDS*, Civil-Military Alliance to Combat HIV and AIDS, 1999.

identifies the following elements as essential components of a comprehensive prevention and care programme:

- advocacy to mandate policies such as ensuring that STI treatment is confidential, inclusion of condoms in travel kits, adequate supplies of STI drugs, and continued service if HIV-positive
- qualitative assessment of soldiers’ perceptions of risk, access to STI treatment, condom use, recreation activities, sources of information on HIV and value systems
- strategic planning to integrate HIV/AIDS into existing systems and structures
- behaviour change communication to develop peer educator networks, interpersonal and group communication strategies, and use of mass media
- basic and in-service training on HIV/AIDS for all recruits and personnel
- condom distribution and policies, including the promotion of 100% condom use policies in surrounding communities and garrison towns
- strengthened STI services
- voluntary counselling and testing services
- care and support for people living with HIV/AIDS and their families
- monitoring and impact evaluation.

### 7.3 Civil-Military Collaboration

Civil-military collaboration is an essential aspect of prevention and care. In addition to sharing a common goal of reducing the spread and impact of HIV, the civilian sector has much greater experience of the issue which it can share; it can provide facilities, such as counselling and care, which are not always readily available in the army; sharing scarce resources and expertise reduces the burden on both sectors.

Civil-military collaboration occurs at many levels, including governmental (such as the National AIDS Programme), intergovernmental (UNAIDS and other UN agencies) and non-governmental (such as the Civil-Military Alliance internationally and many national bodies). Other international organisations working in the field include the All Africa Congress of Armed Forces and Police Medical Services and the International Committee of Military Medicine.
7.4 **Essential Components**

“In the past, police and soldiers were always present at brothels or bars (night clubs) but now it is rare to see them there.”

Military peer educator, Cambodia

Effective prevention programmes require both appropriate content — what soldiers need to know — and appropriate methodology — to not only inform soldiers, but encourage and enable them to change their behaviour. The spouses and children should also be involved in prevention activities.

Various prevention programme models, including curricula for trainers, peer educators, medical staff, peacekeepers, and advocacy for senior officers are available in printed and electronic format. These are available from the Civil-Military Alliance, Family Health International, UNAIDS and others. Contact details are given in the Resource section.

The content of prevention programmes should cover:

- basic facts about STIs, including HIV and means of preventing transmission.
- awareness of alcohol and substance abuse and the subsequent sexual risks.
- coerced and violent sex.
- sex between men and other sensitive issues.
- implementation of techniques to reduce the risk of transmission in medical and battlefield settings.

The methodology should include:

- lectures, slide shows, films, etc., which provide clear, practical information.
- printed materials that are easy to carry and in language that is easy to understand.
- discussion groups and other activities which allow soldiers to comment on what they have learnt, ask questions and discuss prevention options in a supportive and non-judgemental setting.
- easy access to VCT, with anonymity guaranteed.
- easy access to condoms (see below).
- prevention programmes directed at soldiers’ partners and children.
- prevention briefings before troops are deployed, particularly if the posting is in another country.
- prevention briefings *after* troops are deployed, when troops may be at greater risk of contracting HIV or transmitting the virus to others if they contracted it while on mission.
- monitoring and evaluation of programmes, including testing knowledge of HIV/AIDS before and after attending military school or having been with the military a certain number of years.
- experience exercises to bring the epidemic from the abstract to the personal, an essential element in services that have long experience of lectures but not participatory exercises.
Factors to be taken into consideration should include

- good training of willing trainers (officers or medical personnel who have been ordered to undertake training are less likely to be effective).
- widespread use of peer educators and a buddy system (where soldiers in pairs or small groups encourage each other to act responsibly).
- different education and literacy skills of conscripted troops (and differing language competencies in multilingual societies) that may require reduced emphasis on the written word.
- psychological profile of troops, including whether they are conscripts or volunteers.

Where possible, militaries should promote the principle of GIPA (greater involvement of people with AIDS), although this may initially appear to conflict with policies of discharging or downgrading the responsibilities of soldiers with the virus. Nine Eritrean soldiers with HIV have played an integral part in that country’s HIV prevention programme by sharing their personal testimony and experience on living positively with thousands of military personnel.

