

**HIV/AIDS AND UNIFORMED SERVICES:  
STOCKTAKING OF ACTIVITIES IN KENYA,  
TANZANIA AND UGANDA**

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## **EXECUTIVE SUMMARY**

Uniformed services, including men and women serving in defence and civil defence services, are an important population group in the present fight against AIDS, as expressed by the international community in the Declaration of Commitments on HIV/AIDS.

In recognition of this, the UNAIDS secretariat has initiated and supported several projects in different regions of the world with partners and national entities to address HIV/AIDS among uniformed personnel. In order to identify gaps and opportunities for HIV/AIDS activities among uniformed services in the East African region, a mission was undertaken to present a situation and response analysis of the HIV/AIDS among each of the uniformed services in Kenya, Tanzania and Uganda.

As a result, a country overview was elaborated for each of the countries, concentrating on the situation and response of HIV/AIDS among the uniformed services, notably the military and police. This overview led to an analysis of the main issues including several cross-cutting issues which emerged among the uniformed services of all three countries. This analysis in turn allowed for a further examination of opportunities and gaps.

Recommendations have been made at the international, regional and national levels with the view of triggering comprehensive and coordinated responses to HIV/AIDS among uniformed services in East Africa.

## **INTRODUCTION**

In June 2001, the United Nations General Assembly Special Session on HIV/AIDS unanimously adopted the Declaration of Commitment on HIV/AIDS which aims to have in place by 2003 national strategies to address and respond to the spread of HIV globally. One of these objectives focuses specifically on national uniformed services<sup>1</sup>. The focus on uniformed services was prompted not only by the special nature of the profession which exposes defense and civil defense personnel to risky behaviour leading to higher incidences of sexual infections, but also by their prominent role as guarantors of security, without which, society is threatened.

The age and environment of recruits to uniformed services make them a highly susceptible group to sexually transmitted infections (STI) and HIV, but they simultaneously offer a unique opportunity for HIV awareness/training with a large "captive audience" in a disciplined and highly organized setting. UNAIDS, together with its cosponsors and partners, is committed to strengthening and supporting member states in involving defense and civil defense personnel as key players in the global fight against HIV/AIDS.

The UNAIDS Humanitarian Unit is targeting national uniformed services with a focus on youth and new recruits, as well as on out-posted personnel, especially future peacekeepers, and on demobilized personnel. A regional approach is also anticipated, including identifying, documenting and sharing "best practices," with the aim of stimulating cooperation among developing countries and encouraging capacity building.

Until now there has not been a coordinated response to addressing uniformed services as a group

although several initiatives have taken place amongst UNAIDS cosponsors and partners. As one of the leading cosponsors in this area, UNFPA is engaged with various activities related to sexual and reproductive health with uniformed services. They have collected data from six selected countries (Botswana, Madagascar and Namibia in Africa, and Ecuador, Nicaragua and Paraguay in Latin America) and are currently preparing country case studies with experiences in providing sexual and reproductive health for the military and other uniformed services. The purpose of this is to learn from previous experiences in order to inform, guide and trigger future initiatives of those who are interested in planning and managing programmes of partnership with uniformed services.

Working on HIV/AIDS-related issues and opportunities with the uniformed services is an essential part of the national and regional responses. In order to further define and develop this area of work, it is crucial to understand and describe the current state of HIV/AIDS-related activities with uniformed services, with the ultimate goal being the reduction of HIV prevalence amongst uniformed services, especially with emphasis on young recruits.

## **BACKGROUND**

The uniformed services are central to the good governance of a country, not merely in terms of their defence role, but also in natural disasters. Furthermore, uniformed services may be involved in local and regional conflicts and/or may be involved in international peacekeeping operations. The uniformed services reach large sections of the population, especially young men, not otherwise easily accessible, especially in countries whose armed services are augmented by conscript uniformed services personnel.

Uniformed services personnel are believed to be at increased risk of HIV infection because they tend to be:

- Young sexually active people
- Away from home on duty
- More inclined to take risks
- Subject to high stress periods, interspersed with long periods of boredom
- Engaged in risky sex, often with commercial sex workers and/or casual contacts
- Suffer occupational stress and relax by abusing alcohol, drugs
- Less subject to social controls whilst on leave
- Deployed where drugs are easily available

Female personnel or workers may be at particular risk because uniformed services are predominately male and the organisation is hierarchical. Finally the male environment may also provide increased opportunity for men to have sex with men.

In some cases, the high level of HIV/AIDS in the military can undermine its overall preparedness, and, thus, increase the risk of insecurity. Ministries of Defence of countries in sub-Saharan Africa report HIV prevalence averages of 20-40% within their armed services, and rates of 50-60% in countries where HIV/AIDS has been present for more than a decade.

The spread of HIV can have far reaching consequences for the uniformed services including: (1) Reduction in uniformed services readiness; (2) Gaps in key personnel; (3) loss of skills and experience; (4) Teamwork affected as key workers are lost and positions replaced; (5) loss of morale; (6) Trust between uniformed services personnel.

According to a United States of America National Intelligence Council document, the military cost of AIDS is likely to be highest among the more modernized armed forces in sub-Saharan Africa, and especially in their officer ranks. As more officers and key personnel fall ill, the combat readiness and capability of such military forces are expected to deteriorate. In addition, when uniformed services personnel are demobilised or on leave, they return to their homes (with any new diseases), to the far corners of their countries, and to other sexual partners.

## **OBJECTIVES AND METHODOLOGY**

Eastern and Southern Africa are regions at the epicentre of the HIV/AIDS epidemic. UNAIDS and others have advocated for a strong response from all sectors of government and civil society, including for a special focus on youth. One area not yet fully developed for work is with the uniformed services, especially the young recruits. Thus, it is proposed to take stock of the existing HIV/AIDS-related activities with uniformed services in order to learn from what presently exists and to advocate for additional activities and to help countries learn from each other.

