



## A NEW SECURITY THREAT:

# HIV/AIDS IN THE MILITARY

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Addressing the United Nations General Assembly in 2001, U.S. Secretary of State Colin Powell likened the HIV/AIDS epidemic to a war that destroys countries and destabilizes regions: “I was a soldier. But I know of no enemy in war more insidious or vicious than AIDS—an enemy that poses a clear and present danger to the world.”

Powell’s assertion rests on the premise that HIV has compromised the very institution charged with maintaining security and stability—the military. Military populations are among the most vulnerable to HIV infection, and in many countries infection rates are several times higher in the military than among civilians.

Senior military officers and national defense ministries are beginning to recognize that HIV/AIDS is a security threat. Even the United Nations Security Council has discussed the issue at length. As a result, some progress has been made, at least with respect to international peacekeepers, in developing HIV/AIDS policies addressing risk, prevention, and treatment. In practice, however, there are considerable differences in how militaries approach the issue, particularly in their willingness to do HIV testing.

While HIV threatens all of the roughly 22 million soldiers in militaries around the world, those in the less-developed regions with high infection rates appear most vulnerable, although public data on HIV prevalence in the military are not comprehensive. Not all militaries want, or can afford, to test their soldiers. Some defense ministries, fearful of exposing military weakness, may conceal the full extent to which their troops are affected.

According to a recent assessment by the U.S. National Intelligence Council, HIV prevalence in the militaries of several sub-Saharan African nations ranges from 10 to 60 percent (see chart above). However, estimates often differ depending on the source. For example, the South African defense minister recently estimated that 17 percent of the national military was HIV-positive, but security analysts such as the Chem-

ical and Biological Arms Control Institute (CBACI) think that estimate is too low, given that South Africa’s adult HIV prevalence exceeds 20 percent. While South African media have reported that 50 to 70 percent of the military is HIV-positive, CBACI places the estimate between 40 and 50 percent, with some units as high as 90 percent.

While militaries in sub-Saharan Africa are the hardest hit (as is the region as a whole compared with the rest of the world), troubling levels of HIV infection have

**HIV Prevalence in Selected Sub-Saharan African Nations**

Country	Estimated Military Prevalence (percent)	Estimated Adult Prevalence (percent)
Angola	40–60	5.5
Congo	10–25	7.2
Côte d'Ivoire	10–20	9.7
Dem. Republic of the Congo	40–60	4.9
Eritrea	10	2.8
Nigeria	10–20	5.8
Tanzania	15–30	7.8
South Africa	40–50	20.1

Sources: 1999 DIA/AFMIC data published by NIC (Jan. 2000); CBACI (Sept. 2002); UNAIDS (July 2002).

also been observed in national militaries elsewhere. In Cambodia, 12 to 17 percent of soldiers were estimated to be HIV-positive in 1999, while in neighboring Thailand, prevalence in the Royal Thai Army was 12 percent in 1993 and only fell below 3 percent in 1998 after massive government efforts. In Russia, where the disease is spreading rapidly, 1 in 3 Russian military recruits is rejected for drug-related chronic hepatitis or HIV, compared to 1 in 20 in 1985.

## THE VULNERABILITY OF ARMIES... AND CIVILIANS

Susceptibility to disease has long been part of a soldier's life. The harsh physical conditions and social chaos of war have often created breeding grounds for infection and disease—the bubonic plague during the twelfth-century crusades, the huge pre-antibiotics flu epidemic of World War I, and the outbreaks of malaria and dengue during World War II. The toll can be staggering. During the Napoleonic wars, four French soldiers died from disease for every one killed in battle.

Modern medicine has sharply reduced the chances of entire armies being wiped out by epidemic disease. But all militaries remain vulnerable to a specific group of maladies called sexually transmitted infections (STIs). STI rates in military populations are generally two to five times higher than in civilian populations, and during times of conflict they can be 50 times higher.