A cornerstone of HIV prevention is management of STIs. This includes offering confidential testing, counselling and treatment for all STIs, removing the stigma from STIs (for example, by not making it a matter of punishment), working with private practitioners and pharmacies where military personal go for treatment and using STIs as an entry point to discuss sex and sexuality, risk behaviour and HIV/AIDS.

The following required skills for soldiers were identified at an international meeting in Ghana in early 2001:5

- use of male and female condoms
- communication and negotiation with sex partners
- communication with peers
- accessing prevention and care services
- use of information and education materials
- living with HIV/caring for people living with HIV
- buddy skills/esprit de corps — operating in pairs and looking out for each other.

Prevention interventions for women need to address the physical, psychological and sociocultural risk factors that particularly affect them. These include:

- greater vulnerability through vaginal and anal intercourse
- peer pressure
- pressure from superiors
- low self-esteem and reluctance to be assertive.

The fact that women are a minority in the armed forces and surrounded by many men can increase the psychological pressure. In cultures where motherhood is seen as an essential component of womanhood, women who are childless face even stronger pressure to have sex.
7.5 Promoting Condoms

“We have to supply soldiers with condoms and give them information on the risks of unprotected sex.”

Dr Broto Wasisto, Indonesian Ministry of Health

“Frankly speaking, I use condoms. If I am going to pay for a prostitute, I might as well use protection.”

Career soldier, Philippines

“When going in operation areas, they give each one a big box of condoms. Even in the barracks when you go to the hospital you ask for them and they give you. That encourages us to use them, because we know the army cares for us they don’t want us to die.”

“I think giving out condoms does not mean that people use condoms. This is something very personal. Maybe someone likes using condoms, maybe someone doesn’t like using condoms. It depends on the individual soldier.”

Career soldiers, Zambia

Condoms should be used during vaginal and anal intercourse — with both sexes — to prevent HIV transmission. They are also recommended for fellatio (when the penis enters the partner’s mouth), although the risks of infection are lower unless there are ulcers or cuts in the mouth.

Some men are unaware that they should use condoms. Many are aware of HIV/AIDS but are deterred from using condoms by a strong aversion that may have psychological, social, religious or cultural roots. They are seen as a restriction on their masculinity, they reduce sensation and, some believe, they are infected with HIV rather than prevent infection. Religious objections, such as those of the Roman Catholic Church, may also influence their decision. Others, who wish to use them, may find that they are unavailable; distribution is hampered either by inefficiency or lack of resources, or by cultural — frequently religious — opposition.

Some wives and girlfriends reject condoms, because they dislike them or see them as a symbol of promiscuity. Others, aware that their partners may not be faithful, prefer to use them, but are afraid to ask because of their partners’ objections; some men react aggressively or violently, accusing their partner of being unfaithful, or denying that they themselves are unfaithful, if a condom is proposed.

Male condoms are sold in every country, although they are not always accessible to those who need them. Female condoms are much less accessible and are more expensive (at US$0.50-US$1.00 each they are 10 to 20 times more expensive than male condoms) but are preferred by many women and men.

While many militaries promote and provide — usually male — condoms to their troops (82% according to the CMA survey), the approach is often
passive, there is inadequate instruction on effective use and “on request” distribution does little to overcome soldiers’ resistance. In Slovakia, for example, condoms are not distributed free; they are available in some army shops but they are not on display, assortment is poor and soldiers do not like asking for them. Other issues, such as reduced sensation and making different sizes available, are seldom addressed.

In Cambodia, a brand of condoms is marketed specifically at the military, resulting in significant behaviour change, with over 60% of soldiers reporting condom use with women sex workers. Condoms achieve their full potential for HIV prevention only if they are part of a wider package of activities, including initiatives which are driven and owned by the soldiers themselves. The Ethiopian Army is reported to frisk soldiers who leave base to confirm they are carrying condoms. Instructing soldiers to practice safer sex can be counterproductive if in their recreation soldiers tend to abandon or rebel against the normal restrictions that characterise military life. Such an approach makes sense only alongside initiatives that help soldiers understand why condoms are good for them and their loved ones and give them the skills to turn this understanding into practice during sexual encounters.