*Three countries-- Kenya, Tanzania, Uganda -- were selected based on the needs for both prevention and care interventions with uniformed services, as well as the readiness of the uniformed services to respond, and potential opportunities for accelerated action in the near future.*

The main objectives of this exercise were:

- ⌘ To describe the context of HIV/AIDS-related activities with the uniformed services in Kenya, Tanzania and Uganda.
- ⌘ To review the national commitment to addressing HIV/AIDS in uniformed services, including the focus in national strategic plans.
- ⌘ To identify the factors that promote transmission, the lessons learned and the opportunities that exist to make effective interventions.

*An interview guide was devised to cover key areas of interest (Annex 1), but the actual process was a free flowing discussion initiated by:*

- ⌘ *Explaining the nature and purpose of the exercise.*

✧ *Understanding the experiences in the respective countries of tackling HIV in uniformed services, the problems they encountered and the solutions they developed in order to assist with the development of national and regional strategies to stem the tide of the HIV epidemic.*

*The in-depth interviews were with individuals at various levels of the uniformed services, and also with the National AIDS Programme teams and with special interest groups. Visits were made to camps and barracks to observe education sessions, and to see housing and other health services. In addition informal interviews were held with commercial sex workers (CSWs) and with men who have sex with men.*

*Participants, for the most part, endeavoured to be helpful, but there were clearly anxieties about the enquiry, and sometimes participants answered by saying the situation was simply "very bad," or that they did not know about HIV activities. This was particularly true when enquiring about specific data.*

Limitations during the stocktaking exercise included managing the protocol and the hierarchical nature of the uniformed services, especially given the sensitive topic of HIV/AIDS.

### **COUNTRY OVERVIEW: KENYA, TANZANIA AND UGANDA**

HIV/AIDS marks a severe development crisis in sub-Saharan Africa, which remains by far the worst-affected region in the world. Nevertheless, the hopeful example of Uganda indicates that the epidemic can be brought under control. In Uganda and Kenya, because of the current economic situation, the educational level of the applicants to the military, police and other uniformed services is rising. Many personnel have knowledge of the risks of HIV infection and may have avoided infection until after their entry to the uniformed services. However, the longer they remain in the services the more likely they are to have been infected. Significant increase in infection was reported among

those who stay in service six years or more.

#### **Kenya**

Kenya has a population of 32 million, and a national HIV prevalence of about 15%.

Number of people living with HIV/AIDS, 2001	2 500 000
Children orphaned by AIDS 2001	890 000
HIV prevalence rate in young people (15-24)	Female 12-18%
	Male 5-7%
HIV prevalence in urban male STI patients 1996	14%
HIV prevalence in urban female sex workers 2000	24-51%
High-risk sex in past year (15-59)	Female 20%
	Male 45 %

Reported condom use at last high-risk sex	Female 16%
	Male 42%

## (1) The Military

**The size of the uniformed services (excluding the prison service) is approximately 45 000 in the military (40 000 in the army, 2500 in the navy and air force respectively), with 5-8% of them being women.**

The HIV/AIDS policy within the Kenya Armed Forces include the following provisions:

- All personnel must be physically and mentally fit on recruitment
- All members of the Kenyan Armed Forces must test for HIV and be HIV negative prior to deployment abroad.
- Voluntary HIV testing is offered upon recruitment
- HIV-positive candidates are not recruited

People living with HIV who are well can continue to work. Those with AIDS-related diseases receive medical care and support. When an individual is unable to continue to work or to fulfil his/her duties, a medical board is convened and the person is discharged on medical grounds, with pension rights, as would happen with any other disease, although many choose to die in service, keeping their HIV-serostatus secret.

The military has a Voluntary Counselling and Testing (VCT) Programme in 16 sites, for which a total of 64 counsellors have been trained. Three of the VCT trainers are HIV- positive and are open about their status which has been helpful as the HIV-positive counsellors have been able to provide support and set a good example in how to cope with diagnosis. The training is provided by a UK based group from Liverpool University which was contracted to provide the three-week long training courses. Those selected for training are nurses and non-medical personnel. They are carefully selected, and also volunteer to be trained. The military are currently offering VCT to pregnant women, which leads to difficult issues for mothers regarding infant feeding

A TB management course for military medical staff was also conducted in order to screen all those found to have TB for HIV (again using a VCT programme) and all of those known to have HIV for TB. A further workshop on counselling, management, care and treatment of people with HIV infection and with AIDS for medical services providers is in the planning stage.

There is a condom distribution programme and condoms are easily available in the barracks. Although there has been a noticeable decline in STDs it is unclear whether this is a result of increased abstinence or as a result of the condom distribution programme.

For the most part, HIV/AIDS interventions among the Kenya Armed Forces have until now been supported by the US (Department of Defence, USAID and CDC) and UNICEF. The HIV/AIDS

programme with the military services began in 1994, sponsored by UNICEF. The programme began by training Peer Educators.

Funding from the World Bank from 1997-1998 enabled awareness training and capacity building initiatives to be undertaken, resulting in improvement in STI training for doctors, in data collection and collation and in providing data processing hardware for military doctors. From 2001 to 2003, further funding was obtained from USAID and the Centre for Disease Control (CDC) for developing Counselling and Testing programmes and developing HIV awareness in the armed forces, with 98% coverage achieved.

The Department of Defence (DOD) has formed HIV/AIDS Service Committees to develop strategic plans for combating the epidemic in each of the three services (army, air force, navy). The Committees are each chaired independently by the Deputy Service Commanders and consist of the Deputy Service Commander (Chair), a medical officer, an HIV/AIDS co-ordinator, a chaplain, a member of the educational service, a spouse of a soldier, a sailor or air-force personnel, and a youth representative (secondary school level).

The Services Committee receive reports from its sub branches or 'area committees' in each of the three military services. These area committees meet on a monthly basis to generate plans of action on HIV/AIDS and STIs for their area. They identify training needs and suggest candidates for training which are then presented to the Service Committee to decide priorities and allocate resources.