Soldiers are at greater risk of contracting STIs for several reasons. The relative youth of many soldiers places them in the age group that is most sexually active. Soldiers are also trained to be aggressive and take risks in combat. Many observers believe this risk-taking ethos may increase risky behavior off the battlefield, including risky sex. For example, a study of Dutch sailors and marines on a five-month peacekeeping operation in Cambodia found that 45 percent had had sex with a prostitute or a local civilian. Having one STI can raise the odds of contracting another; studies show that people are two to five times more likely to contract HIV if they have some other STI at the time of intercourse with an HIV-infected partner.

Posting military personnel far from their homes and families for long periods is, according to the United Nations Programme on HIV/AIDS (UNAIDS), probably the single most important factor that heightens their risk of contracting STIs. Emotional stress, boredom, and loneliness have long led soldiers to engage in casual sex with civilians or pay for commercial sex. In the 1830s, for instance, one-third of the mostly bachelor British soldiers in India were hospitalized for an STI, compared to only 1 in 30 Indian soldiers, many of whom lived with their families. During the 1960s, the STI rate among American soldiers in Vietnam was nine times higher than among American soldiers at home and 15 times higher among American soldiers in Thailand. The French Army Health Services found that overseas assignments among the French military increased their risks of contracting HIV by a factor of five.

The duration of a distant posting also matters. A study of Nigerian peacekeepers found that 7 percent of peacekeepers returning after one year of duty were HIV-positive, 10 percent were HIV-positive after two

years of duty, and 15 percent were HIV-positive after three years of duty. (Nigeria requires peacekeepers to test HIV-negative prior to deployment.)

An explosion of commercial sex work near peacekeeping installations has been documented in several countries, such as Sierra Leone, which has hosted as many as 17,500 UN peacekeepers from over 30 nations. The UN Mission in Sierra Leone is headquartered near Lumley Beach in Freetown, a place rife with nightclubs favored by prostitutes and their clients. Sex workers seek out peacekeepers, who generally have more money than locals. Sex without a condom is also available for a higher price. While most sex work is consensual, Save the Children UK and the United Nations High Commissioner for Refugees (UNHCR) have documented the sexual exploitation of young girls by peacekeepers.

Perhaps not surprisingly, HIV infection rates have been rising in Sierra Leone. In 2001, 7 percent of adults were HIV-positive, up from 3 percent in 1997. No direct link has been established between the spread of the virus and peacekeepers, and many countries try to ensure that soldiers are HIV-negative prior to deployment. But the UN and other authorities recognize the likelihood of peacekeepers contracting (and spreading) HIV through unprotected sex while on active duty.

Cambodia offers another example of the link between peacekeepers and the growth of the commercial sex industry and AIDS. Prior to 1992, when peacekeepers were first sent into Cambodia, there were no recorded cases of HIV in the country; nor was there much prostitution. Ten years later, Cambodia was experiencing widespread prostitution and the highest rate of HIV infection in Asia. Indonesian peacekeepers in Cambodia in 1992 and 1993 tested positive for HIV of the subtype E found more commonly in Thailand (and the likely source of Cambodia's virus), as opposed to the subtype B in Indonesia.

Not all sexual relations are with commercial sex workers. The power of the uniform can attract impoverished local women to enter into either casual or long-term relationships with soldiers in return for food, gifts, or protection. In some ports or military bases, soldiers may outnumber potential sexual partners, and many men from the same unit are likely to have sex with a limited number of women. Later units may then share the same women as partners. In this sort of environment, HIV can spread rapidly.

War triggers mass movements of people, breakdowns in basic services, and general chaos. A related consequence is the increased incidence of rape, which is often used systematically by armed forces to terrorize individuals and communities. Sexual violence can profoundly affect rates of HIV and other STIs among civilians. Before the 1994 genocide in Rwanda, for



catalyzed a series of meetings in the Security Council in 2000. The subsequent adoption of a resolution addressing HIV/AIDS made history as the first time the Security Council had deliberated on a health concern.

Resolution 1308 recognized that HIV/AIDS could reduce the capabilities of infected peacekeepers and thereby prevent the Security Council from meeting its primary responsibility of maintaining peace and security. The resolution called for integration of HIV/AIDS prevention education into United Nations Department of Peacekeeping Operations (DPKO) training for peacekeepers, and urged Member States to consider voluntary HIV testing and counseling for personnel to be deployed as peacekeepers. (Regional organizations, such as NATO, the Organization of Security and Cooperation in Europe, and the Economic Community of West African States, also engage in peacekeeping. This article only discusses UN peacekeeping operations.)