A CODE FOR PEACEKEEPERS

Recognising the sensitive issues involved, in July 2000 the United Nations Security Council adopted resolution 1308, which strengthened HIV/AIDS education for peacekeepers. UNAIDS and DPKO (Department of Peacekeeping Operations) have begun collaborating on the issue and an AIDS policy officer is planned for every peacekeeping operation. UNAIDS and DPKO have also produced an HIV/AIDS Awareness Card for Peacekeeping Operations, in 10 languages, as a practical training tool for peacekeepers with basic facts on HIV/AIDS, relevant Codes of Conduct and a pocket for condoms.

Given the many cultural backgrounds from which peacekeepers come, it is difficult to develop a comprehensive code of conduct for UN peacekeepers that all countries will subscribe to. Nonetheless, policy guidelines have been developed; a summary is given here and the complete text is available in the AIDE-MÉMOIRES listed under Resources.

STI and HIV Prevention Education should include frequent education programmes that pay attention to individual approaches based on personal assessments of risk. Prevention education should be conducted before, during and after deployment.

Condom Promotion should be based on surveys of soldiers’ knowledge, attitudes, beliefs and practices and adapted to social and cultural conditions and sensitivities. Condoms should be made widely available and their use actively promoted, together with education and practice in correct use.

HIV Testing and Counselling should be made available after the ethics, goals and cost/benefit ratios have been carefully considered. Whenever testing is practised, it should be accompanied by pre- and post-test counselling.

Costs and Consequences When planning and implementing military HIV/AIDS Policies, care should be taken to ensure that operational funding is not placed in jeopardy. This can be mitigated through integration of military and civilian HIV/AIDS programmes.

The extent to which these guidelines are put into practice varies. The responsibility for condom procurement and provision for peacekeepers rests with the contributing nations. Condom availability is inconstant and some contingents are poorly supplied.
7.6 Good Practices

In recognition of the complex issues that surround HIV transmission, the Armed Forces Program on AIDS Control (AFPAC) in Nigeria treats HIV/AIDS as a welfare issue, not just a health problem. In developing an appropriate response, each of the three services is represented, as are interested groups such as associations of officers’ wives, people living with the virus, teachers, instructors, commanders and religious leaders in the military communities. Planned and ongoing activities include information and education, a mobile film unit, training of peer educators for students of Command Secondary Schools and allied civilians as well as soldiers, counselling centres, condom distribution, and training of people with HIV/AIDS as counsellors, and outreach workers conducting home visits.

The Thai Ministry of Defence has ordered all military units of battalion size or larger in all services to organise their own AIDS committee or working group. The Medical Department of the Royal Thai Army (RTA) is responsible for health services for all army personnel and their families: around one million people. It also cooperates with the Ministry of Public Health to provide health services to people living near army camps. The Department’s three responsibilities are (1) education and training, including of doctors treating the disease, (2) counselling and treatment, including establishing counselling services and HIV/AIDS care in 37 RTA hospitals in every region of the country, and (3) research, including prevalence, vaccine research and development, risk assessment and appropriate antiretroviral drugs for prevention of perinatal transmission of HIV.

The RTA army works extensively with new conscripts to provide HIV-related education through a series of workshops. The majority come from lower socioeconomic groups and few have received formal education beyond primary level. Those involved in workshops often report a history of multiple sexual partners and frequent visits to sex workers. A few have injected drugs.

Workshop activities, including quizzes, competitions and role-plays, can be used to introduce young men to a wide range of HIV-related issues. Workshops are usually conducted out of uniform to help men talk more openly about their thoughts and experiences. The support and active involvement of senior army officers has been crucial in successfully carrying out the work and delivering messages about HIV, safer sex and safer drug use. This has meant that all the authority figures the conscripts are exposed to have reinforced the same messages about sexual health. Those participating in the programme have reported a reduction in risky behaviour, including increased condom use, especially with sex workers.

A UNAIDS Strategic Meeting on HIV/AIDS and National Security held in April 2002 developed a generic plan of action on HIV/AIDS interventions for uniformed services, with emphasis on young recruits. UNAIDS is also working with a range of partners to develop HIV/AIDS interventions for uniformed services in several countries in Eastern Europe, Central Asia, West and Central Africa, Southern and Eastern Africa and South East Asia.
7.7 Difficulties

However, while many militaries pay lip-service to the principles of effective HIV prevention, the reality may be different. In Slovakia, while some information is widely available, such as booklets for instructors on ‘Partner Relationships and Sexual Education’ and publicly displayed details of counselling services, information on sex and drug abuse is often limited to 4 to 6 hours of lectures once a year. Attendance is compulsory, but many soldiers are prevented from attending by other duties. Peer educators have been trained, but many prevention programmes are implemented by doctors, psychologists and priests whose attitude and initiative may vary. In a survey of conscripts, 36% claimed never to have received HIV/AIDS information from the armed forces, while another 47% gave no answer or an answer that was unclear. The figures were similar for education on drugs and health in general. In the Philippines in early 2002, officers were aware of the disease, but few in the ranks had received any information.

