

**ASIA-PACIFIC MILITARY MEDICINE CONFERENCE XIII  
HIV/AIDS REPORT  
Bangkok, Thailand  
May 12-16, 2003**

HIV/AIDS is a global and regional security issue that impacts the stability of the defense environment. Prevention, treatment, and program management of HIV/AIDS are vital medical issues and concerns for the force protection of the uniformed services. International HIV/AIDS military and civilian experts presented essential information for military leaders. The Asia Pacific Military Medical Conference XIII (APMMC XIII) provided a forum for presenting the issues and lessons to date and collaborative strategizing among the regional militaries against the HIV/AIDS threat.

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*The Center of Excellence (COE) in Disaster Management and Humanitarian Assistance, Medical & Public Health Unit prepared this report. It summarizes the views, comments, and work products of session speakers and participants. June 2003*

**Asia Pacific Military Medical Conference XIII**  
**HIV/AIDS Sessions**  
**After Action Report**

**Introduction**

The Center of Excellence (COE), in collaboration with the Royal Thai Army (RTA), organized three HIV/AIDS sessions for 13th Asia Pacific Military Medical Conference (APMMC). Military and civilian experts spoke on various aspects of HIV/AIDS. These sessions were the first devoted to HIV/AIDS at the annual conference. The plenary focused on the looming transnational HIV/AIDS epidemic in the region, security concerns, and force protection issues based on the Royal Thai Army (RTA) experience and as it relates to UN peacekeepers. Plenary speakers included representatives from the United Nations Development Program, the Civil Military Alliance to Combat HIV/AIDS, the RTA, and the United Nations Department of Peacekeeping Operations. The sessions titled - Continuing the Dialog on HIV/AIDS - included presentations on HIV/AIDS policy challenges, civil-military interface to combat HIV/AIDS, specific country HIV programs, updates on the HIV vaccine research trials and laboratory technology and resources issues. The sessions emphasized the threat posed by HIV/AIDS to individual militaries and regional security and underscored the need for a regional effort to prevent the spread of HIV/AIDS in Asia Pacific/South Asian defense forces.

**Rationale**

The HIV/AIDS sessions were organized to highlight and address the growing HIV/AIDS epidemic as a transnational security threat in the Asia Pacific/South Asia region. Through its effects on economic growth and societal integrity HIV/AIDS has the potential to undermine stability and cooperation in the Asia and the Pacific and is increasingly viewed as a threat to both national and regional security. Within Asia-Pacific militaries, HIV/AIDS can undermine discipline, training, and overall military readiness. Military leaders need to recognize the scope of the emerging pandemic and the utility and limitations of current interventions to protect those they command and the societies they serve.

**Background**

The Asia-Pacific represents the region with the second largest numbers (absolute) of HIV/AIDS infection in the world. The National Intelligence Council (NIC) estimates that by 2010, Asia will overtake Africa as the region with the greatest number of HIV infected persons. The NIC and the United Nations Security Council Resolution 1308 - 17 July 2000 have both identified HIV/AIDS as a security issue and a threat to global stability. In addition to the detrimental effect of HIV/AIDS on societal structure and

economic development, there are direct and indirect effects of HIV on the security interests of a highly affected country. Military and peacekeeping forces worldwide may be at higher risk of HIV infection than the general population. Failure to mitigate the spread of HIV/AIDS will reduce the overall health of these forces, jeopardizing discipline and readiness, the health of the military families, populations under their care, and national and regional stability. Military leaders must be proactive in protecting their forces against the threat of HIV.

The World Health Organization estimated over 6 million HIV/AIDS cases in the Asia-Pacific region in 2002. Continued growth in the number HIV/AIDS positive cases, as illustrated among African countries, can reduce economic growth, disrupt societal controls, reduce confidence in governments, and contribute to regional instability. An opportunity exists to implement sustainable HIV/AIDS prevention programs to stem the spread of the infection within the Asia-Pacific region. The APMCM provided a forum for senior military leaders and medical professionals to learn about the growing HIV/AIDS epidemic, to discuss the HIV/AIDS situation in their respective countries and to consider the actions taken by several countries to prevent HIV/AIDS infection.

### **Current Situation and Near-Term Projections**

India now has the second largest number of HIV/AIDS cases in the world (second to South Africa) despite a low prevalence rate. The Asia Pacific/South Asia Region will surpass Africa in total HIV infected persons if no action is taken to stop its within 5-7 years. China may have an estimated 10-15 million HIV/AIDS cases by 2010. Based on current estimates, India may have 20-25 million HIV/AIDS cases by 2010.

Foreign militaries tend to have higher infection rates than the civilian populace and are both a risk and at risk in regards to HIV/AIDS. However, Thailand subverted the spread of HIV/AIDS by recognizing the security implications of the disease early and implementing a comprehensive surveillance and prevention program; continued vigilance is required to maintain success. Cambodia modeled its HIV/AIDS programs on those of the Royal Thai Army. Countries with military HIV/AIDS prevention programs are most likely to show improved results in decreasing HIV/AIDS infections in all sectors of society. Furthermore, it is clear that the 37,000 uniformed personnel from 89 nations serving in peacekeeping operations are at risk of contracting HIV/AIDS in their host nations and further spreading the virus both locally and within their home communities. Training and prevention efforts among peacekeeping forces could be adapted for use in regional militaries.

### **Conclusions**

1. HIV impacts force readiness and regional security.
2. Military policy development to combat HIV should include: epidemiologic surveillance, education, promoting preventive behaviors, testing, treatment, civil/military collaboration, and military to military collaboration.

3. Adequate resources need to be allocated within the defense establishment to counteract HIV. These resources should also provide funding for education programs, research, surveillance, and clinical trials.
4. HIV education should be included in pre-deployment, mid-deployment and post-deployment training curriculum.
5. Militaries in the regions can adapt and modify existing, successful HIV/AIDS prevention programs to meet their needs and circumstances.
6. Culturally appropriate sustainable indigenous prevention programs should be established.
7. Research informs the development of effective intervention and is critical to the identification of best practices and the monitoring of prevention activities to optimize efficacy and resource utilization.

## **Summary**

The three HIV/AIDS sessions at APMMC provided a venue for military medical professionals to learn about HIV/AIDS as a security challenge and the best practices and lessons learned worldwide and regionally for HIV/AIDS prevention, treatment and care. Multi-national information exchange about current HIV/AIDS incidence, perceptions, and related prevention activities in the Asia/Pacific region occurred. These sessions facilitated a regional dialogue within the defense community, and a consensus emerged that the transnational threat posed by HIV/AIDS mandated a more coordinated regional approach to the control of this pandemic. A more coordinated mil-to-mil regional effort to limit the impact of HIV/AIDS would strengthen military-to-military relationships, contribute to human and technical infrastructure within partner countries, and partially mitigate the devastating effect of the pandemic in this strategically important area.