In response, UNAIDS and DPKO have sought to develop and implement policy in three areas:

- **Prevention education:** The intensive training that DPKO gives to senior peacekeeping officers includes considerable attention to HIV/AIDS. The DPKO-trained officers are then expected to train their contingents before and after deployment. The training contains information on the impact of HIV on the military; the links between HIV, other STIs, and drug abuse; risk assessment; prevention strategies; and behavior change.

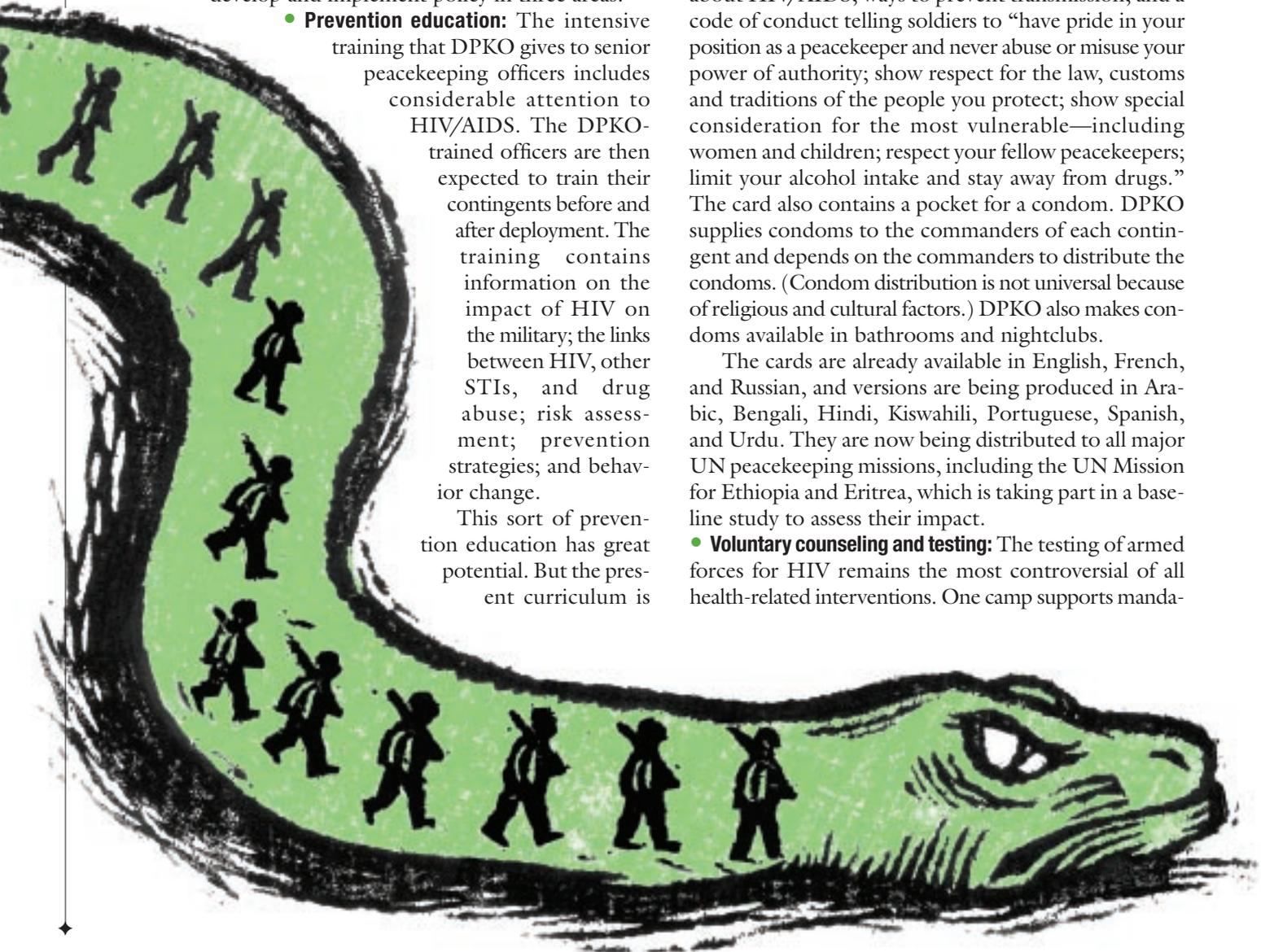
This sort of prevention education has great potential. But the present curriculum is