A spokesperson for COPRECOS in Peru pointed out that their long-running and widely respected testing and counselling programme included a multidisciplinary team, but admitted that this functioned better in some parts of the country than in others. Personnel changes meant that certain posts were not always filled and at one point the whole team had to be retrained.

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SEX EDUCATION FOR SRI LANKAN SOLDIERS

The Institute for Development of Community Strengths (INDECOS) contacted senior officers in the Sri Lankan army to seek their approval and cooperation to conduct sex education programmes amongst their soldiers. The officers were supportive and, wherever necessary, organised leave for the soldiers. They also provided the venue and meals.

One-and-a-half day programmes were conducted with groups of 30 to 40 participants ranging from new recruits to senior officers. Both men and women attended. The methodology used included group work, discussions, role-play, a practical session on condom use and group presentations rather than lectures. Communication techniques were taught to encourage participants to inform friends and family about sexual health issues. Soldiers were also asked to contribute experiences of STIs and HIV/AIDS; these were compiled anonymously into a book of case studies.

Around 900 soldiers attended the programmes. They were each encouraged to speak to approximately 5 others, so the ultimate number informed cannot be accurately determined. A syllabus was created to be shared with other NGOs. Since completion of the programme, further requests have been made to continue to educate new recruits.

Conducting the programme, it became apparent that soldiers had little knowledge of sexual health issues. However, they were very interested to learn and suggested more topics to learn about such as family planning.

The ‘Communication’ sessions were an integral part of the programme, teaching participants to pass on information they learned. It was also important to involve senior officers so they could understand the principles and integrate concepts into their regiments. Any problems or feelings of discomfort caused by discussing sexual issues was overcome by allowing participants to work in small groups and supporting them to introduce their own ideas and to ask questions.

On subsequent visits to the army camps, soldiers were found to be carrying condoms, signifying their understanding and willingness to protect themselves from STIs and HIV.

Source: www.unaids.org/bestpractice/digest/files/sexforsoldiers.html
Even where soldiers receive considerable information and training, immediate results cannot be expected. Widespread behaviour change is a long-term process requiring considerable investment of the military’s time and ongoing review of activities. Despite years of education, condom use in the US military is under 45% (the Department of Defense goal is 50%) and Nigerian soldiers continue to practise unsafe sex.

### 7.8 Providing Care

“Those of us in the armed forces are insured. If you are sick with anything or have something or an operation, they have a hospital or a clinic or a surgery where you go first, and to the hospital if it is serious. Everything is free.”

**Career Soldier, Peru**

AIDS is a leading cause of death in many militaries in the developing world. In the light of the expense of treating the disease and caring for those who are ill and their dependents, several questions arise. Should military health facilities provide special facilities for soldiers and their families living with HIV/AIDS? At what point should soldiers with HIV/AIDS be discharged and sent home? 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 dependents of soldiers who have died from AIDS?

In the absence of studies of cost-effectiveness, militaries respond to these questions in different ways. However, increasing numbers recognise that providing appropriate medical and psychological care is an essential part of HIV prevention. When soldiers known to have HIV/AIDS are offered poor care or no care, their colleagues are reluctant to seek testing and are less inclined to pay attention to messages that encourage them to practise safer sex. Ultimately, withholding proper care for HIV/AIDS or any disease sends a message to the ranks that the military do not have their best interests at heart.

In the mid-1990s, virtually all armed forces in the CMA survey claimed to provide care and support for personnel with HIV/AIDS and their families. Eighty-five per cent of respondents cared for patients in military hospitals and 88% specifically trained medical officers to treat the disease. Forty-five per cent offered additional home care and 71% offered counselling and support to the families of military AIDS patients. While such figures probably reflected the reality in wealthier countries, the armed forces of many poorer countries increasingly recognise the importance of training medical staff to respond to the disease and of providing the best possible treatment within their resources.

