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HIV/AIDS AND THE MILITARY

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Since Nigeria's first AIDS case was reported in 1986, the health, demographic, and socioeconomic effects of the epidemic have become readily apparent. Only recently, however, has the epidemic been recognized as a national security issue. Epidemiologic evidence indicates that throughout the world men and women in the military are among the most susceptible subpopulations to sexually transmitted infections (STIs), including HIV. In peacetime, STI rates in the military are two to five times higher than in comparable civilian populations; during wartime the rates tend to climb (1). Conflict situations involving troops, vulnerable populations, and humanitarian workers further promote the transmission of HIV.

In many African countries, the uniformed services report HIV prevalence rates higher than the national averages. In Uganda, for instance, the HIV prevalence rate of 27% among the military in 1996 was more than three times the 1999 national prevalence rate of 8.3% (2). Researchers in South Africa have reported prevalence rates of 60% to 70% in the armed forces, compared with 20% in the adult population (3). In Cameroon, Nigeria's neighbor to the east, an HIV rate of 6.2% was reported in the military compared to 2% in the general population in 1993 (4). In Malawi, 25% to 50% of army officials are already HIV positive (5). Indeed, AIDS is now the leading cause of death in the military and police forces in some African countries, accounting for more than half of in-service mortality (6).

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National leaders and military strategists must take the HIV threat seriously for several reasons. First, the capability and experience of military forces will diminish when prevalence rates are high and prevention and mitigation efforts are ineffective or insufficient. Second, some analysts speculate that when prevalence is high, soldiers increase their risk-taking behavior (7). In addition, without access to treatment, counseling, and other coping methods, soldiers with HIV face a dramatically shortened life, which reduces their drive to end conflict and work toward long-term stability. In certain cases, high prevalence has led to the extension of conflict by governments afraid to demobilize infected soldiers and to increased illegal activity among soldiers keen to earn extra money, perhaps for treatment they cannot afford (3).

HIV prevalence figures are unavailable in the public domain for Nigeria's 150,000-strong armed forces, since force-wide HIV testing has not been conducted. Nigeria is Africa's largest contributor of troops—including military observers and civilian police—to UN peacekeeping missions. Preliminary results from an ongoing study funded by the U.S. Naval Health Research Center found a 15% HIV seroprevalence rate among soldiers on active duty (5). One study of veterans of the country's peacekeeping efforts in Sierra Leone and Liberia during the 1990s suggests that 11% were infected, compared with a 5% infection rate in the general adult population (8).

This chapter examines the risk factors that favor transmission of HIV in the Nigerian military and discusses prevention and control strategies. It also highlights the special cases of demobilization, peacekeeping, and the growing proportion of women in the military, and it outlines several policy issues and recommendations that will help control the spread and limit the impact of HIV/AIDS in the military.

TRANSMISSION AND RISK FACTORS

The military community is considered a high-risk environment for HIV transmission. A number of risk factors increase the susceptibility of military personnel to HIV infection:

- Danger and risk taking are integral parts of their profession.
- They tend to be young, single, and sexually active.
- They are highly mobile and stay away from their families and home communities for extended periods.
- They are influenced by peer pressure rather than social convention.
- They are inclined to feel invincible and take risks.
- They have more ready cash than other males where they are deployed and hence are surrounded by opportunities for casual and commercial sex.

Militaries are also often closed and secretive organizations, although they are among the most likely groups to introduce successful and compulsory control measures, such as screening. A large-scale survey in the U.S. military showed that sexual activity was significantly higher in this group than in the civilian populations (9).

An important knowledge, attitudes, and practices (KAP) survey of the Nigerian Armed Forces conducted in 2001 provides an opportunity to better understand the dynamics and factors underlying the

spread of HIV and other STIs in the military (4). Only 40% of respondents had good HIV transmission and prevention knowledge, while 25% of those surveyed had poor knowledge of HIV/AIDS. Four percent of those surveyed reported symptoms of STIs in the previous 12 months; more than 10% did not seek any form of orthodox medical care and treatment.

In the same KAP survey, the risk perception of HIV/AIDS was low. Forty-one percent felt they faced no risk of contracting HIV, while 22% felt they carried only a small risk despite high-risk exposures. Moreover, the respondents' condom use did not vary with the level of perceived risk. Indeed, evidence suggests that some soldiers consider the acquisition of an STI to be a symbol of sexual prowess and proof of manhood.