incomplete on several counts, according to the U.S. General Accounting Office (GAO). Developed in the United States, the curriculum does not address issues specific to some cultures, such as social acceptance of multiple sexual partners. Gender issues are not fully developed, and the broad manner in which gender is addressed in the training is not sufficient to sensitize peacekeepers to respect women and girls rather than view them as sexual commodities. Because DPKO does not monitor whether the contributing nations provide the training, it is unclear whether all peacekeepers receive it. Neither does DPKO collect baseline data on peacekeeping troops' knowledge and awareness of HIV/AIDS, making it impossible to evaluate the long-term effectiveness of specific training sessions.

- **Condom promotion and provision:** With help from UNAIDS, DPKO produced an HIV/AIDS Awareness Card (box, page 19) for distribution to peacekeepers. The palm-sized, plastic-coated card contains basic facts about HIV/AIDS, ways to prevent transmission, and a code of conduct telling soldiers to "have pride in your position as a peacekeeper and never abuse or misuse your power of authority; show respect for the law, customs and traditions of the people you protect; show special consideration for the most vulnerable—including women and children; respect your fellow peacekeepers; limit your alcohol intake and stay away from drugs." The card also contains a pocket for a condom. DPKO supplies condoms to the commanders of each contingent and depends on the commanders to distribute the condoms. (Condom distribution is not universal because of religious and cultural factors.) DPKO also makes condoms available in bathrooms and nightclubs.

The cards are already available in English, French, and Russian, and versions are being produced in Arabic, Bengali, Hindi, Kiswahili, Portuguese, Spanish, and Urdu. They are now being distributed to all major UN peacekeeping missions, including the UN Mission for Ethiopia and Eritrea, which is taking part in a baseline study to assess their impact.

- **Voluntary counseling and testing:** The testing of armed forces for HIV remains the most controversial of all health-related interventions. One camp supports manda-



tory testing of all soldiers (with or without their knowledge) and conditioning recruitment or continuing service on a negative result. The opposing camp advocates voluntary counseling and testing (VCT), in which an individual undergoes confidential counseling and is thereby enabled to make an informed and voluntary choice about being tested, the results of which are also kept confidential. In comprehensive VCT, confidential post-test counseling is also provided.

Militaries must consider three sets of factors in choosing a policy: combat readiness, public health, and ethics. Those in favor of mandatory testing argue that excluding HIV-positive soldiers or restricting their duties both ensures combat readiness and protects public health. Opponents, including UNAIDS, say that mandatory testing violates human rights, including the right to privacy and protection from discrimination. Proponents counter that soldiers knowingly forfeit many rights, including freedom of movement and free speech, when they enter the military. (The South African military, for instance, does not have to follow national labor laws protecting employees from discrimination on grounds of HIV status. In Argentina, no-consent testing of soldiers is allowed by presidential decree.)

A UNAIDS expert panel on the testing issue, noting that an HIV infection can lie dormant for years without producing symptoms, concluded that "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 forces, including peacekeeping." The panel concluded that "fitness to perform," not HIV status, should serve as the standard for recruitment, deployment, and retention of peacekeepers, and that fitness should be determined through frequent medical examination. The panel also noted that physicians, surgeons, and others who perform highly cognitive and stressful jobs are not generally required to be tested for HIV. To ensure the capability of military personnel charged with highly skilled and stressful duties, such as piloting aircraft, the reasonable test would be screening for cognitive impairment.