## **Asia Pacific Military Medical Conference XIII -- HIV Sessions**

### **I. Plenary: Looming Transnational Issues: HIV/AIDS**

#### **Moderators:**

MAJ GEN Suebpong Sangkharomya, AFRIMS, Royal Thai Army

LTCOL Tom Crabtree, Center of Excellence in Disaster Management and Humanitarian Assistance

#### **Presentations:**

*Asia & the Pacific Regional HIV/AIDS Situation Update*

Robert England

UNDP

*HIV/AIDS- An Expanding Menace to Health and Regional Security*

Stewart Kingma

Civil Military Alliance

*AIDS: The Unfinished War*

MAJ GEN Suebpong Sangkharomya, AFRIMS, Royal Thai Army

*HIV/AIDS and Peacekeeping*

Roxanne Bazergan

UNDPKO

### **II. Continuing the Dialogue on HIV/AIDS – Part 1**

#### **Moderators:**

LTCOL Ram Rangsin, The Royal Thai Army

LTCOL Thomas Crabtree, Center of Excellence in Disaster Management and Humanitarian Assistance

#### **Presentations:**

*HIV infection in Vietnam: high- risk groups and high prevalence sites (follow-up study 1994-2003)*

MAJ GEN Bui Dai

Vietnam

*HIV/AIDS and UNDPKO: Policy, Practice and Challenges*  
Roxanne Bazergan  
The United Nations Department of Peacekeeping Operations

*HIV/AIDS in the U.S. Department of Defense*  
Captain Glenn Schnepf  
US NAVY

*Royal Cambodian Armed Forces Fights Against HIV/AIDS Epidemic*  
COL Tan Sokhey  
Cambodia

*Sharing the Responsibility for a Healthy Military*  
COL Alberto Gabriel  
Philippines

*Armed Forces Medical Services*  
Group Captain Mandeep Singh  
India

*Collaborative Phase I/II Trials of Preventive HIV Vaccines among the US Army, The Royal Thai Army and the Thai AIDS Vaccine Evaluation Group*  
Senior Colonel Sorachai Nitayaphan  
AFRIMS, Thailand

### **III. Continuing the Dialogue on HIV/AIDS – Part II**

#### **Moderator:**

LTCOL Thomas Crabtree, Center of Excellence in Disaster Management and Humanitarian Assistance

#### **Presentations:**

*National Program of Struggle Against the HIV/AIDS Involvement of the Malagasy Army*  
LTCOL S.A. Ralamboson  
Madagascar

*Critical Policy Issues for Civil-Military Collaboration in Fighting HIV/AIDS*  
Stewart Kingma  
Civil Military Alliance

*Foundations of HIV Vaccine Efficacy Trial*  
LTCOL Art Brown  
AFRIMS, Thailand

*Towards Quality: Preparation for the College of American Pathologist Inspection of Clinical Laboratory at AFRIMS*

Colonel Chirapa Eamsila  
AFRIMS, Thailand

*Increased prevalence of hepatitis C co-infection among HIV-infected Royal Thai Army recruits: Evidence of a changing pattern of HIV transmission in Thailand*

COL Penprapra Chanbancherd  
AFRIMS, Thailand

*HIV- 1 Cross Clade Serum Antibody Dependent Cellular Cytotoxicity (ADCC) Activity in HIV-1 Subtype CRF01\_AE (E) Infected Thai Individuals with Different Rates of Disease Progression*

LTCOL Thippawan Chuenchitra  
AFRIMS, Thailand

## Summary of Key Presentations

### HIV/AIDS PLENARY

"Disease is woven into the fabric of war. The story of one cannot be told without the other. Soldiers seem destined to repeat the stories of each other."

#### **Presentation by Robert England - Asia & the Pacific Regional HIV/AIDS Situation Update**

*Abstract: The Asia Pacific Region is currently at the "tip of iceberg" phase of the HIV/AIDS epidemic. It will surpass Africa's HIV numbers with irreparable economic damage and undermining national and regional security if left unattended.*

Robert England, from UNDP, provided a regional picture of HIV/AIDS. He remarked on the insidiousness and seriousness of HIV within the region as a threat to global security. A commitment to address this issue was made in the UN Security Council meeting in Africa, UN General Assembly Special Session on AIDS. There are 42 million cases of HIV in the world. Asia has reported 7 million, indicating that Asia is at the tip of the iceberg of the epidemic. Given trend analysis, the Asia-Pacific will represent the second largest numbers of HIV. India is the second largest country in terms of HIV numbers in the world. It is predicted that China by the year 2010 will have 10-15 million and by 2020 maybe 20 million. The Asia-Pacific will soon surpass Africa's HIV numbers, with irreparable economic damage. The growth of nations' migrant population, increased poverty, and expansion of East/West highways will increase vulnerability and inequality.

Evidenced by the absence of head of states at the UNGASS meeting, England addressed the lack of political leadership and action as the biggest problem. HIV needs to be preempted, however, there is still stigma, denial, discrimination, and inability to talk about HIV. Yet, the most important ingredient is to talk about HIV, not deny or stigmatize it. The Armed Forces are particularly vulnerable to HIV infection. Military forces are away from home for long time periods; highly mobile; interact within their host community; and HIV is not rank sensitive. An example of this vulnerability is the military recruit population in Vietnam. The recruits are part of a risk taking culture. There is a higher level of HIV prevalence among the military recruits. On the other hand, the Thai military has a lower prevalence rate than the civilian population because of control on HIV positive persons. Thailand's decrease in HIV prevalence can be attributed to the success in Thailand to address HIV/AIDS and top-level leadership's ability to talk about the issue. Thailand's success has an impact on the success of the country. HIV has a great impact on armed forces and peacekeeping forces that will reduce overall health and productivity of labor, impact the health of their families, and incur economic costs.

The UN disapproves of discrimination of HIV positive persons. The Asia-Pacific is at the tip of the iceberg phase. HIV can subvert national security. Security starts at the heart of the country, not just at the borders. What needs to be done? Commanding

officers have to acknowledge that HIV needs to be addressed. Full access to condoms needs to be provided to troops. Early detection and treatment is the key to reducing vulnerability. A clear policy within uniformed services needs to be developed. The military has a huge role to play to address HIV. Top commanding officers need to talk to top political leadership. They can set an example within the armed forces to be role models in society at large. The military are key players in a multi-sectoral approach to security. It is a behavioral issue not just a health issue. There are benefits to larger society in addressing HIV prevention in the military because the troops go back to their families and homes. It shows how it can affect how society as a whole can address the issue. HIV can disrupt economic growth and undermine national and regional security. Currently, in this tip of iceberg phase, HIV can easily develop into a very serious problem if left unattended.