The functions of the Service Committee include:

- Plan HIV/AIDS interventions
- Coordinate Training
- Liaise with other HIV/AIDS BCI (?) campaigners
- Data collection and dissemination

## **(2) The Police**

Approximately 40 000 personnel are in the various police services, with about 5-8 % being women. The number of staff in the prison service is 10 000. In addition there are 68 000 in the National Youth Service. The police began to address HIV in a small way in 1986. Initially it was not recognised that HIV presented a big problem. They felt it was important to generate awareness among senior staff using external trainers. Subsequently, they have relied on external trainers to carry out HIV training because senior officers are not comfortable talking about sex to junior staff.

The police effort has since been directed to prevention of the spread of HIV. A one week seminar was held last year for senior officers, deputy commissioners and other high ranking police figures. It was led by the former head of the Police College, and included resource figures from the Ministry of Health. Other HIV education programmes have been directed to new recruits and



young police officers. In addition, all senior officers stress the importance of HIV at each available opportunity.

There is no HIV testing on recruitment or subsequently, and there is no condom distribution system in operation.

### (3) Wildlife Services

There are approximately 3500 park rangers in the Kenya Wildlife Service, with 25 % being women. There are 60 park stations and several hundred outstations. Some of these outstations are so remote that the male rangers normally spend 6 months on a tour of duty, though frequently this is longer. It is not unusual for families to be split for a year or more because of these duties.

To date 20 senior officers have been trained as HIV educators, 6 of these are at the headquarters in Nairobi and 10 in the game parks. This training was initiated by the government and took place in conjunction with the police and the GSU (General Service Unit, the para-military unit of the Kenya Armed Forces). The training was separate from that provided by the military forces. It consists of a one-month training module providing: an overview of HIV/AIDS; prevention and management; home-based care; strategic planning; communicating behaviour change; and stigmatisation. In addition, with the support of Smith, Kline-Beecham, they have provided a 3-day training course involving a mixed group of 500 rangers, recruits and family members. The Wildlife Services have been slow to react, but they now have in place a skilful and dedicated team who exhibited a good grasp of the problem. They have developed a strategic plan are now seeking resources to implement it.

## **Tanzania**

The country has a population of 30 million, with national HIV prevalence of about 12%.

Number of people living with HIV/AIDS, 2001	1 500 000
Children orphaned by AIDS 2001	810 000
HIV prevalence rate in young people (15-24)	Female 6-10%
	Male 3-4%
HIV prevalence in urban male STI patients 1997	5%
HIV prevalence in urban female sex workers 2000	1-6%
High-risk sex in past year (15-59)	Female 29%
	Male 52 %
Reported condom use at last high-risk sex	Female 23%
	Male 34%

The first three HIV/AIDS cases were reported in 1983 in Kagera, an area bordering Uganda. Fifty percent of hospital admissions are related to HIV/AIDS. The main mode of transmission is heterosexual accounting for 77.2% of all cases.

On 31 December 1999, the President His Excellency W. Mkapa declared HIV/AIDS a national disaster, and called on the entire nation, including the government and political, religious and civil leaders and non-governmental organizations to take new measures to put the nation on a war-footing against HIV/AIDS. The national response, lead by the National Aids Control Programme (NACP) under the ministry of Health, is now complemented by the Tanzania Commission for AIDS (TACAIDS) under the Prime Minister's Office.

The size of the uniformed services is approximately 224,000 (military, police, National Service, Customs, etc), with about 8% being women. HIV/AIDS prevalence in the uniformed services (military and police) is higher than the National prevalence by about 1%. This is to say that; the HIV/AIDS prevalence in the uniformed services is estimated to be between 15-16%.

The Uniformed Services have an organized system for a joint campaign against HIV/AIDS spread. There are no VCT programmes but the current developed work plan addresses the issue. Condom distribution lacks for Border/Custom service personnel who are found to be the most vulnerable. Although there is a joint effort for distribution of condoms, there are no pronounced approaches for doing so. Promotions and follow up for proper condom utilization lack.

At the national level, leaders and commanders at top level have not been well sensitized to support the programme. Consequently, there are no programmes for care of People Living with HIV/AIDS nor are there any programmes for prevention of Mother to Child Transmission. In addition, Behaviour Change Communication is not being addressed adequately and selectively. Lack of openness was seen as a factor which has dwarfed a combined effort of combating the pandemic.

Coordination of activities and support between NGOs, UN agencies and the Uniformed Services is not well pronounced. Most work plans/ programmes have stalled due to lack of funding. However, UN agencies and most NGOs are ready to cooperate and work jointly with the uniformed services in checking the spread of HIV/AIDS.

## **Uganda**

*The population of Uganda is 22 million. From a national prevalence of HIV in the early 1990's of 25%, it has been declining, first to about 11% in 1997/98. Now it is estimated to be about 8%, although some optimistic reports put this as low as 5.6%.*

Number of people living with HIV/AIDS, 2001	600 000
Children orphaned by AIDS 2001	880 000
HIV prevalence rate in young people (15-24)	Female 4-6%
	Male 2-3%
HIV prevalence in urban male STI patients 1999	23%
High-risk sex in past year (15-59)	Female 14%
	Male 28 %
Reported condom use at last high-risk sex	Female 38%

Uganda has pursued an open and active policy in its attempt to reduce the spread of HIV and is held up as one of the world's best examples of how this can be done. Because of its plight and its openness in combating HIV, it has been the most successful of the three countries in attracting international aid and technical assistance. Nevertheless, there is a great deal left to be done, especially in the uniformed services.

The number of people in the uniformed services (military 50k, police 18k, prisons 25k staff in prisons of whom 6k are women and border guards, customs and national service 96k) is approximately 190,000. The military was involved early in the campaign against HIV, as was the prison service. However, the police have been less successful in attracting attention to the need to act in relation to AIDS.

Because of its recent revolutionary history, the military response to HIV was early and considerable. In the 1980s, following the victory of the Ugandan People's Liberation Army, troops were to be sent to Cuba for further military training. At that time it was discovered that large numbers of the troops designated to go to Cuba were infected with HIV, and hence this ensured not only an early warning to the society about the extent of the problem, but also that the military would be included at all stages in the development of the strategic plan. The same is not true for other services or for other countries.