In Burundi, the armed forces have created a solidarity fund for treatment of soldiers and dependants affected by HIV/AIDS. A certain percentage of the individual’s salary (higher according to grade) is paid into the fund in order to purchase the necessary treatment for those soldiers living with HIV/AIDS. As a result of this successful initiative, the Burundi police force in Burundi has established a similar solidarity fund.
7.9 Antiretroviral Therapy

Antiretroviral drugs prevent HIV from disabling the immune system and allow many people with HIV to live normal lives for many years. Such drugs are increasingly available in the developing world, although they only reach a very small percentage of those who need them. The cost varies widely — from US$350 to US$6,000 a year, depending on the source of the drugs — and must be supplemented with investment in physical and human resources to ensure that the equipment and trained personnel are in position to monitor the immune systems of each patient and prescribe the appropriate drugs. Furthermore, the commitment to supply drugs must be on a lifelong basis and include recognition that costs will rise as more people are diagnosed with the disease.

The advantages of prescribing antiretroviral drugs to soldiers with the disease is that their skills can be retained for much longer and the costs of replacement delayed or avoided. However, very few militaries can afford to prescribe them. While some of these costs can be shared with civilian institutions, who themselves face financial pressures, military health budgets in countries with high rates of HIV infection, such as Southern Africa, will find it very difficult to provide antiretroviral treatments.

Countries where soldiers have access to antiretrovirals include Brazil, where the drugs are available to the whole population, and Nigeria and Peru, where they are available to very few civilians. Furthermore, Peruvian soldiers have 2 years to recover from AIDS, after which, if they are still ill, they are discharged — a policy that applies to all forms of illness.

The difficulties of maintaining a constant supply of antiretroviral drugs are illustrated in Peru where, a spokesperson admitted in 2002: “There have been times when the supply has been regular, but recently the budgets of all the services has been cut. I hope that this can be resolved in that the cost of drugs is coming down.”

Where antiretroviral drugs are not available, diagnosis of AIDS, confirming illness as well as infection, usually leads to a medical discharge. In the mid-1990s, such a diagnosis led to discharge in 32 countries in the CMA survey; of the 21 respondents stating reasons for AIDS-related discharge, 14 indicated medical criteria and the remaining seven specified only an HIV test or risk factor.10

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Increasing numbers of armed forces have developed or are in the process of developing comprehensive HIV/AIDS policies. These are usually designed (a) to reduce the prevalence of the virus in the ranks, (b) to help soldiers protect themselves from infection, (c) to provide an appropriate response for soldiers found to be living with HIV, and (d) to care for those who fall ill. Such policies indirectly affect soldiers’ sexual partners, in that they also benefit from measures that reduce the risk of soldiers contracting the virus. The spouses and dependants of soldiers also benefit directly where they are entitled to counselling, treatment, care and pensions.

8.1 Developing policies
Policies addressing HIV/AIDS in the military are not easy to initiate or implement. There is often reluctance in the higher command or government to address the issue (because of the link between the military and issues of national security and national politics). Once that obstacle has been overcome, a wide range of practical issues must be addressed. These include reaching personnel who may be scattered over a wide geographic area and in many different departments and companies. A wide range of issues must be covered, including testing, discrimination and care. Training programmes must be developed for the ranks, officers, medical personnel and other specialists. Sexual behaviour must be addressed, which may run counter to local sensitivities. Above all, finance must be found for all aspects of the programme.

Institutionally, policy is required at the following levels:

- **International**: inclusion of HIV/AIDS in conventions governing conflict and in peace accords, including peacekeeping.
- **Regional**: inclusion of HIV/AIDS in structures and policies that affect regions with common concerns, such as Central America, the Great Lakes Region (Africa) and South-east Asia.
- **National**: a Ministry of Defence policy must be developed which reflects and contributes to national AIDS policy.
- **Armed Services**: a policy for each of the armed forces must be developed, based on Ministry of Defence policy, but adapted to the specific needs of each service.
- **Insurgent Forces**: while some insurgent forces are weak and poorly disciplined, others may be influential, well-disciplined and aware of the
need to protect both personnel and their partners; HIV/AIDS policies should be developed in insurgent forces wherever possible.