### **Presentation by Stewart Kingma - HIV/AIDS: An Expanding Menace to Health and Regional Security**

*Abstract: HIV is aggressively expanding in this region. The window of opportunity to control the spread is closing fast. Health care systems are being affected extensively as they become inundated in high prevalence countries. Demands for care lead to rising healthcare costs and loss of resources in the healthcare system. Inability to meet those demands will lead to loss of confidence; producing another factor of potential instability and loss of security.*

Stuart Kingma, founder of the Civil Military Alliance to fight HIV (CMA), presented another sobering look into the threat of HIV to security. He identified that the HIV pandemic is spreading and moving into a younger population. The HIV pandemic is reaching epidemiological terms. There are three thousand new cases every day in this region and 7.2-7.5 million people have HIV/AIDS. Heterosexual contact, as seen in the growth in China, is overtaking the spread of the epidemic; previously it was intravenous drug use. The spread in India is an epidemic concern. Projections are that by the year 2010, it may reach beyond 10-20 million. Social disparities, a vulnerable migrant population, and mobility are all factors. HIV is aggressively expanding in this region. The window of opportunity to control the spread is closing fast.

In the last five years in Eastern Europe, prevalence has increased 700 percent. Incidence rates increase at an alarming pace. The World Health Organization estimated in 2002 that in South and South East Asia there are over 6 million HIV/AIDS cases. Destabilization has an economic impact. HIV dramatically shortens life and human potential and drains national resources. The pandemic threatens to do the same as it has in Africa. HIV erodes the economic and social fabric of Africa and Asia affecting households, education, and formal economic sectors. This includes mining, tourism, agriculture, transportation, and especially fishing because of the long distance travel and mobility factor. Health care systems are also affected extensively as they become inundated in high prevalence countries. Demands for care lead to rising healthcare costs and loss of resources in the healthcare system. Inability to meet those demands will lead

to loss of confidence; producing another factor of potential instability and loss of security.

HIV affects the Gross Domestic Product. In Africa by the year 2005, Kenya's GDP will have dropped by 17 percent in just five years because of HIV. Tanzania, which is already fragile, will be 30 percent lower than what it was five years ago in 2010. Threat to national and regional stability is very real and should bring a sense of urgency to bring plans of action up to scale. Having an up to scale plan is important. Lack of funding leads to program failure to go beyond the funding stage and low scale implementation. HIV and STI have been the plague of militaries on the move. HIV is a significant risk to peacekeeping forces. We continue to find that military recreation establishments attract sex workers and those doing drugs. These peacekeeping forces usually have cash but no condoms in their pocket. Diminished capacity in the health sector can be part of large factor in stability.

An agenda for urgent policy development and support should be developed which address ways that can be shared with civil society and are specific to the military. They should be sensitive to trends on legal, constitutional and human rights matters. Thailand and Cambodia are success stories in civil and defense cooperation. Policy issues should include education, promotion of condom use, testing, treatment, care, civil/military collaboration and international military to military collaboration. The military workplace is a unique setting. The military command and control structure can facilitate the implementation of these things. The psychological impact is under researched. HIV needs to be part of the training of the military. There is a relationship between length of deployment and risk: the longer the deployment, the higher the risk.

HIV is a threat to the military, at home, and to those in post conflict peacekeeping and humanitarian relief. Behavior change and prevention is the key and it needs to be adapted to the military. Intensive training and behavioral issues start at the recruit level and need to be reinforced prior and during deployment.

### **Presentation by MAJ GEN Suebpong Sangkharomya - AIDS: The Unfinished War**

*Abstract: HIV remains a serious national concern and potential for epidemic relapse is high. From 1996 to the present was an adjustment period in which there were the most successful examples of action against HIV. Continued vigilance is important. There are new identified risk factors and new generations need to be educated to carry on the fight and point out the direction.*

Thailand's first case of AIDS was reported in 1984. This generated concern for medical and public health professionals but was not shared by the public. In 1985, HIV was declared as a reportable disease. In 1987, the first reported case of HIV was found in Army personnel. In 1988, the formation of the Royal Thai Army (RTAMD) AIDS committee was formed. In 1989, five years after the first clinical case, enough alarms were raised for people to sit up and take notice. Numerous attempts were taken to show the astounding seroprevalence in Thailand. HIV was found in all hosts except neonatal. Seroprevalence showed there was an epidemic. Despite public health measures, the first positive antenatal cases were found in 1999. Now it was found in all of society. In 1989-

2001 the seroprevalence in the RTA was 3.7 percent, compared to 0.7 in 1983. The state of the Thai epidemic in 2002 was 1 million infections; 300,000 people have died from HIV/AIDS and 700,000 are still living. There are 30,000 new infections each year and an estimated 55,000 HIV positive persons will develop serious illness and die each year. The number of newly infected will continue to grow. Ten years ago had the trend continued, by 2000, 6 million people would be infected. The current number is not more than 1 million so the Thai efforts to avert the epidemic prevented about 6 million infections.

HIV remains a serious national concern and potential for epidemic relapse is high. This was a turning point in the fight because HIV/AIDS was a threat to national security. HIV/AIDS causes disease burden, loss of manpower and psychosocial problems. The Thai Armed Forces had a unique role against the HIV/AIDS fight. In 1984-1988 the RTA was aware of a problem, but there were no real attempts to find facts and gather intentions. Alarmed in 1989-1995, real actions started. Interventions and collaborations formed internally and externally were implemented. From 1996 to the present was an adjustment period in which there were the most successful examples of action against HIV. There was no rebound in the epidemic as expected. Northern Thailand is the area hardest hit by the epidemic. Qualitative studies through interviewing forces, group studies, intervention models, and development were completed. After the initial fact finding period, the Army found strategies to prevent infection, identify infected personnel and supportive measures, and treatment.

The RTA also identified the need for multi-sectoral, domestic, and international collaboration. This was seen in agency cooperation with the Civil Military Alliance, international cooperation, UNICEF missions in China, and the UNDP in Cambodia. The UNDP in Cambodia assisted the Ministry of National Defense to devise an HIV plan in 1998. An inter-sectoral concept of relationship with other sectors, AIDS training programs, and HIV molecular studies are also imperative. Military policy needs to focus on risk reduction and general education. It should include AIDS classes in all military curriculum training; interventions on peer groups; a component to measure access to care for infected personnel. Policy should also encourage voluntary testing and counseling. HIV/AIDS is an unfinished business and war. Continued vigilance is important. There are new identified risk factors. New generations need to be educated to carry on the fight and point out the direction. Thailand's prompt assessment and response to HIV can be attributed to their view that HIV is a security fight and a national threat.