The Uganda People's Defence Forces has been active responding to personnel affected by HIV/AIDS. Two main initiatives have been taken, notably the "Post-Test Club" created in 1990 and the "Network of PLWHAs" created in 1997 which both aim to improve the quality of life of PLWHA and advocate for their involvement at all levels of HIV/AIDS interventions and programme management. However, there is still much ignorance at military command level about HIV and its impact and soldiers in operational areas do not receive good HIV education nor education on STIs.

Recent surveys amongst the youth entering the army show similar rates to those nationally (8%). A most recent sample survey carried out by the Joint Clinical Research Centre in 2001 showed a prevalence of 4%. It is important to note that this lower figure may be due to the fact that HIV+ individuals are discouraged from applying.

## SITUATION ANALYSIS

In all three countries there have been attempts to meet the challenges presented by HIV, although there are important differences between countries and between services, both within and between countries. In all three countries, the following cross-cutting issues were found :

- *The understanding of the impact of HIV on the uniformed services and the national commitment to address the issue remains limited.*
- *There is a growing awareness that HIV/AIDS in the uniformed services is significant, especially due to the growing numbers of deaths of personnel and the increasing numbers of widows and orphans who are left with little social support.*

- *The involvement of uniformed services in national AIDS policy documents appears to have been minimal, with the few exceptions of the military in some countries, notably Uganda.*
- *The military have consistently shown more willingness and greater awareness of the problems presented by HIV than have other uniformed services such as the police.*
- *The military has been the first to react to HIV, and in some cases they began as early as the 1980s.*
- *In the military, HIV activity is often led by the medical services, and as a result, has been somewhat marginalized from the main command structure and tends to be based on a medical model.*
- *The police and the other services have been slower to react, but they are now increasingly aware that HIV is important to them, mainly because they have reached a stage where they are now witnessing large numbers of deaths and cases of serious HIV-related diseases, including the significant social consequences, nobly among widows and orphans.*

#### Factors promoting transmission

*The factors promoting transmission are relatively similar in all the services and in all three countries. They are:*

- ***The age of the population.*** *The majority of the men and women in the services are aged between 18 and 26, usually the most sexually active group in a population.*
- ***Deployment.*** *All the services are deployed to remote areas: the military to deal with border disputes, incursions, insurrections, and peacekeeping in other countries; the police to maintain law and order; and the game park rangers to do their job in remote regions, frequently for considerable periods of time.*
- ***Separation.*** *The service personnel cannot bring their families with them when they are deployed. They often spend considerable periods of time apart from their families and therefore form liaisons with sex partners in the areas in which they are deployed*
- ***Separation for dependents.*** *Those who are left behind are often in difficult circumstances. The money remitted is often erratic, due to the long distances, remoteness and poor communications.*
- ***Income disparity.*** *When the Services operate in remote areas, they have much more money to spend than the local population and are therefore targeted by women who need to earn money to survive.*
- ***Income deficit.*** *Women left back at base with an irregular income are often driven though need and loneliness to find another supportive partner(s) to help make ends meet.*
- ***Attraction.*** *In remote regions the influx of young, fit, apparently healthy and clean*

*personnel dressed in uniform are attractive to the local population.*

· **Accommodation/housing.** *The living quarters of the police and rangers are often cramped accommodation, with between families. This inevitably leads to partner sharing, not only between adults but also between adults and adolescents and between adolescents themselves. In the remote areas, a woman who accompanies a serviceman home for the night will often stay on after he has begun his morning shift to serve his colleague or colleagues who have come off the previous shift.*

· **Alcohol.** *All services have a culture of heavy drinking. For many; there is an understanding that in bars (particularly out of the big cities) they do not pay for their drinks. Heavy drinking often leads to risky sexual behaviour.*

· **Drugs.** *Drugs do not appear to be a problem for the services. They are still relatively rare but are becoming more common in East Africa, according to press reports, and may pose a problem in the future.*

· **Power.** *The Services appear powerful to the local communities and often these young people feel powerful. They are fit, active, armed and feel themselves to be invulnerable, including to infectious diseases. In addition, although in all services, sexual harassment of female service personnel is forbidden and attracts severe penalties. Only in the Ugandan military is there a clear procedure for redress and where impunity does not prevail in these instances.*

· **Sexual favours.** *Bullying is known to take place, although there is much denial. There are also some suggestions that it might be more widespread than appreciated. In some armed services, particularly in all male environments, this can have sexual overtones. Servicewomen, although not subject to open sexual harassment, are targeted for sex by their colleagues. They may therefore seek 'protection' from a powerful soldier or policeman. Community members will also seek the protection of the armed services, and this is often granted in exchange for sex.*

· **Poverty .** *Service personnel often meet and form relationships with women when they are on deployment, and these women are not integrated into the extended family. They are often unknown by their husband's relatives who feel no responsibility for them or their children when the husband dies. The widow is left to fend for herself and her children, and because of the inadequacy of pension, will try to liaise with another serviceman to look after her and the children. In the absence of this she will turn to prostitution.*

· **Stigma.** *This is widely denied, but some respondents suggested that HIV positive service personnel conceal their status in order not to damage their chances of promotion, or to avoid the possibility of being declared medically unfit. Because the pensions are poor, HIV-positive personnel endeavour to remain in the service as long as possible. It is clear that many service personnel conceal their HIV status for as long as possible, and this carries its own risks, given the frequently over-riding emphasis of uniformed services on sexual prowess as the 'mark of a man'.*

## Gender analysis

HIV risks for women are enhanced because:

- Women are more vulnerable in East African culture, as women are expected to accept or accede to male desires, and most women find it difficult to refuse a man. Forced marital sex as well as `dry' or anal sex can cause trauma and increase the probability of HIV infection.
- Men dislike and rarely use condoms with their regular partners.
- The main STIs in women are herpes and candidiasis, which also increase the likelihood of HIV and other STI transmission.
- Covert sexual pressure is exerted on women working in the services, as well as on the wives or partners of servicemen.