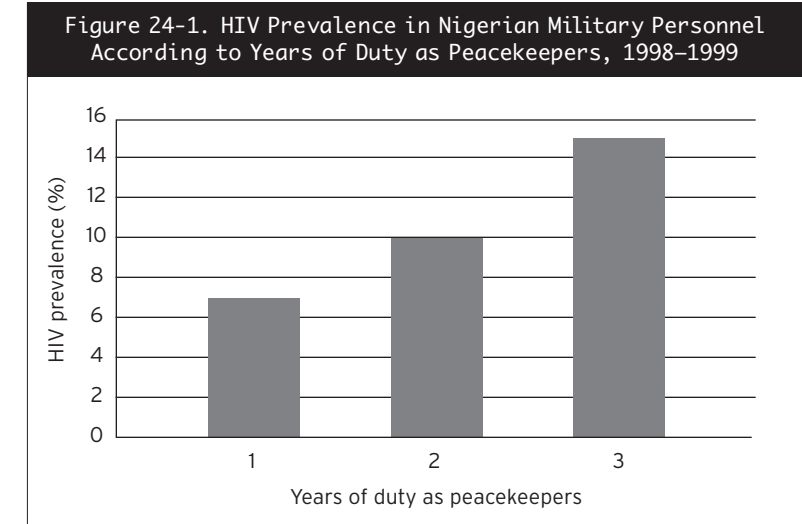
Only 40% of the respondents had been tested for HIV, 35% of whom had taken the test voluntarily. Eighty-nine percent indicated, however, that they would take an HIV screening test if it were provided free of charge. Military personnel scheduled for international postings undergo mandatory testing.

The survey also showed that the high-risk behavior that military personnel engaged in included multiple sexual partnering, with 15.3% of the respondents reporting having had at least two sexual partners during the previous year. Of these partners, one-third were non-regular sexual partners, including casual acquaintances, girlfriends or boyfriends, and paid sexual partners. Although less than 5% of the study population admitted having paid for sex, only slightly more than half used a condom on that occasion. The study did not ask about same-sex relationships or other potential risks.

A large proportion of respondents knew condoms could provide protection against HIV and other STIs, and 98% of the respondents knew where to obtain condoms. Only half of the respondents reported using condoms on a regular basis with their non-regular partners, however. Only one-quarter of the respondents had ever received condoms from the armed forces; of those who did, two-thirds thought the supply was inadequate.

The high mobility of the men and women in the armed forces also places them at risk of HIV infection. Two-thirds of the respondents were married, but 17% did not cohabit with their partners because they were either on peacekeeping missions or had to leave for training. Almost half of the respondents who participated in the various peacekeeping operations admitted having sexual partners during their time away from home.

The longer the time spent away, the higher the chances that the soldiers had sexual partners. With these sexual partners, only half of the respondents used condoms. Deployment to unsettled areas



Source: Adefolalu A. AIDS in the Nigerian military. *Third All African Congress of Armed Forces and Police Medical Services*, Pretoria, South Africa, 1999.

increases their chances of acquiring HIV, as they are exposed not only to socially disrupted settings, but also to the possibility of infection through wounds and contaminated blood. Adefolalu has found that HIV prevalence in the Nigerian military increased with years of duty as peacekeepers (10) (Figure 24-1). No studies, however, have compared the proportion of HIV cases in the military that are due to sexual transmission with the proportion attributed to exposure to contaminated blood or other risk factors.

Nigerian military personnel find themselves in professional and personal situations that increase their likelihood of engaging in behavior that places them at high risk for contracting STIs, including HIV. In view of the fact that military personnel live with and interact freely with the civilian population, they could serve as a potential core transmission group to the larger population.

PREVENTION AND CONTROL

Data on HIV prevalence among the military are difficult to obtain, as governments are often unwilling to disclose high rates, for fear of seeming vulnerable to enemies and coups. For similar reasons, comprehensive HIV testing programs for military personnel in sub-Saharan Africa are rare.

While considerable attention has been paid to the role of antiretrovirals in AIDS therapy, treatment includes a range of care options, including therapies for opportunistic infections and palliative care. Furthermore, treatment itself should be seen as part of a comprehensive workplace program. Such programs are increasingly expected to include nondiscriminatory policies, education about HIV prevention, condom distribution, voluntary counseling and testing, and the provision of care, support, and treatment.

Treatment can also serve as an entry point to ensure that these other components are in place. Elements of a comprehensive workplace program response are interdependent and include sound non-discrimination and confidentiality policies that promote a secure environment for employees to receive testing as well as treatment services. Experience shows that people are more likely to take advantage of testing services when they are linked with treatment programs.

