REPUBLIC OF SIERRA LEONE ARMED FORCES

HIV AND AIDS POLICY

By Command of the
Defence Policy Committee

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MINISTRY OF DEFENCE,
TOWER HILL
FREETOWN

FORWARD

Since the formation of the Republic of Sierra Leone Armed Forces (RSLAF) HIV and AIDS Program in 2002, the RSLAF has successfully trained and established Peer Educator Committees throughout the Formations and Units force wide, with the sole aim of sensitizing troops and their dependants about reducing and mitigating the impact of Sexually Transmitted Infections (STIs).

It is with enthusiasm that I implore Commanders to disseminate this revised HIV and AIDS Policy to all troops under their command. It is also incumbent on all commanders to adhere to the issues raised in the document and also to reduce stigma and discrimination within the RSLAF, ensuring that the force is not robbed of the achievements made so far in the fight against the epidemic. One significant achievement made by the RSLAF HIV and AIDS program is the formation of the PLHIV group within the force called the CONCERN family whose Human Right is their retention in the force.

In my capacity as Minister of Defense I therefore urge all men and women of the Republic of Sierra Leone Armed Forces to go for VCCT in order to know your status thereby living positively. As Commanders, you are duty bound to lead your men and women of the Force to live a HIV free life, as you cannot be Commanders of sick troops.

MAJOR PAOLO ALFRED CONTEH (Rtd)
Hon. Minister of Defense

PREFACE

It is a well-known fact that HIV is more than just a health issue and now considered a global security concern. AIDS can overturn decades of national development and devastate our communities, economies, political institutions and even our armed forces. Invariably, the HIV prevalence within uniformed services is mostly higher than the civilian population. In a situation where HIV is not adequately addressed within the army, it has the potential of hampering command structures and compromising the readiness and capacity of the military to respond to security threats and instability.

It has been widely acknowledged that uniformed services including the military are highly vulnerable to Sexually Transmitted Infections (STIs) including HIV. This is mainly due to their work environment, mobility and other facilitating factors that expose them to higher risk. Both the UN Security Council and the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) adopted Resolutions calling for HIV and AIDS interventions in international and national uniformed services to adequately respond to the pandemic within their structures.

The RSLAF has made significant progress in several areas in addressing key issues across the rank and file of the military to slow down the spread of the infection in its domain. Training of personnel in intervention areas, establishment of structures and support groups of HIV positive serving personnel and a host of others have succeeded in reducing the high level of stigma and discrimination related to HIV that once pervade the army. The challenges though are still present.

The review of this policy was timely and has taken onboard several key and pertinent issues that informed the approach of HIV response in the army in a better light. It sets to address issues of Human Rights of PLHIV, retention and maintenance of HIV positive serving personnel and adopted an implementers' approach that allows mainstreaming of HIV and AIDS into its operational activities. Experience has shown that with the right policy environment, intervention activities can successfully bring about reductions in HIV prevalence especially where they are combined with high-level political commitment and leadership.

The RSLAF as an outfit has the ideal environment, and with such a policy document, if well implemented will succeed in the near future to halt the spread of HIV within its ranks and file.

I am pleased to preface this policy to all concerned and hope it will be a useful reference for HIV and AIDS intervention planning and implementation within the army.