In addition, the women in the remote areas or around the bases are viewed as `reservoirs' of infection. There appears to be little understanding that the deployment of young men with money to spend is a contributory factor. The uniformed services tend to view their personnel as `clean-cut young men' who are preyed upon and infected by women.

Specific activities addressing HIV/AIDS prevention for women include:

- Empowerment of Women (Tanzania, military).
- Health/peer education.(Tanzania, Uganda)
- STIs syndromic management. (Uganda, Tanzania)
- Planned Voluntary Counselling and Confidential Testing (VCCT) (Kenya, Uganda - some services, some sites, Tanzania - more generally)
- Counselling (some services, some sites in all 3 countries)

### Men who have sex with men (MSM)

Men who have sex with other men do exist in all three countries, although not addressed in HIV campaigns in the services or elsewhere. Their existence is denied and official respondents claim not to have heard of such activities, except in relation to the colonial period or as a result of modern tourism. It is described as un-African and is roundly condemned. It is said to be taboo and sinful, and is illegal. Homophobia is rampant, as well as the resulting stigma, discrimination and hiding.

Even though there is no `gay society' in the capitals, there are places to meet - parks, particular streets (often near where the female sex workers are) and in some nightclubs, generally late at night. The CSWs are either hostile or supportive, and some will pass on clients who are looking for men. The ones who are hostile often denounce them to the management or to the police.

Little research has been done on MSM. One study commissioned by the prison service from

Makerere University tried to look at the numbers of MSM contacts between prisoners. They found that no men admitted during the interviews to having sex with other men, though this was probably as a result of the research design, which relied on face-to-face interviews and asked men directly whether they had had sex with other men.

### Stigma and discrimination

There are two main areas of stigma and discrimination in relation to HIV in the uniformed services: 1) recruitment and promotion; and 2) opportunities to work in international peacekeeping missions or on overseas courses. Fear of stigmatisation exists if one fails to be recruited, promoted or sent abroad; if medical retirement based on an HIV-related condition is found; or for HIV-affected widows and orphans.

### **Perception of HIV risk**

Across all ranks, tribal memberships and religious affiliations, sex was for the many service personnel a recreational pastime involving multiple partners and recourse to CSWs. In the streets, the bars, nightclubs, restaurants and major hotels, CSWs were distinguishable by their dress and behaviour. They range from the highly educated and sophisticated (many spoke more than one European language as well as Kiswahili), to the very poor and needy CSWs encountered in the meaner streets and in the stopping points. The areas surrounding the bases are easy sources for recreational sex as were the bases themselves and all of this behaviour is fuelled by money and by alcohol. It appears that for many men in the uniformed services, even those who are of rank and experienced in service, the risk of HIV does not feature much in their everyday thinking. Knowledge, attitude and practice (KAP) surveys were alluded to in many of the discussions, particularly by military respondents, but no data was provided from them.

### Education and training on HIV/AIDS/STIs

The military has the most developed programmes. The prison service in Uganda also has a well-developed approach, as well as the wildlife services in Kenya, but the police generally appear to be lacking. All the major areas are covered in education programmes, but what is generally provided is information and there appears little opportunity for dealing with sensitive topics such as condom use, negotiating safer sex, saying no, managing alcohol and risk situations, attempting a cultural change in the macho culture and rarely, if ever an attempt to develop empathy and understanding of those with HIV infection.

There is a great shortage of HIV and STI educational materials and of the means to deliver them. Attempts have been made to educate the various services and some of these are on-going, but they lack materials, the means to deliver them (often in remote bases there is no electricity and so educators need to bring portable generators in order to show videos or slides. Posters and leaflets have been produced from time to time but they run out and are not replaced because the grants, which enabled their production and distribution, have ceased.

### **Condom distribution**

In Kenya and Uganda, condoms are widely available from a variety of sources in the military. The prison and the police services do not appear to have developed a way of ensuring easy access to condoms, but this appears to be left up to individuals. Female condoms are promoted in Uganda but are rare in Kenya. The best scheme is the one devised by the Kenya Wildlife Services where condoms are packed into the rangers' combi-rations. That way they reach all personnel, even those in the very remote game ranges and they can be sure both of distribution and of maintaining expiry date quality control.

In Tanzania, the picture is somewhat different. No interventions for condom promotion and distribution exist. Though supplied free, the quantities issued are inadequate. Female condoms are not known to most people.

### Sexually transmitted infections (STIs)

*There was no data made available on sexually transmitted infections. However, for example, in Uganda, the military, police and prisons were all involved in the national STI programme, funded by the World Bank and condom distribution is a major feature of that programme. The military in all countries appear to be best at STI treatment, and generally this is done using a syndromic management approach. This is probably because the military have a dedicated medical service and their own hospitals and clinics. STI diagnosis and treatment is an individual concern in the other services, and is often undertaken privately and from pharmacies (some of which are of dubious quality). The treatment can be haphazard, including taking antibiotics only until the symptoms disappear or until the patient feels better, which can contribute to the problem of antibiotic resistance.*

### Counselling and HIV testing

In the military, applicants are tested as part of the medical examination without much pre-test counselling as it is assumed that the majority will test negative. This is because it is common knowledge that applicants must be HIV-negative in order to be accepted. This policy is general to the military and is defended on the basis that military training is so rigorous, nutrition is poor and progression to disease so rapid in Africa, that it is a kindness to the potential applicants who are HIV-positive. The potential breach of human rights is rarely considered. The other services (prisons, police, and wildlife) do not test on entry or later.

Military personnel on promotion, selected for training abroad or for peacekeeping international service, also undergo 'voluntary' HIV testing and if found positive are de-selected, with post test counselling remaining rare. (It is described as 'voluntary' because the candidates for promotion or training abroad or peacekeeping service are volunteers and need not volunteer for selection, knowing that HIV negative status is a condition of selection).

Much lip service is paid to pre and post test counselling, and everyone understands the nature and importance of VCT. This is sometimes available in some services and at some sites, but is far from universal. Nevertheless, there was a widespread recognition that VCT was desirable not only for the service personnel, but also for wives and partners of individuals found to be infected, but their resources are lacking.