### **Presentation by Roxanne Bazergan - HIV/AIDS and Peacekeeping**

*Abstract: UN supports VCCT. UNDPKO policy testing for peacekeepers includes troops, civilian police and military observers. . Voluntary, confidential, counseling and testing (VCCT) does not happen on it's own. It requires training awareness and care.*

Roxanne Bazergan, United Nations Department of Peacekeeping Operations (UNDPKO) HIV/AIDS policy adviser, spoke on behalf of Dr. Christen Halle, UNDPKO Senior Medical Advisor and Chief of the Medical Support Unit. Bazergan reiterated the UN's commitment to the fight on HIV by discussing UNDPKO Policy. HIV seems like

an obvious issue but it is not. HIV is a deadly virus; there is no known cure. Death can be postponed but not prevented. The Department of Peacekeeping Operations code of conduct stresses respect for the host country and vulnerability of women and children. A UNAIDS peacekeeping card is given to all peacekeeping forces. UNDPKO policy testing for peacekeepers includes troops, civilian police and military observers. Many countries are represented here and more are emerging that are part of this. Mandatory HIV testing is a common practice in many militaries. However, there is also voluntary testing, confidential pre and post testing counseling. All scientific data shows it's beneficial to know one's HIV status. It may lead to behavior change and only change in behavior will affect the risk for infection. The intention to test all peacekeepers is to conduct quality assessments; to protect the host population; to protect other peacekeepers and the individual being deployed; and to stop the spread of the HIV virus.

HIV status does not reflect the health status of a person. The person can test positive but that does not indicate how long a person will stay fit. International Labor Law states that testing positive is not a reason to hire or fire. A pre-deployment medical examination is required for peacekeeping forces. All troops must have a health clearance certification. Examinations are offered prior to deployment. Individuals with chronic diseases and immunodeficiency disqualify. Testing reflects a moment of time to protect the host population, apart from the complication of the window period it would take to show up in a host. Someone that tests negative can retest positive. Testing does not make someone safe from acting irresponsibly. Testing does not protect anyone from infection. If a peacekeeper abides by code of conduct he will not spread the disease and protect other peacekeepers. The UN has screened blood supplies. It discourages sharing cutting utensils, exchanging blood, and having unprotected sex. Abstinence is the key to protect peacekeepers and their responsibilities to protect the host nations they serve. There is no indication that mandatory testing is better for the individual and for society. There are no scientific indications that testing influences the spread of HIV. There is no data suggesting that this is the case. The key is that the human rights of the individual may yield to those of the country but only if yielding to the individual will give significant gain to society.

There are four parts of testing advocated by UN policy. Voluntary testing is not coerced by others or of your own choice without repercussion or discrimination. Testing is confidential. It should be assumed that medical issues are in confidence between examiner and the patient. Sharing confidentiality to partner is strongly supported but must be your own choice. Shared confidentiality with employer must not be coerced. Counseling should also be a systematic, comprehensive part of testing. Testing must include counseling to explain the reason to test and the consequences of any results. Policy should also include counseling after the results even if the person is found to be negative. Testing must be *lege artis*- in an acknowledged lab with adequate hygiene and standard for verification. Voluntary, confidential, counseling and testing (VCCT) does not happen on it's own. It requires training awareness and care. UN supports VCCT. The UN has a generic standard operating procedure for voluntary testing, provides 5 male and 2.5 female condoms per soldier each week. It also supports condom marketing within the country. However, commanding officers decide whether or not to disseminate them among troops. The UN policy encourages abstinence above all and advocates, "if you are going to fall don't fall flat".

## **CONTINUING THE HIV/AIDS DIALOG – PART I**

*Multi-sectoral collaboration is key to the coordination of the success of the country response. There is a significant role in the army to bring about consensus to the national level. A change of perception and corresponding action to change policy and resources became easier. Everybody found himself or herself worrying and fighting HIV. Everybody knew our house was on fire and everyone needed to put out the fire. It is the duty of everyone to put the fire out. Can't leave the job to a single person. Resources within any armed forces can be used to help country response.*

*Major General Subpoeng*

## **UNDPKO POLICIES AND CHALLENGES**

### **Presentation by Roxanne Bazergan - HIV/AIDS and Peacekeeping**

Roxanne Bazergan, UNDPKO HIV/AIDS policy adviser, discussed HIV/AIDS and peacekeeping. HIV/AIDS is a concern for UNDPKO. Soldiers have been identified as high-risk groups in conflict and post conflict. Currently, 37,000 uniformed personnel from 89 nations participate in 14 different missions. There are no reliable HIV surveillance systems in those countries, making it difficult to accurately assess the level of infection and impact of HIV. Resolution 1308 (in 2002) and Resolution 1325 (in 2000) declared the need to address HIV as a security issue and for more gender awareness training. UNGASS declared that the UN is committed to the fight against HIV.

Positive expectation is imposed on peacekeepers -- soldiers in 'blue helmets.' In their position as peacekeepers, they often influence local standards. They have food and money; can offer security, and are often lonely with little social contact. Peacekeepers can transmit and contract HIV in their operating area. Peacekeepers come from countries of high levels of infection and can go to countries of low levels. The UN supports voluntary counseling and testing (VCCT) and that HIV is not an indication of fitness for deployment.

The UN offers HIV awareness pre-deployment training models, induction and mission training, and in country policy advisers for MONUC, UNAMSIL, UNMEE, UNMISSET. Mission training cells have been formed in several missions. Each country has a specific training adviser. UN policy promotes abstinence and condoms. Distribution of condoms is encouraged. Counseling should accompany an HIV test. There should be a formal agreement between member states and peacekeeping forces for training. However, most host countries do not have trained counselors and need to build up capabilities to train trainers. In January, the UN sponsored training to set up counseling and testing centers. The UN encourages contingents with at least 200 soldiers to have at least one trained HIV/AIDS counselor, a screened blood supply, and post exposure prophylactic (PEP) kits.

Some challenges include the obtaining baseline data, needed to assess the impact of HIV prevention interventions. A knowledge, attitude, and practice survey is required to ascertain levels of awareness and to assess the impact of interventions. UN policy is to

build on training provided by troop contributing countries. UNDPKO can only build on what the countries have already built. Unfortunately, often the attitude of officers is that training is not needed. It is assumed that peacekeepers are safe in the military and the military culture in itself is protection from HIV. Once away from home, the soldier will conform to the military culture but may deploy to a different culture where sexual mores are opened. Soldiers also do not understand all the implications being HIV positive will entail for them. Another assumption is that discipline will by itself protect troops from HIV.

Examples of good practices include HIV training as part of military curriculum and general training. South Africa declared HIV as one of its most pressing issues. Good practices include: awareness campaigns; capacity building; VCCT; syndrome management of sexually transmitted infections; monitoring and evaluation; and gender equality programs. The next steps are to give pre-deployment specific training. Countries can send a request to have emergent, specific training via a specific mission but this does not replace the need to have their own program. UN interventions for the uniformed services include UNAIDS small-scale peer education projects, DPKO and UNAIDS collaboration, UNFPA condoms distribution, peer training by UNIFEM and collaboration with other organizations.