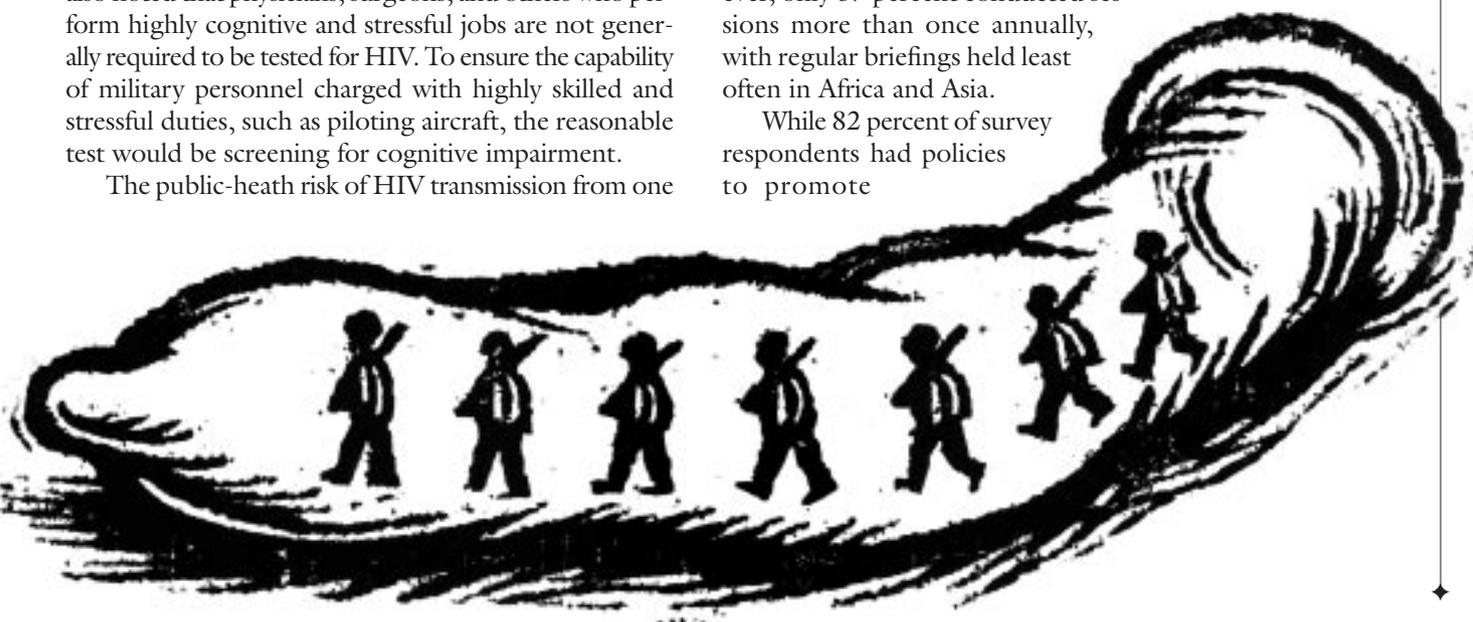
The public-health risk of HIV transmission from one

soldier to another lies primarily in blood transfusions or direct contact with blood during battle. The latter risk, while of concern in certain military situations, is relatively small in peacekeeping. The UNAIDS panel recognized that standards for blood safety vary among nations, presenting a challenge in maintaining a common blood supply for peacekeeping operations. However, it noted that the World Health Organization (WHO) blood screening precautions used by DPKO are adequate in most cases.

The panel also determined that the best way to prevent the sexual transmission of HIV from peacekeepers to their sexual partners is through prevention education. The panel argued that while even the best prevention education will not eliminate all high-risk behavior and HIV transmission, neither would mandatory testing unless it were conducted far more often than is realistic. The panel concluded in general that mandatory testing does not provide sufficient military and public health benefits to justify its use, since it can result in significant negative outcomes for those testing positive, including depression and suicide, and does not in itself help people to change their behavior. The panel stressed that counseling is necessary to provide individuals with coping mechanisms, emotional support, and information on HIV prevention and behavioral change. Following the recommendations of the panel, DPKO does not require mandatory testing of peacekeepers.