### Specific health services



*The military and the prison services have their own health care, laboratories and hospitals, but this is not so in the police and wildlife services. In Uganda, the police are eventually building their own hospital. The primary purpose of the prison service's medical staff is the health of prisoners, but they do look after staff. The police and wildlife services are cared for by the general health services in the country.*

*All of the services lack medical and laboratory resources. There are major problems in obtaining drugs for opportunistic infections, and none provide anti-retroviral therapy, even to pregnant mothers giving birth. The more complicated opportunistic infections can be diagnosed in some sites, but their treatment remains problematic because of the cost of the drugs. Often the medical staff knows what to do, but they simply lack the means to deal with these illnesses.*

### **Impact of morbidity and mortality rates**

No concrete data was available on the trends in morbidity or mortality in Kenya, Uganda & Tanzania uniformed services. This was true of HIV, STIs and even deaths. However from discussions it was clear that in all services and each of the three countries, the number of deaths and sick leave due to prolonged illness were increasing. The three countries nationally and also in uniformed services have now passed through or are reaching the maximum stages of infection and are now entering the phase when increasing numbers of people are falling ill. This was evident from the Kenya Rangers who noted a dramatic rise in the numbers of funerals they had to arrange for rangers who died in service, from the Kenya police hypersensitivity at the UNAIDS figures that  $\frac{3}{4}$  of all deaths were related to HIV. In Uganda they are seeing an increase in the numbers of widows and orphans, they have to manage. The data is often obscured because deaths are often cited as the 'result of a long illness' on death certificates and the actual cause of death is not made clear. The data gathering and processing capacities of the services are less than ideal and this is an important area for capacity building.

### **Non-governmental and bilateral organisation involvement**

This is very patchy. The uniformed services have sometimes been included as part of the national programme strategy (such as the STI programme in Uganda). Some non-governmental organisations have refused to assist the Uniformed Services.

Some assistance is provided by the bilateral agencies. For example, the Kenyan and Ugandan military received grants from USAID, the UK Department for International Development and the British Council. Ireland Aid has funded a conference on Health Care and HIV in prisons, and Marie Stopes International has promoted condom use amongst soldiers and other uniformed services personnel.

*It is likely that part of the problem lies in the lack of expertise in Uniformed Services applying for grants and assistance. They do not seem to be fully integrated into the national HIV strategies in any of the three countries and they may lack the capacity to set out and cost budget proposals.*

There is considerable scope for expanding the HIV prevention and particularly the care activities of NGOs and Bilateral Organisations with Uniformed Services. This will require considerable advocacy on the part of the UN agencies, both with the Governments, the Bilateral AID

Agencies and the NGOs.

- It needs to be made clear to Government that these key state services are at risk of losing valuable and highly trained personnel at the most productive phase of their careers
- That the uniformed services are important vectors in the spread of HIV and other STIs
- That the plight of the dependents of the servicemen and women are the direct concern of government

The reluctance of the NGOs and the bilateral agencies to become involved is difficult to comprehend. They need education on the key position these services have in relation to the stability of the state, the role these services play in HIV transmission and their need for assistance. To date the involvement has been patchy and has not been sustained over time. A genuine long-term commitment is required, involving considerable resources (both in terms of capacity building and in material terms). This will require advocacy at high level between the UN and the other agencies.

### **Demobilization**

None of the services are conscripted and so there is no general demobilisation. There is no indication that any of the three countries provide demobilisation services. People leave the services on retirement, or because they have found other work or because they have had a medical board which has declared them unfit for duty. This last case is rare. It is common for the services to support members who are ill and on sick leave even if this is for considerable periods of time. The military, particularly in Uganda are skillful at finding other work for personnel who are not fit and often use them as peer educators. It not unusual for people to die-in-service, because the housing and other benefits encourage people not to leave or retire and the pensions are inadequate. People who do leave the services through illness are said to become depressed and to resort to alcohol and risk behaviour.

## **OPPORTUNITIES AND GAPS**

### **Opportunities**

There is a genuine willingness on the part of countries to address the issues of HIV and the uniformed services. There are genuine opportunities to assist countries to develop their strategies, learning not only from one another, but also sharing approaches between the services.

The structure of the services and their discipline, which is often an obstacle to appropriate action in relation to an infectious disease, can be mobilised to ensure that an agreed plan is implemented. The staff in the services is a captive audience and the structure can ensure a high uptake on any initiative which is planned to take place. In addition, by educating a substantial number of young men and women who are subsequently deployed across the country, even to remote areas, this can mean that prevention and education messages are transmitted to difficult to reach populations.

The national recruitment and the current high educational level of the recruits will assist the understanding of key messages and by contact with their extended families these messages can reach groups who would not otherwise hear of them.

Some of the services have shown remarkable innovation in not only retaining-in -service known HIV positive individuals but have also used the experience of these members to transmit vital peer education. Others have been used to support newly infected colleagues or the widows and orphans of service personnel who are also becoming ill. Such a system is not only useful to the personnel and the people they serve but also provides an important example to other employers who may otherwise act harshly with infected employees in a short-sighted attempt to minimise the economic disruption that might be caused to their firms.

In general, all of the services in the three countries face the same kinds of problems related to the spread of HIV and the increasing morbidity and mortality from AIDS. They all recognise that VCT and prevention of mother-to-child transmission need to be part of their overall solution, and they appreciate the importance of providing education, treatment, care and support to service personnel, their families and the surrounding communities, both as a way of encouraging people to come forward, minimising the spread of the infection and reducing the impact that the loss of experienced personnel is having on the services.

The essential problem is that because there is a fragmented approach to HIV within and across services, and little co-operation between neighbouring countries that are each experiencing the same problems, there is a failure to learn from each others' experiences and solutions. This is compounded by the fact that the services are somehow separated from the general societal approach to HIV because of their different structures, hierarchies and cultures.

However, because there appears to be rapidly rising numbers of service personnel becoming ill and the increasing burden of widows and orphans of service men and women, there is a growing recognition that action needs to be taken. This presents an opportunity for ensuring that successful approaches are scaled up and shared for rapid uptake in all countries.