## **UNITED STATES HIV/AIDS DOD POLICY**

### **Presentation by Captain Glenn Schnepf - HIV/AIDS in the Department of Defense**

*Abstract: HIV testing is mandatory in all US DOD services. The accession policy is that HIV positive personnel cannot be active duty. Military members' HIV positive status makes them unfit for troop deployment and troop readiness. Armed Forces Epidemiology Board meeting held at West Point in 2002 concluded that current US DOD goals are directed towards prevention and decreasing duty limitations.*

HIV/AIDS DOD policy is written in the US DOD- DODOD 6485.1 (March 1991). All the services have different HIV policies. However, testing is mandatory in all of them. Military members' HIV positive status makes them unfit for troop deployment and troop readiness. The military needs to maintain a safe blood supply and status of forces agreements (SOFAs). Reasons to conduct HIV test include the safety of the sexual partners, co-workers from unsafe transfusions, and patients to medical providers. Testing also helps to prevent other infectious diseases in the person. The accession policy is that HIV positive personnel cannot be active duty. Civilians are tested at MEPS station and tested again after arrival of at Recruit Training Center. The Army tests every two years. The Air Force tests every five years, except for pilots who are tested every 3 years and those who have active TB. In the Navy, there is no fixed timing. However, 93-95 percent are tested every year or during routine medical exams. HIV positive personnel are sent to evaluation sites. The Army has 6, the Navy 3 sites and the Air Force 1 site.

Duty limitations include not bring deployable overseas. There are also service specific restrictions, i.e. the USMC does not allow HIV positive recruiters. HIV positive

personnel may be restricted to select billets in CONUS, Alaska and Puerto Rico. The UCMJ also plays a role but information is kept confidential. Healthcare workers with HIV follow CDC and/or OSHA guidelines. The number of reported infections in the Army is 30, Navy 39.8, Air Force 18.6, and the Marine Corps 6.6. HIV is not very common in the Department of Defense; less than 1000 active duty personnel are infected, out of almost 1 million total HIV cases in the U.S. The incidence rate is 0.1-0.2 percent are found HIV positive per 1,000 active duty tested. Less than 5 percent are women compared to 30 percent in total US population.

Treatment depends upon the CD-4 count. 73 percent are fit for duty and do not require medication. Distribution of infection is highest among the 30-34 year olds. There is no demonstrated risk in normal activities, but HIV positive personnel are non-deployable. Post exposure prophylaxis is recommended for healthcare workers and they cannot perform invasive procedures. Active duty members living with HIV are fit for duty and can remain in CONUS, Alaska, and HI. Medication treatment is started if the CD-4 count is less than 350 cells/mm<sup>3</sup> or if viral loads greater than 35,000 copied per ml. at HIV evaluation and treatment units. Medication compliance is identified as a problem and follow-up monitoring is required. Only a few military members are separated because of AIDS. An Armed Forces Epidemiology Board meeting was held at West Point in 2002. The meeting resolved that clinical testing is appropriate and that future challenges include targeting prevention. The goal should be to decrease duty limitations. There also need to be better sero-diagnostic programs and confidentiality of databases, and more research on the use of live spread virus as vaccinations.

## **CAMBODIA**

### **Presentation by COL Sokhey Tan - Royal Cambodian Armed Forces Fights Against HIV/AIDS Epidemic**

*Abstract: The Cambodian Ministry of National Defense (MND) established the HIV/AIDS program in 1995, modeled after the Thai's successful prevention program. In 2000, Cambodia established a military HIV prevention committee. Success in interventions has been seen through increased condom use from 1997-2001 but success is limited by lack of human resources, staff burnout, and lack of government funds. HIV infects 7.1% of Cambodian Armed Forces members. The Ministry of National Defense is member of the national AIDS Authority.*

The first reported case of HIV in Phnom Penh was in 1991. The first AIDS case was reported in 1993. At the time, no one knew HIV/AIDS was a problem for the people of Cambodia. In 2002, an estimated 157,000 people were infected from age 15- 49 years old. Having a responsibility to look on the health issues among their militaries, the Ministry of National Defense (MND) established the HIV/AIDS program in 1995. Modeling after the Thai's successful HIV prevention program, a peer education program started in 1996. HIV prevalence in the military was 7.1 percent in 1997, according to national surveillance derived from the Ministry of Health. At the national level, the MND became a member of the National AIDS Authority in 1999, an entity established

by the Government. In 2000, Cambodia established a military HIV prevention committee. The objectives of the committee were to strengthen and to provide the official response to HIV for all military services. Support from those who were not in the medical sector was essential because HIV is viewed mostly as a health Ministry issue and not a defense issue. However, the military was identified as one of the high-risk groups because of behavior; and in 1995, within the military 5.9 percent and 7.1 percent in 1999 were infected.

The military structure is divided into regional, divisional, provincial, and district levels. Advocacy is imperative at the Ministry level. The Ministry of National Defense developed a five-year HIV/AIDS strategic plan of prevention and care. Senior military officers met with UN, IO, and GO agencies to address the need for advocacy and commitment from policy makers and leaders. This increased the responsibility and accountability of our commanders because it became policy for the defense establishment. Senior people attended the workshop including a 3 star General and the Family Health International (FHI) director. Interventions at the regional and provincial levels are very important because the majority of troops are located within those levels. Involved regional commanders have an impact on the individual and the unit.

Six strategies of the NMD include advocacy, prevention, capacity building, care and support, research, monitoring and evaluation. Interventions include capacity building through training of trainers, project management, and peer education. Developing education and counseling material and strengthening condom promotion activities are also part of the interventions. In 1998, before support was given, there was also a need to defend the rights of personnel living with AIDS for care and support. A committee to care for those affected by HIV sensitization meeting occurred. On World AIDS Day, Prah Net Prah, a demonstration for condom promotion was conducted at the district level. Sexually transmitted infections prevention training needs to be provided at all levels from the ministry, regional, regimental, provincial to battalion levels. Another intervention was the Human Immunity game telling how HIV makes people sick. The game explains the role of the immune system on AIDS and opportunistic infections. Collaboration occurs at all levels within Cambodia's borders and transnationally. The first Indian delegate visited the MND and another visit from Indian Parliament and Senate delegate to discuss HIV policy. Coordinating with UNDP, IOs, GOs, NGOs and other ministries, is part of the plan in multi-sectoral approach. Other future challenges for Cambodia include strengthening the commitment from policy makers to make a sustainable program by integrating HIV/AIDS in all military training curriculums. Success in interventions can be measured by increased condom use from 1997-2001. Current challenges include the lack of human resources, staff burnout, and lack of government funds. A paradigm shift should occur when fighting HIV is seen as a military task.