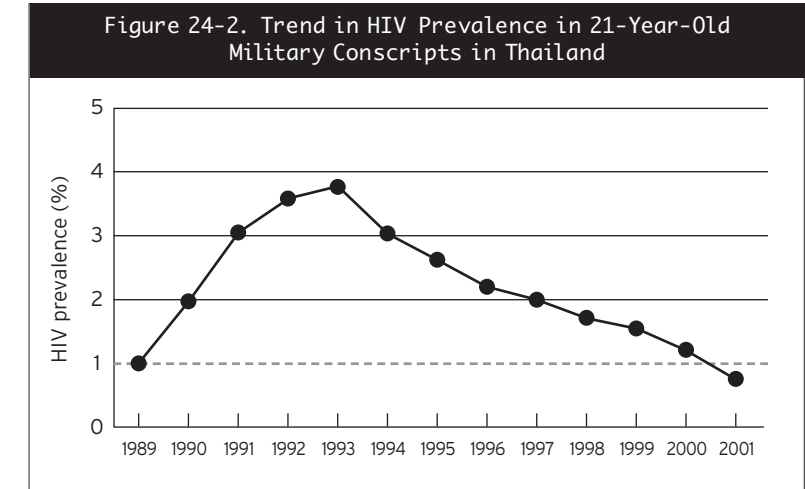
In a study to evaluate the effectiveness of a situationally based HIV risk-reduction intervention for the Nigerian uniformed services to adopt condom use with casual partners, 36% of participants in the intervention and control groups reported that they had not thought of using condoms with casual partners at baseline (11). A positive intervention effect was observed in the intervention but not the control regiment at the 6-month (40% vs. 0.9%) and 12-month (46.8% vs 4.3%) follow-up assessments ($p < 0.05$). These data confirm that a situationally based intervention with uniformed service personnel has a significant and powerful impact on reported condom use.

Prevention activities should be implemented both during and after conflicts. Such activities should be designed to be sustainable, and uniformed service personnel should offer training as peer educators. Even when soldiers are not deployed abroad they are generally posted away from their families and sex-

ual partners. In spending months at a time in the barracks, military personnel often seek out sexual partners locally, and it is not unusual for them to have regular contact with sex workers (8).

Responsibility and respect for rank and position should be used constructively to promote the notions of safe sex and other personal protection options, as well as protection of families. All peacekeepers should have unlimited access to information about HIV/AIDS and the various ways to protect themselves. They should also have unlimited access to condoms, and the assurance of an appropriate supply of condoms should be included in logistical planning.

The experiences of some countries suggest that HIV control programs can be effective in the military. Since the beginning of the epidemic, for example, the Royal Thai Army has realized that HIV poses a threat to individual military members as well as to national security at large. Through a strong and ongoing commitment to fight HIV in Thailand, the country has been able to control its epidemic, notably among its young soldiers, whose HIV prevalence rate dropped from nearly 4% in 1993 to under 1% in 2001 (Figure 24-2). In Uganda, HIV prevalence rates among soldiers aged 19 to 22 years decreased from 18.6% in 1991 to 4% in 2002.



Source: Armed Forces Research Institute of Medical Sciences, Thailand.

SPECIAL ISSUES

A number of other issues unique to HIV/AIDS in the uniformed services include demobilized personnel, peacekeeping operations, and the growing proportion of women in the military.

Demobilized Personnel

As conflicts around the world end, military and uniformed services demobilize troops in large numbers. Demobilization—which involves reducing the number of members of uniformed personnel in national armies or disbanding and disarming irregular armies and militias—presents both a challenge and an opportunity. The challenge is to reach troops prior to demobilization with HIV/AIDS prevention and care education and information, before they function as bridge populations to the general community. Demobilization also presents a significant opportunity to create a cadre of change agents that will be reintegrated into the general civil community.

Peacekeeping Operations

Peacekeeping has become an important role for military forces the world over. National armies are increasingly requested to contribute troops and support staff to war zones and post-conflict milieu. During the past two decades, Nigerian troops have been involved in peacekeeping operations in many countries, including Congo, Côte d'Ivoire, Liberia, Sierra Leone, and Sudan. The United Nations Department of Peace Keeping Operations recommends that military personnel infected with HIV or other STIs not be deployed to peacekeeping operations and that all countries contributing peacekeepers provide their troops with standardized guidelines and training on prevention and control of HIV and other STIs (7). Once deployed, otherwise healthy HIV-positive UN peacekeepers are not repatriated on account of their HIV status; those with AIDS symptoms, however, are sent home.