The preamble to a policy should note the institution's concerns, such as security and respect for human rights. The content of all policies should be in broad agreement, allowing for differences depending on local circumstances and needs, such as whether antiretroviral drugs are available and the health requirements for specific posts or tasks. Hierarchies of policy can and should be used to inform each other: national policy should refer to and follow the model of international policy, and the policy for each service should incorporate the concerns of national policy.

8.2 International Policy

The twentieth century saw considerable development in international law relevant to the consequences of armed conflict, including refugee law (1951 Convention and 1967 Protocol); human rights (including the Universal Declaration of Human Rights 1948); the International Covenant on Civil and Political Rights (1966); Convention on the Elimination of All Forms of Discrimination Against Women (1979); the Convention on the Rights of the Child (1989); and humanitarian law (1949 Conventions and their 1977 Protocols).

HIV/AIDS and conflict first appeared in international policy in 1988, with a memorandum issued by the United Nations High Commissioner for Refugees (UNHCR). In 1992, UNHCR affirmed that refugees should not be subject to mandatory HIV testing, in 1998 it issued an updated “Policy Regarding Refugees and Acquired Immune Deficiency Syndrome (AIDS)” and in the same year it signed a cooperation framework with UNAIDS.

In July 2000, the UN Security Council passed resolution 1308, which requested the Secretary-General “to take further steps towards the provision of training for peacekeeping personnel related to preventing the spread of HIV/AIDS” and “to encourage Member States to increase international co-operation... to assist with the creation and execution of [appropriate] policies.” In June 2001, several clauses in the Declaration of Commitment on HIV/AIDS, agreed at a UN General Assembly Special Session, addressed the issue of HIV/AIDS and conflict, including a mandate to member states to:

(Para 77) By 2003 have in place national strategies to address the spread of HIV among national uniformed services... and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/AIDS awareness and prevention activities including participation in emergency, humanitarian, disaster relief and rehabilitation assistance.

(Para 78) By 2003 ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel.
The Special Session also committed governments to implement national strategies with HIV/AIDS awareness, prevention, care and treatment elements into their responses to emergency situations, and urged UN agencies, peacekeepers and NGOs to urgently incorporate HIV/AIDS training for their staff.

According to the Geneva Conventions of 1949 and customary international humanitarian law, armed groups have an obligation to protect civilian populations in armed conflict, which includes protection from STIs, including HIV.

8.3 National Policy

An appropriate national policy on HIV/AIDS within the armed forces can only be developed within the context of the National AIDS Programme established by almost every country to coordinate and/or provide an appropriate response to the epidemic. In practice, this means having armed forces representation on the committee or institution responsible for drafting and implementing national policy. It has also been recommended that United Nations Theme Groups on HIV/AIDS, which help coordinate international technical and financial assistance in developing countries, should also consider co-opting a representative of the armed forces. Where peacekeeping troops are deployed, a representative from the mission should also be included in the Theme Group.

Military representation on national bodies responsible for drafting military policy should be matched by representation by civil institutions, including the government and non-governmental organisations working with the military. A soldier living with HIV/AIDS should also be a full member of that body.

While the specifics of a national policy may vary, there is general agreement on the points to be covered. These include the following, which were agreed at a meeting of military personnel from 8 Southern African countries in Namibia in February 2001:

**Recruitment**
- Medical assessment for fitness for each candidate, including HIV test, should be agreed.
- Medical criteria for exclusion of an HIV positive recruit should be established.

**Incapacity**
- Serving personnel who test HIV positive may, if necessary, be reassigned to duties appropriate to their level of fitness.
- Existing rules regarding incapacity should apply when they are medically unable to continue in the job in which they are employed.

**Periodic assessment**
- Medical assessment of fitness for all personnel, including HIV test should be carried out periodically throughout the period of service.
- Medical assessment results must be kept confidential and restricted; an appropriate policy on confidentiality, notification, reporting and surveillance should be adopted.
Surveillance and Monitoring the Epidemic

- Lack of baseline data and the capacities to collect and analyse data adversely affects planning; strengthen and develop military health information systems, conduct prevalence surveys and build capacity for data collection and analysis.
- To create an enabling environment for surveillance and monitoring, and to overcome resistance to blood sampling and surveillance, provide adequate counselling services.