## **INDIA**

### **Presentation by Group Captain Mandeep Singh – Indian Armed Forces Medical Services**

The Armed Forces Medical Services AIDS Program priorities are prevention, HIV surveillance, and treatment of HIV infected persons. India offers treatment to all people

who are HIV positive with a CD-4 count less than 200 to treat opportunistic infections. India also has phase I, II, and III clinical trials. The Director General Armed Forces Ministry and the Chairman of the National Aids Council Organization devised a combined service policy. This built up the capacity to 78 testing hospitals and 52 licensed blood banks. The result is that 100 percent of blood and products are screened for HIV and syphilis. In 1997, prevention programs were started. The rates of infection decreased in 2001 but it is uncertain whether there is a true correlation between decrease in infections and interventions because only high-risk groups were screened. Cumulative cases of HIV infection are increasing in the military because HIV positive personnel are not discharged, except those with TB infection, cachexia, or other duty limiting medical causes. The military needs to continue to care and support them. Among the ranks of those infected 3 percent were officers, 1 percent recruits and 90 percent of Army other ranks. There were 5 recruits per 1,000 that tested positive. The Navy has the highest contributing infection rate, which can be related to sailors' absence from their families. The 25-29 year olds at 39 percent had the highest infection rates. There is a trend of possible risk in Mumbai and Pune. Possible sources of HIV infection are casual sex (7 percent), CSW (62 percent), and not known (28.9 percent). Most of those infected had reported not using a condom during sex.

## **PHILIPPINES**

### **Presentation by COL Alberto Gabriel - Sharing the Responsibility for a Healthy Military**

*Abstract: HIV/AIDS in the Philippines has a low and slow seroprevalence: 1,834 in February 2003. HIV training is mandatory for foreign military training, foreign assignment, and peacekeeping operations. Military leaders have a role in advocacy to strengthen relationships with the Government for fund sourcing so program money is allocated each year in the budget.*

The Armed Forces Pacific (AFP) HIV/AIDS prevention program in the Philippines is a priority in the military. The AFP with the Philippine National AIDS Council and UNAIDS developed the AFPAIDS development prevention program. HIV/AIDS in the Philippines has a low and slow seroprevalence: 1,834 in February 2003. There are 1,236 asymptomatic HIV cases and 598 AIDS. Sexual intercourse, mostly heterosexual, was the mode of transmission for 251 AIDS cases. Other course of transmission includes 6 by IVDU, 27 peri-natal, and 219 were non-reported exposure. No personnel tested positive from 1995-2002 of 4,246 active and reserves forces. In April 1995, the AFP came up with policy to determine the presence of HIV infection among military personnel. HIV training is mandatory for foreign military training, foreign assignment, and peacekeeping operations.

HIV effects military preparedness. Some are complacent about the battle against HIV. However, there are tremendous impacts on infected individual and families. The AFP formed an alliance with CMA and found a prevention program that started in 2002. Senior and junior military personnel were involved and action plans made to address the

risk of the disease. The prevention program includes education, training, research, advocacy, and policy development. HIV education is incorporated into training and into existing curriculum. Training should provide trainers with appropriate attitude and skills. Research needs to design strategies to prevent HIV through other components.

The HIV/AIDS prevention program is two parts. The first part is an education project that includes the development of education material on HIV/AIDS. The second project was transmission of information through the radio, film and other mediums. Trainers especially on each island are needed to reach out to the lowest level of troops throughout the country. Soldiers do not consult military doctors because of concomitant punishment if found positive for sexually transmitted infections (STIs). More research to strengthen data on STIs should also be conducted to assess risk behavior activities to different programs in upcoming year. Military leaders have a role in advocacy to strengthen relationships with the Government for fund sourcing so program money is allocated each year in the budget. The current situation is seemingly not a problem but will be one in the future.

## **VIETNAM**

### **Presentation by MAJ GEN Bui Dai - HIV infection in Vietnam: high-risk groups and high prevalence sites (follow-up study 1994-2003)**

The current status of HIV in Vietnam and the findings of a follow-up study in 1994-2003 show accumulative HIV infections of 61,851. The prevalence rate in Vietnam is low but increasing. The majority of HIV positive persons are intravenous drug users (IVDU) (about 60 percent). The second group is TB patients (4 percent). Commercial sex workers (CSWs) are 3.8 percent of the total population. The distribution of HIV by gender is 15 percent male; 85 percent female. The prevalence in females is increasing. Distribution of HIV by age is greatest in 20-29 year olds. In Quang Ninh, there are 503 per 100,000; in Hai Phong, 246 per 100,000; and in Ho Chi Minh City, 228 per 100,000. The cities and seaside provinces have the highest prevalence rate.

The highest risk groups are among IVDU (29 percent), detention camps (15 percent), sex workers (5.9 percent), TB patients 3.62 (percent), and those with STDs (2.13 percent). The prevalence in high-risk groups in Vietnam increased from 2000-2002. There were also increased sexually transmitted infections 1.32-2.13 percent, 4.39-5.9 percent in CSW, 22.9-29.35 percent in IVDU and 1.72- 3.62 percent among TB patients. In 2002, the prevalence in selected groups was .34 in pregnant women, .64 for youth in the army, .25 for students, and 0.17 for blood donors (volunteers and sellers). Prevalence in young male recruits pre-screening was 0.96- 0.64. HIV prevalence is rising in 5 provinces where trends of sexually transmitted HIV infection have increased since 1994. HIV is concentrated in young persons less than 30 years old. The most frequent mode of transmission is IVDU; second is sexual transmission. In general, the population groups with increased HIV prevalence are among pregnant women, youth, and military recruits. Increasingly hospitals are now screening patients who are admitted for reasons other than for HIV.

The Vietnamese Government is attempting to solve the problem of IVDU by establishing six drug centers and detoxification programs in 35 provinces. However, the rate of readmission to these drugs centers has increased. Major General Dai commented that preventative measures might not be sufficient to combat HIV transmission in an environment where the economic and social pressures are too great.

## **CLINICAL TRIALS**

### **Senior Colonel Sorachai Nityaphan - Collaborative Phase I/II Trials of Preventive HIV Vaccines Among the U.S. Army, The Royal Thai Army and the Thai AIDS Vaccine Evaluation**

Colonel Sorachai spoke about preventive vaccine trials including Biocene (1995), Chiron (Nov 1997), VaxGen (January 2000) and GP 120- B/E trial. Trials have been successful thus far. Immunizations were well tolerated; antibodies developed in vaccines; and there was no evidence of antigen interference. The prime boost trials are ALVACHIV 1521. In order to move to phase III trials, political commitment, scientific commitment, volunteerism, funding, good infrastructure, and collaboration are needed.

## **CONTINUING THE HIV/AIDS DIALOG – PART II**

The third session included presentations on the importance of developing sustainable programs and civil military cooperation in the fight against AIDS, the need for policy and resource allocation for testing and clinical trials, and issues and findings in AIDS research in Thailand.

## **MADAGASCAR**

### **Presentation by LTCOL S.A. Ralamboson - National Program of Struggle Against the HIV/AIDS Involvement of the Malagasy Army**

*Abstract: The Ministry of National Defense Health Service entered into the fight against AIDS in 1991. The goal of the military program is to increase cooperation of HIV/AIDS in the Madagascar Army; to increase knowledge; to adopt less risky behavior; to institute a social, ethical and legal environment; and to continue the struggle.*

Madagascar has a burgeoning youth population that is extremely vulnerable to contracting HIV. More than half the Malagasy are less than 20 years old; the median age of the population is 16 years old. There are 99 women per 1000 men. Population density is 21 people/km. The government is presidential with a prime minister who is the chief of government of the ministry. The first two cases of HIV were found in 1987. In December 2001, there were 271 HIV seropositive people out of 218,297. Commercial sex workers comprised 10 percent, farmers 5.9 percent, the military 1.5 percent and

students 3.6. The youth, 20-29 year olds, are the most threatened by HIV. Women are more vulnerable than men. In 1989, 1 person out of 5000 was seropositive. The numbers continued to increase by 1992, 1 out of 3,000; in 1997, 1 out of 1,500; and in 2000, 1 person out of 600 was seropositive.