### **Constraints and Gaps**

There are several constraints and gaps that must be addressed in order to ensure a comprehensive and efficient response to the HIV/STI epidemic in the uniformed services. They include the following:

Constraints:

- **Sensitivity.** There is much sensitivity in relation to HIV and STIs in uniformed services. This is clearly a political issue. These services are central to state functioning and are responsible for the integrity of the State and to the maintenance of law and order within the State. It is difficult for a Government to admit that there is an STI or HIV crisis in the uniformed services because of the association of transmission with partner-change, extra-marital relationships, CSW and perhaps with MSM. For any government to admit that its uniformed services might be an important vector of HIV transmission because their service personnel, drink heavily, engage in rapid partner change, pay for sex and maybe even has sex with one another is clearly very difficult. Moreover, if it is compounded by

the fact that inadequate housing and long-term deployment to remote areas means that the disease is carried across the country, perhaps into areas currently low in prevalence, then it is easy to understand why there is great reluctance. Sensitivity appears to exist at higher levels within the services and even at unit levels where those charged with discussing HIV and bringing the dangers to the attention of their personnel are inhibited by culture and often by religious affiliation from doing so.

- **Hierarchy.** Uniformed services are hierarchical in nature. Their major preoccupation is not health but defence, law and order. The very features, which make a service successful in a war or in dealing with criminals, are not the most conducive to prevention of the spread of transmissible diseases, particularly when these involve risky behaviour. Work is needed to ensure that these services appreciate that they will lose talented, expensively trained people at the most productive phase of their career unless they act. They will need help in coming to terms with the fact that their services are important vectors of transmission and in being able to communicate that to the politicians and to the general public.

- **Confidentiality.** The uniformed services, probably for the two reasons above are reluctant to divulge the extent of the spread of HIV and other STIs in their personnel or to research the factors that lead to transmission. They also appear to have minimal capacity for data collection and compilation. This is partly due to lack of resources but also due to lack of capacity. By admitting and detailing the scale of the problems they will be more able to deal with them and be more successful in attracting external funding and technical assistance. Such information can be explosive and care will need to be taken to ensure that the information is communicated to the public in a way, which is positive, that Uniformed Services are contributing to the national struggle for the prevention and control of HIV and other STIs.

- **Fragmented approaches.** There have been a large number of projects to assist the services in each of the three countries: prevention, awareness, VCT, counselling, testing and diagnosis, provision of care and treatment for, at least some of, the opportunistic infections. Doctors have been sent on expensive courses in Public Health, counsellors have received detailed and expensive training, trainers have trained other trainers but the overall impression is of a patchwork of approaches, of assistance that has lasted for two or three years and then nothing until the next grant is available. Much of this work has not been strategic. It has all too often depended on short-term finance from the international donors and when that has dried up the work has finished or been redirected to the specific interests of the new donor agency.

- **Organisational structure.** The services operate independently of one another, and thus, neither do they share perceptions and experiences, nor do they learn from one another. Currently the military are the most favoured service and there may be some reluctance on their part to become involved in a general uniformed services effort.

Gaps:

- **Lack of data.** There appears to be a lack of capacity within uniformed services in data gathering and collation. This varies from country to country and between services within

countries but in general terms the data on HIV prevalence, the numbers of people requiring medical assistance and the numbers dying from HIV related diseases is lacking. This makes difficulties in planning for medical, counselling and social services to meet the needs of HIV+ personnel, their partners and their families and eventually the orphans.

· **Communication for Behaviour Change.** There are similar gaps in HIV education and counselling activities. Again, in general terms the military services appear to be most advanced and to have more developed activities, but even, as in the Kenyan military, where wide coverage has been achieved, this has largely been information based education about the routes of transmission and the importance of condom use rather than focussed on how to achieve behaviour change and the development of empathy both with those who have been infected and with those who are at risk of HIV.

· **Capacity Building.** The development of VCT, medical and HIV educational services requires good information, careful planning, training and material resources (money, equipment, drugs, computing and data processing equipment, transport, targeted educational materials) requires the capacity to develop appropriate and adequate initiative proposals to be submitted to the National AIDS Committees and to external donor agencies. These currently appear to be either lacking or underdeveloped.

## RECOMMENDATIONS

### International

· Strengthen advocacy, mobilisation and coordination within the UN, international donors and implementing partners to address HIV/AIDS comprehensively within uniformed services.

### Regional

· Liaise with already established regional initiatives and mechanisms such as the Greater Lakes Initiative on AIDS (GLIA) and the Southern African Development Community (SADC) for concerted coordinated action with the uniformed services and for sharing of experiences and lessons learned.

· Organise a regional workshop to bring together delegations from each of the uniformed services in order to (1) describe and define the major challenges and (2) devise a strategy for each service that dovetails with the plans of the other services within each country

### National

· Enlist co-operation at high levels - political, chiefs of staff, commissioners and NAC- to ensure that commanders and senior officers provide the necessary commitment to the development and implementation of uniformed services co-operation on HIV.

· Mobilise extensive and sustained resources to prevent the spread of HIV in the services and to manage its impact in the uniformed services, as most have remained outside the

general funding for AIDS that has been dispensed in the countries. In this regard, defense and civil defense sectors should be fully integrated into any national planning mechanisms on HIV/AIDS.