Women in the Military

Although women are often in the minority in military and police forces, more and more women are enlisting in the uniformed services. In Nigeria, for instance, females constitute 6% to 10% of the military (4). These women are exposed to the same—and sometimes even greater—pressure as men to enter into casual sexual relationships. Women are also more vulnerable to HIV transmission through sex with infected partners. Efforts are needed to ensure that their needs are met through gender-sensitive AIDS control programs.

POLICY RECOMMENDATIONS

Some form of qualitative assessment should be instituted to assess the knowledge, attitudes, and practices of officers and the general military personnel about HIV and other STIs. This assessment should determine not only perceived risk and high-risk behavior, but also where they seek treatment for STIs, when they use condoms, what they do for recreation, whom they listen to for information about HIV and other STIs, and what they value. A trained counselor or health professional should conduct this assessment on a regular basis. A strategic plan based on this assessment should then integrate HIV/AIDS and other STIs programs into existing systems and structures and foster behavior change through information dissemination. A clear network of peer educators and other communication means should be developed to ensure that all soldiers have unlimited access to information and understand how to protect themselves.

Policies should be instituted to make condoms regularly available and freely distributed, with the goal of achieving a 100%-condom-use rate. This policy is particularly important when men and women are posted to foreign missions or are away from their families for more than six months.

Further studies are also needed to determine the ideal duration of time military personnel can spend away from their base yet still avoid high-risk sexual relationships.

Moreover, effective voluntary counseling and testing (VCT) and sentinel surveillance should be established in the military. Those confirmed to be HIV positive should receive assurances not only about the confidentiality of their test result, but also about their job security and the possibility of advance-

ment in rank at least until medical discharge from the service. Such assurances will encourage people to take part in VCT without fear of stigmatization or discrimination.

Also critical is the establishment of a fully integrated and comprehensive care and support system for infected people, support groups, and their families. HIV prevention should be integrated into demobilization activities, and outreach programs should be extended to personnel who have been discharged from service. Finally, an effective monitoring and evaluation system of various strategies should be established to identify which strategies are workable and to ensure quality services at all levels.

CONCLUSION

Two decades after Nigeria's first AIDS case was reported, it is increasingly clear that the epidemic constitutes a security threat that cannot be ignored. The military is a high-risk population because of its demographic constitution, social norms, and occupational exposures. It is also clear that the walls of military bases constitute no barriers to the bidirectional transmission of HIV between military and civilian populations. With increasing funding available for HIV prevention and treatment in the country, the growing HIV epidemic in the military deserves more serious and sustained attention.

REFERENCES

1. UNAIDS. *AIDS and the Military*. Best Practice Collection. Geneva: UNAIDS, 1998.
2. U.S. Bureau of the Census, Population Division. *International Programs Center HIV/AIDS Surveillance Data*. Washington, DC: U.S. Bureau of the Census, 1998.
3. Sarin R. *A New Security Threat: HIV/AIDS in the Military*. Washington, DC: Worldwatch Institute, 2003.
4. Adebajo SB, Mafeni J, Moreland S, et al. *Knowledge, Attitudes and Sexual Behaviour Among Nigerian Military Concerning HIV/AIDS and STD: Final Technical Report*. Abuja, Nigeria: POLICY Project, 2002.
5. UNAIDS. *Engaging Uniformed Services in the Fight Against HIV/AIDS*. Accessed at <https://uniformed-services.unaids.org> on July 8, 2005.
6. Noah D, Fidas G. *The Global Infectious Disease Threat and Its Implications for the United States*. Washington, DC: National Intelligence Council, 2000.
7. United Nations. Press Release: Security Council Holds Debate on Impact of AIDS on Peace and Security in Africa. SC/6781. January 10, 2000.
8. Lovgren S. African Army hastening HIV/AIDS spread. *Jenda: A Journal of Culture and African Women Studies*, 2001;1,2.
9. Temoshok L. HIV exposure and transmission risk in military populations: uncharted prevention frontier. *XI International Conference on AIDS*, Vancouver, Canada, July 12, 1996 (abstract Mo.D.354).
10. Adefolalu A. AIDS in the military. *Third All African Congress of Armed Forces and Police Medical Services*, Pretoria, South Africa, 1999.
11. Essien J, Meshack A, Ekong E, et al. Effectiveness of a situationally-based HIV risk-reduction intervention for the Nigerian Uniformed Services on readiness to adopt condom use with casual partners. *Counselling, Psychotherapy, and Health*, 2005;1(1), 19–30.