The spread of HIV has increased because of the growth of the sex trade. Also, people having multiple sexual partners (7 per week on average) without condom use have increased. Transmission of HIV from mother to child is rare. Other causes are contamination by blood or other organic liquid, reuse of syringes, and invasive procedures performed without gloves. Some cultural customs constitute factors of risk and vulnerability. Poverty leads to poor access to care. There are traditional ceremonies that offer human brewing allowing sexual intercourse, blood circumcisions and tattooing. Alcoholism and addiction is also a factor but there is little data showing IVDU. The high prevalence of sexually transmitted diseases increases the risk of HIV infection.

Decentralization and engagement of chief of the state of the government and religious and communal leaders is one of the most important factors in the struggle. Among 271 cases of seropositive Malagasy, about 2 percent are soldiers. The Ministry of National Defense Health Service entered into the fight against AIDS in 1991. They started an awareness campaign involving the soldiers and their families, STD/AIDS clubs in the Army and state police schools, and distribution of condoms. Authority participates in training to know more about HIV so that they can be more involved with the fight including the chief of military service staff to Madagascar. The goal of the military program is to increase cooperation of HIV/AIDS in the Madagascar Army; to increase knowledge; to adopt less risky behavior; to institute a social, ethical and legal environment; and to continue the struggle. Implication of the president and the supreme chief of the Army military hierarchy are vital in order to spearhead the struggle within the Ministry against HIV/AIDS. The Army can become one of the best tools in the struggle against HIV in Madagascar.

## **CIVIL MILITARY COLLABORATION**

### **Presentation by Stewart Kingma - Critical Policy Issues for Civil-Military Collaboration in Fighting HIV/AIDS**

*Abstract: Militaries do not exist in a vacuum; they always interface with the civilian community. The only successful means of mitigating HIV transmission is through changes in behavior, along with the protection and care of those already infected.*

Stewart Kingma addressed the concern of the “second wave” of an HIV crisis in the Asia-Pacific. Militaries within the region can be a part of the solution. The Ministries of Defense need urgently to address policies relating to HIV/AIDS. These are difficult policy issues that tread on ethical, legal and constitutional rights matters that involve civil and military collaboration. Militaries do not exist in a vacuum and always interface with the civilian community. The only successful means of mitigating HIV transmission is through changes in behavior along with the protection and care of those

already infected. These actions must also be sensitive to human rights values and resources.

Military policy should include HIV prevention and education. Effective prevention and education have to be more than information transfer. The motivational learner need to be involved and reinforced by trusted role models as well as become a part of an ongoing interactive relationship. Peer education is key. Effective and repetitive peer education requires time and resources. Education needs to be incorporated into recruit training and reinforced before and after the first leave period. It must also be included in officer and enlisted training, especially before and after deployment.

Mutual fidelity and stable sex partnerships are still the first line of defense against HIV. However, condoms remain our best practical, preventive response. It is imperative to promote fidelity, but the reality must be accepted ---- not everyone can maintain abstinence and fidelity. A culture of consistent condom use can only emerge when HIV education goes beyond briefing and pamphlets. Condom use should be perceived as normal and part of individual sexuality. The use of condoms should be promoted along with fidelity and abstinence. Commanders can protect the troops by teaching them to protect themselves.

HIV testing and counseling continues to be one of the more thorny issues that we face. The US military adopted an HIV mandatory testing policy in 1995. The UN position presented previously that mandatory testing violates basic rights to privacy and freedom from socio-economic and political discrimination. Mandatory testing fails to serve what is so often stated to be its justification: the prevention of HIV transmission. Compulsory HIV screening is being adopted by more militaries. Defense ministries need to equably balance the issue of military readiness and security versus treatment, care, and support of those they affect. National treasuries need to assure their military establishments are accorded a share of HIV budget support to enable them to train needed staff as long as possible. Financial and technical support is urgently needed. Humanitarian and developmental assistance equals the first link for successful HIV programs. A catalytic and complementary role exists between civil-military collaboration and transnational military to military collaboration. Countries that pursue vigorous AIDS programs in the military are more likely to show improved results in all sectors of society.

Military specific HIV policy questions take on expanded and critical significance when peace breaks down. The military in that situation may be the only group that can restore order. In these circumstances, the military has the most difficult, yet essential role in restoration. The military workplace draws from men and women that are 15-25 years of age and has unique patterns of travel and distant postings. Stress, alcohol, and risk-taking add to the increased risk of HIV spread. HIV transmission is further enhanced in conflict, post-conflict and complex humanitarian emergencies. The intensities of reconstruction greatly advance the vulnerability circumstance for HIV. Sex for sale is a common coping mechanism. The chain of command provides the best possible means to induce change, but change is often very difficult. These behavioral issues become difficult to manage and must go beyond codes of conduct

Command and control structures need to recognize that commanders may respond differently. Commanders may have more concerns about maintaining deployable force strength examination. Critical policy issues lead to dynamic and proactive programming

in the military. Commanders need to be sensitized to the issue and to the sense of urgency that the situation compels. Adequate human resources and greater external support need to be allocated and committed. The defense establishment should be aware of the impact of the progression of HIV infection on military life. Some argue that refusing recruitment of all HIV positive persons is justified because studies have shown training weakens immune defense and accelerates progression to symptomatic AIDS. However, studies of this aspect have been small and not well structured. A Nigerian study in peacekeeping in Liberia and Sierra Leone showed the longer the length of deployment, the higher the risk is for exposure and higher risk to HIV. In these countries, they face up to 3 years non-stop deployment in peacekeeping. In the area of complex humanitarian emergencies, vulnerability is also very real. People tend to focus on the risk of commercial sex workers, but everyone is exposed. Red Cross workers and NGO workers will bring HIV home with them as well.

Demobilization, reinsertion, and reintegration are critical moments in the life of a military person. When troops are demobilized, prevention and peer education should occur. Otherwise, proliferation of infection will occur in their home communities. Troops have the potential to be agents for change in their home communities as well as carrying out community-based surveillance of changing attitudes. HIV is a threat to the military in operations other than war and in low intensity conflict. Behavior change is key. Training should be reinforced prior to deployment, during deployment, and revisited after deployment.