- Advocate at the highest levels of government and uniformed services for addressing stigma and discrimination, including of men who have sex with men commercial sex workers, people (infected and affected) living with HIV/AIDS, and other vulnerable groups.
- Create workplace policies within the uniformed services, based on the International Labour Organisation (ILO) Code of Practice on HIV/AIDS and the World of Work (2001).
- Ensure that relevant Codes of conduct reflect proper behaviour to be respected, especially regarding sexual behaviour, and particularly with vulnerable populations including women and children.
- Strengthen HIV/AIDS related institutional capacity within the uniformed services, particularly for: (1) Epidemiology of HIV, STIs and TB, (2) training for medical and laboratory staff as well as for counsellors and trainers, (3) voluntary counselling and testing services, (4) care and support services, including diagnosis and treatment of opportunistic infections, TB, STIs, palliative care from home to hospital, and (5) prevention of mother-to-child HIV transmission and better nutrition.
- Develop capacity in terms of strategy development, planning, data gathering and processing, monitoring and evaluation, in order to ensure sustainability.
- Review the availability of condoms to all uniformed services and link with existing partners and develop new partnerships to ensure a regular supply of male and female condoms, including to remote areas.
- Provide targeted training and educational materials, books, leaflets, posters, videos, etc.
- Promote greater outreach of services for People Living with HIV/AIDS (PLHA) and their families.
- Review housing and posting policies, especially in regards to the families of the personnel.
- Ensure that female personnel receive necessary protection within the service and that they take an active part in integrating a gender approach to HIV/AIDS training.
- Address the issue of men who have sex with men, and develop targeted messages for safer sexual practices.

## **CONCLUSIONS**

There have been many efforts to address the challenges presented by HIV/AIDS and STIs in the uniformed services of the three countries, but the quality and duration of the interventions is variable and patchy, and dependent on short term grants from international agencies and from governments.

The response is not systematic in any one service or in any one country. There are individual instances of good practice, but no overall plan or integrated approach either within or between services. At the same time, the issues facing them are often the same and the risk factors are similar. The living conditions vary, but there is much overlap in the problems of accommodation and the situation of widows and orphans of uniformed services. Each service and each country is learning on its own, and this is both unnecessary and wasteful. There is much communality between the different countries that a common approach could be adopted.

What is needed is a common integrated approach to HIV in uniformed services and a degree of international collaboration between the neighbouring countries affected. Such an approach could be piloted in Kenya, Tanzania and Uganda and provide a model for collaborative efforts in other African countries.

If governments and the international community are serious about finding a solution to the spread of the AIDS epidemic, efforts must be at all levels and in all areas simultaneously: information, education and counselling; medical care and support for those who are becoming ill in increasing numbers and for their dependents and the surrounding communities which are also affected; for laboratory services and for hospice care and finally for funerals and the care and support of widows and orphans.

The State not only owes uniformed services and their families a duty of care as would any employer, but the conditions under which they work place them at greater risk. The State depends on their services. They are charged with the security and integrity of the state and the maintenance of law and order. Therefore, the State owes them a double duty of care.

The United Nations and the international community have recognised the dangers that HIV presents to particular groups in society. One major group, the uniformed services, have to a large extent been neglected. This must not continue. A sustained, well-funded effort is needed to rectify the situation. The need is urgent. The reward will be not only reduced levels of HIV infection in a crucial population group, but efforts with this population group will have far-reaching effects within the societies they serve.

## **Annex I: Interview Guide**

### **Situation and Response Analysis of HIV/AIDS Interventions**

#### **within Uniformed Services**

##### **National Perspective**

What is the status of the HIV/AIDS epidemic in the country?

What do national AIDS policy documents and the national strategic plan include about addressing HIV/AIDS in the specific groups of Uniformed Services? (Military/police force/wardens/border police/other)

What is the national commitment to address HIV/AIDS in the Uniformed Services? (Are there sector plans, budgets, monitoring and evaluation instruments, partners who fund activities)

### **Uniformed Services Perspective**

What, if any, HIV/AIDS-related policies exist in the Uniformed Services?

What HIV/AIDS prevention activities are being carried out with the Uniformed Services?

Are the family members also targeted in the prevention efforts?

Are the communities surrounding military barracks involved in the prevention efforts?

What type of education/training on HIV/AIDS/STI is available?

What is the availability and use of male and female condoms? Of HIV/STI educational material?

How is voluntary counselling and HIV testing managed for the Uniformed Services?

What HIV activities are undertaken during demobilization?

Are the health services specific for the military or other categories or are they common with the MOH health services?

Do the military have their own lab services and what is the status of these infrastructures?

### **Female Perspective**

What are the particular HIV risks faced by women in Uniformed Services?

What specific activities are addressing special HIV prevention and care issues for women?

### **Non-Governmental Organisations Perspective**

What NGOs are working with the Uniformed Services?

What types of activities are they conducting?

What is the scope for expanding their HIV prevention and care activities with Uniformed Services?

### **Magnitude of the HIV/AIDS Problem in Uniformed Services**



What is the size of the various branches of the Uniformed Services?

What is the HIV/STI prevalence in the various branches of the Uniformed Services?

What is the trend in related statistics of the Uniformed Services, e.g. morbidity and mortality rates?

What are the main factors determining the transmission of HIV/STI? (CSW, violence related transmission, MSM, home visits; is there any research on each of these modes of transmission)

What is the perception of HIV risk of the Uniformed Services and of individuals within the Uniformed Services? Is there any KAP survey, quantitative or qualitative on this?

### **Gap Analysis**

What obstacles exist which might prevent or inhibit the capacity to respond to the HIV/STI epidemic in the Uniformed Services, and how might they be overcome?

What are the major gap areas in the response to the needs for HIV/AIDS prevention and care in the Uniformed Services?

What are the lessons learned in HIV prevention and care in the Uniformed Services?

### **Opportunities for Addressing HIV/AIDS in Uniformed Services**

How willing and ready are the various branches of the Uniformed Services to become involved/expand services in HIV prevention and care?

What relevant human resources are available to Uniformed Services, e.g. health care staff, training institutions?

What activities would make a difference in HIV prevention and care for the Uniformed Services?

Are ARVs administered to infected personnel and what is the number and kind of this intervention?

Is VCT offered and what is the cost in US per test? Are the families being offered the same services as the military or other uniformed categories?

What is the policy on HIV testing, is it mandatory on enrolment, what happens if HIV+ and already in service, are HIV+ people assigned other tasks and what kind of tasks, is care provided after retrenchment or demobilisation or is it stopped completely?

Are PLWA excluded from training programs or treated differently in any other way?

<sup>1</sup> "By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence force 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. 77)