Prevention

- Prevention programmes should follow National AIDS Policy and be in conformity with constitutional provisions.
- Prevention interventions and strategies should include:
  - peer education
  - HIV curriculum development at all training establishments
  - voluntary counselling and testing
  - the provision of condoms and the promotion of safe condom use
  - the promotion of early diagnosis and proper treatment of STIs
  - a supportive living and working environment that reduces the vulnerability of members and spouses to HIV infection.

Counselling

- Adequate, confidential counselling services, staffed by trained personnel.
- Pre- and post-test counselling consistently provided; follow-up counselling should be provided for members living with HIV/AIDS and for their families.
- Education and counselling programmes aimed at partners and other dependants; particularly important in times of deployment and the prolonged absence of partners.

Care

- Continuity of medical, social, economic and spiritual care, including home-based care, until members are medically discharged from carrying out their duties.
- The care needs of partners, children, widows, widowers and orphans should be addressed.

Research

- Research should be undertaken to assess the impact of military training on the health of HIV positive members.

Resource Allocation

- A separate budget allocation for HIV programmes for the Defence Force.
- Advocacy to secure national resource allocations and external finance sources.
- Other issues to be addressed include:
  - security of blood supply
  - adherence to best medical practice
  - a comprehensive gender perspective
- collaboration with the civilian sector
- privacy and confidentiality
- HIV/AIDS education in all military training, making knowledge of the disease a condition of qualification
- prevention and counselling for spouses and dependents
- codification of best medical practice relating to HIV/AIDS
- implementation of prevention activities during conflicts where possible and immediately after conflict
- high rate of training activities and education provided on a peer basis (i.e., soldier to soldier educators)
- constructive use of respect for rank and position to promote the notions of safer sex and other personal protection options as well as protection of families
- subscription to the principles of Greater Involvement of People with AIDS (GIPA)
- encouraging the formation of groups of HIV-positive soldiers
- prior to discharge/demobilisation, identification and training of suitable soldiers as peer educators.

More controversial, but still needing attention, are policies on recreational drugs and alcohol use that address the elevated risks of infection that accompany abuse, and policies that take into account sexual behaviour, such as sexual activity between men, that may fall outside cultural norms.
FURTHER RESOURCES

Sources marked * were used extensively in the preparation of this report. Additional sources of information can be found in the footnotes.

PUBLICATIONS & WEBSITES

**HIV/AIDS AND THE ARMED FORCES: PRINCIPLES AND POLICY**


www.hiv-development.org/publications/subverts-security.asp

*AIDS and the Military*, UNAIDS Point of View / Best Practice Collection, May 1998.

(also available in French and Spanish)


**HIV/AIDS AND THE ARMED FORCES: PREVENTION AND CARE TRAINING AND BEST PRACTICE**


Additional publications are listed on
www.unaids.org/bestpractice/collection/subject/sector/keymilitary.html
www.fhi.org/en/topics/listings/uniformedserviceslist.html
and available from Civil-Military Alliance (address below)

GENDER
AIDS and Men, Martin Foreman (ed), Panos, 1999.
www.panos.org.uk

A package to help facilitators run workshops within communities on HIV/AIDS, communication and relationship skills

PEACEKEEPERS: HIV/AIDS TRAINING

REFUGEES / CONFLICT
http://hivinsite.ucsf.edu/InSite.jsp?page=kb-08-01-08

various publications on
www.unaids.org/publications/documents/specific/index.html#refugees
www.unhcr.org


CHILD SOLDIERS
various publications on
www.child-soldiers.org
www.childsoldier.net

DEMOBILISATION
www.cdr.dk

www.icmh.ch.
ORGANISATIONS

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- **BIBLIOGRAPHIC DATABASE** which holds details of the 20,000 resources held in the Source collection
- **CONTACTS DATABASE** which allows you to search for organisations working in health and disability worldwide.
Combat AIDS: HIV and the World’s Armed Forces is for policy and decision makers, international, regional and national NGOs working in the areas of HIV/AIDS, the military and/or conflict.

Soldiers are both vulnerable to HIV and linked to the spread of HIV, particularly in situations of conflict. This publication outlines some of the reasons why and includes material from focus group discussions with soldiers in Latin America, sub-Saharan Africa, and South-east Asia. It introduces some of the issues involved in, and approaches to working with, the military, including a section on HIV testing and on HIV prevention in the armed forces.

Combat AIDS also looks at general recommendations for policy and decision makers.