## **RESEARCH AND TECHNOLOGY**

### **Presentations by:**

**LTCOL Art Brown - Foundations of HIV Vaccine Efficacy Trial**

**Group COL Penprapa Chanbancherd - Increased prevalence of hepatitis C co-infection among HIV-infected Royal Thai Army recruits: Evidence of a changing pattern of HIV transmission in Thailand**

**COL Chirapa Eamsila – Toward quality: Preparation for the College of American Pathologists' Inspection of Clinical Laboratories at AFRIMS**

**LTCOL Thippawan Chuenchitra - HIV-1 Cross Clade Serum Antibody Dependent Cellular Cytotoxicity (ADCC) Activity in HIV-1 Subtype CRF01\_AE (E) Infected Thai Individuals with Different Rates of Disease Progression**

LTCOL Art Brown discussed the foundations for a Phase III-HIV vaccine trial. AFRIMS' current effort centers on personnel exchanges and technology transfer. Some studies include introducing the pathogen to a human host. Studies are tailored according to the information derived from a geographer's data analysis and also a global systems specialist. Significant research findings were the discovery of two distinct variants of the virus in the Thai epidemic. HIV is found in multiple subtypes. For the US military, these

other subtypes were important to develop vaccines for all the forces that deploy. Diversity has increased in all areas and continues to increase. HIV in Thailand is less diverse than others found in other regions. HIV has recombinations as well. In order to complete the study a population must be identified in advance. However, longitudinal studies are demanding of people, time, resources, medical and research staff, and the clinical trials recruits. Participants come from civilian STD clinic attendees, family planning clinics, and the general community. The HIV vaccine study is a multi-year commitment and multi-disciplinary approach. It requires international collaboration for phase III vaccine trial. The benefits are bi-directional. Factors for success include established relationships and sustained support of royal Thai and US armies. It is a crucial model for the global effort to develop vaccines for HIV/AIDS.

Another Royal Thai Army study followed Hepatitis C (HCV) co-infection among HIV infected recruits. It revealed a changing pattern of HIV transmission in Thailand. Randomly selected 21 year-old Thai males were the population sample. HCV is an RNA virus like HIV. The research was to determine a correlation between HIV and HCV prevalence. A significant increase in persons infected in the year 2000 of anti HCV may be due to increased risk behavior with parental transmission associated with IVDU, tattooing, and body piercing. Parental transmission was previously unrecognized. Previous studies show the main mode was heterosexual transmission. Interventions should also include ways to decrease IVDU to diminish the spread of HIV.

The multi-sectoral approach to combat AIDS also includes the clinical trials and technological resources for testing. Clinical laboratories must follow World Health Organization practice guidelines to have a lab for HIV vaccine trials. The laboratory should be approved by the American Academy of Virologists. Quality assurance programs are needed to ensure trials are in compliance with requirements; to monitor and evaluate quality; to identify problems; and to assure accuracy of testing. Some safety requirements include: biohazard signs at lab entry and personnel spaces, labeled drawers, precautions for electricity, and fire alarms. Personal protection such as donning of proper footwear, lab coats, gloves and goggles is also a requirement. Eyewash stations, spill kits, plastic ware to avoid injury, and flow charts of accident protocols are available on the wall as part of the safety requirements of the laboratory. Food or drink is not allowed in the refrigerator. Infectious waste is separated. Each employee has a safety folder. Vaccine trial data must be on file for at least ten years. Resource allocation for the laboratories to continue research, testing and surveillance is fundamental to the fight against HIV.

**HIV/AIDS NETWORK**  
**ASIA-PACIFIC MILITARY MEDICAL CONFERENCE DELEGATES**

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Air Commodore Tony Austin

**CAMBODIA**

Brigadier General Saly Kong

Lieutenant Colonel Sokhey Tan

**INDIA**

Lieutenant General Bijoy Shahi

Group Captain Mandeep Singh

Lieutenant Colonel Anil Dhall

**MADAGASCAR**

Lieutenant Colonel Solofo Ralamboson

**MALAYSIA**

Brigadier General Abdullah Ramasamy

Brigadier General Haji Mohamad Junaidi

Colonel Hanif Khan

Captain Goh Ai Lin

**NEPAL**

Brigadier General Chhabi Dahal

**PHILIPPINES**

Colonel Alberto Gabriel

Captain Roberto Calupitan

Captain Rogelio Catapang

Major Bernadette Buhayo

**SINGAPORE**

Colonel Surya Kumar

Ms. Serena Chew

Mr. Victor Kow

**THAILAND**

Major General Suebpong Sangkharomya

Senior Colonel Suwicha Tim Chitpatima

Colonel Phiwad Poshyananda

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### COUNTRY HIV PROFILES

COUNTRY	Prevalence of National HIV cases	Prevalence in Military Population	Current Interventions	Future Plans (Country & Regional Efforts)
<b>CAMBODIA</b>	157,000	7.1% (1997)	<ul style="list-style-type: none"> <li>• Peer education</li> <li>• Condom distribution</li> <li>• HIV/AIDS support group</li> <li>• HIV/AIDS education game</li> </ul>	<ul style="list-style-type: none"> <li>• Promote continued advocacy</li> <li>• Continue building on lessons learned from collaboration with RTA and CMA</li> </ul>
<b>INDIA</b>	3,970,000	0.34 (1998) 1.3 (2000) 0.77 (2001)	<ul style="list-style-type: none"> <li>• Armed Forces AIDS Control Program</li> <li>• Surveillance</li> <li>• 78 Blood testing centers</li> <li>• 52 Licensed blood banks</li> <li>• Education activities</li> <li>• Mother-To-Child Prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Procure technology including: ELISA testing material, needle and syringe destroyers, kits for opportunistic infections, centrifuges</li> <li>• Obtain range of educational HIV prevention and implementation programs</li> <li>• Pursue and build bilateral relationship for training in HIV prevention</li> </ul>
<b>MADAGASCAR</b>	271	2%	<ul style="list-style-type: none"> <li>• STD/AIDS clubs in 5 Army and state police schools</li> <li>• Distribution of condoms in Army school infirmaries</li> </ul>	<ul style="list-style-type: none"> <li>• Continue cooperation with government to increase HIV/AIDS knowledge in the military</li> </ul>
<b>PHILIPPINES</b>	1834	0%	<ul style="list-style-type: none"> <li>• Training of trainers</li> <li>• Data booking</li> <li>• Behavioral research</li> <li>• Formulation of Policies on HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Continue resource allocation for current HIV programs</li> </ul>
<b>THAILAND</b>	695,000	0.7 (military recruits)	<ul style="list-style-type: none"> <li>• AIDS classes in military training</li> <li>• Peer group training</li> <li>• AIDS vaccine trial programs</li> <li>• HIV molecular biology studies</li> </ul>	<ul style="list-style-type: none"> <li>• Establish HIV regional training center with partner militaries</li> <li>• Promote transnational collaboration with Asia-Pacific countries and US</li> </ul>
<b>VIETNAM</b>	61,851	.64 (military recruits) 25	No interventions presented	<ul style="list-style-type: none"> <li>• Pursue and build bilateral relationship for training in HIV prevention</li> </ul>