The responses of national militaries to the HIV problem are far less uniform than DPKO's efforts on behalf of peacekeepers. The only comprehensive analysis of HIV/AIDS policies and programs in militaries around the world was conducted in 1995-96. Ninety-eight percent of 62 responding militaries reported providing prevention education, most commonly in the form of group briefings and printed materials. However, only 57 percent conducted sessions more than once annually, with regular briefings held least often in Africa and Asia.

While 82 percent of survey respondents had policies to promote



condom use, only 65 percent reported condom provision policies. Ninety percent of those policies included free distribution, but militaries were evenly divided between those that routinely distributed condoms and those that provided them upon request. Only 69 percent of militaries with condom provision policies offered instruction on proper condom use. Condom provision policies were most common in Africa, followed by the Americas, Europe, Asia, and the eastern Mediterranean.

Some form of HIV testing was reported by 94 percent of militaries. Seventy-eight percent reported mandatory testing, most frequently at recruitment and prior to deployment. Only 21 percent of responding militaries tested soldiers periodically, and 28 percent tested soldiers when they left military service. Pre-test counseling was more common when the test was voluntary (87 percent) than mandatory (62 percent). Post-test counseling, however, was nearly universal.

The number of militaries that do some sort of HIV testing is probably on the rise, according to a recent report by Healthlink Worldwide and the Panos Institute. And in recent years several militaries have made significant progress in tackling the HIV/AIDS epidemic. In Cambodia, which has a brand of condoms marketed specifically to the military, 70 percent of soldiers report condom use with commercial sex workers, up from 54 percent in 1997. The medical department of the Royal Thai Army provides rigorous HIV/AIDS prevention education to conscripts, most of whom have little formal education. The educational format is creative, including roleplaying, competitions, and quizzes. The Ugandan People's Defense Forces has lowered its HIV prevalence from over 10 percent in 1990 to less than 7 percent today, largely due to the efforts of the Post-Test Club of the Ugandan People's Defense Forces to strengthen HIV awareness, reduce stigma, and promote openness about the disease.

Some militaries have addressed the underlying factors of vulnerability. Botswana has shortened the length of time between visits home for troops stationed at remote border posts. In the mid-1990s, Nigerian troops serving as peacekeepers only returned home after two years; now, the time has now been shortened to less than 12 months. The Bolivian armed forces, taking account of the respect and trust enjoyed by soldiers in their communities, has established a "Sentinels of Health" program that allows demobilized soldiers to become HIV/AIDS educators. The Eritrean government has proposed selecting 1,000 "change agents" (demobilized soldiers) from the Defence Forces to foster awareness and build skills to respond to HIV/AIDS challenges in communities across the nation. The government has applied for a \$500,000 grant from the Global Fund for AIDS, Tuberculosis, and Malaria and other donors to support an HIV/AIDS program targeted at demobilized

soldiers, displaced people, and peacekeeping forces.

Good data and funding remain the two biggest challenges. As the GAO has pointed out, baseline data on HIV prevalence, soldiers' knowledge of HIV/AIDS, and their sexual behavior are sketchy, making it difficult to evaluate interventions such as educational sessions and condom promotion. Further research, including a system of monitoring and evaluation of programs and policies, is essential for developing evidence-based policies and programs.

And while interventions can be modeled on successful strategies in non-military populations, the resources available to many militaries for HIV/AIDS programming are inadequate. Even the most effective of current programs, such as the Uganda Post-Test Club, face the challenges of limited support and training. Mark Schneider of ICG believes that the U.S. Department of Defense should provide more support to its counterparts elsewhere to help develop prevention programs and train military officers to administer them. He has recommended the creation of a "military-to-military" HIV/AIDS education and training program under which the Department of Defense would work with the UNAIDS security unit to help militaries and peacekeepers address HIV/AIDS issues.

Former U.S. Vice President Al Gore said at a Security Council meeting in 2000, "The heart of the security agenda is protecting lives—and we now know that the number of people who will die of AIDS in the first decade of the 21st century will rival the number that died in all the wars in all the decades of the 20th century." But we also know that methods exist to sharply limit the damage. Yet to be seen is whether the somber prospect of HIV/AIDS racing unchecked through armies is enough to motivate the necessary investment in those methods, and thus prevent the chaos, destruction, and insecurity this disease threatens to unleash.

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#### **For additional information:**

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