Dr. Brima Kargbo
Director, NAS

RSLAF HIV/AIDS POLICY

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List of Acronyms

1. AIDS	Acquired Immune Deficiency Syndrome
2. ART	Anti-Retroviral Therapy
3. BCC	Behavioral Communication Change
4. CDC	Centre for Disease Control
5. CIMI	Community Initiative to Mitigate the Impact
6. DDMS	Director of Defence Medical Services
7. FA	First Aid
8. GoSL	Government of Sierra Leone
9. HIV	Human Immuno-Deficiency Virus
10. IMATT	International Military Advising Training Team
11. M&E	Monitoring and Evaluation
12. MOD	Ministry of Defence
13. MTCT	Mother to Child Transmission
14. NACP	National AID Control Programme
15. NAS	National HIV and AIDS Secretariat
16. NGOs	Non Governmental Organisations
17. PLHIV	People Living with HIV
18. RSLAF	Republic Of Sierra Leone Armed Forces
19. SHARP	Siera Leone HIV and AIDS Response Project
20. STIs	Sexually Transmitted Infections
21. UNAIDS	United Nations Programme on AIDS
22. UNGASS	United Nations General Assembly Special Session
23. UNICEF	United Nations Children Emergency Fund
24. UNFPA	United Nations Fund for Population Activities
25. US/DoD	United States Department of Defense
26. VCCT	Voluntary Confidential Counseling and Testing
27.WHO	World Health Organization

RSLAF HIV AND AIDS POLICY

INTRODUCTION
Global overview of HIV/AIDS situation

HIV and AIDS is posing a serious humanitarian crisis in many regions of the world, threatening the public health and well being of ethnic societies while decelerating progress in economic and social development.

Since the first reported case of HIV and AIDS in the early 80s there has been an increase in the incidence of pandemic. AN estimated 38.6 million (33.4 million-46.0 million) people worldwide were living with HIV in 2005. About 4.1 million (3.4 million to 6.2 million) became newly infected with HIV and an estimated 2.8 (2.4 million-3.3 million) lost their lives to AIDS. The number of people with HIV has continued to rise due to population growth and more recently the life prolonging effects of antiretroviral therapy.

Sub-Sahara Africa which accounts for more than one-tenth of the worlds population remains the world affected region in the world with almost 64% of all people living with HIV 24.5 million (21.6 million-27.4 million). Among those mostly affected by the disease are children, orphans or otherwise burdened by the devastating toll. Two million (1.5 million-3 million) of them are children younger than 15 years. Nine in ten children less than 15 years living with HIV are in Sub-Sahara Africa. An estimated 2.7 million people in the region became newly infected, while 2.0 million adults and children died of AIDS. Some 12.0 million orphans are living in Sub-Sahara in 2005. Seventy-five percent of all women (15 years and above) living with HIV are in Sub-Sahara Africa. In most of the region, women are disproportionately affected by AIDS compared to men.

Current survey data support the disproportionate impact of the AIDS epidemic on women, especially in sub-Sahara Africa where the ratio of HIV infected Men: Women is 2: 3. Among youths (15-24 years) the ratio broadens considerably with the ratio been 1:3.

South Africa remains the global epicenter of the epidemic. Almost one in three people infected with HIV globally live in the sub region. About 43% of all children under 15 years living with HIV are in South Africa.

National Epidemiological situation

Since the first HIV and AIDS case was reported in Sierra Leone in 1987, nearly 6000 individuals have tested positive for HIV and just over 23000 have developed the AIDS disease, and about 560 are reported to have died. Prevalence of HIV has shifted from 0.9% in 2002 to 1.53% in 2005. Of the 1.53% , 91% are HIV -1 positive,4.5% are HIV-2 Positive and 4.5% dual HIV -1 and HIV -2 positive prevalence does not differ significantly between males (1.5%) and females (1.6%) . The highest prevalence among women occurs in the 20 – 24 years age group (2.0) where as males between the ages of 35 – 39 years have the highest prevalence (3.5%).

Seventy-three percent of the total population sampled in 2005 reported having had sex in the last twelve months and 74% of these within a month before the survey. There was a slightly higher level of sexual activity for Moslems (75.4%) than Christians (69.8 %) . The mean age at first sex for respondents was 16 years.

About 27% of the population was reported to have had sex with more than one sexual partner, and about 2% to have had sex in exchange for money. In general, knowledge related to HIV and AIDS is fairly low especially in rural areas.

Seventy nine percent of Christians were knowledgeable of HIV and AIDS compared to 69% Muslims and 61% of people of other faiths. Males (65.1%) had a higher level of knowledge compared to females (54.2%).

Seventy-one percent of respondents knew that mutual faithfulness is related to HIV prevention. Those with tertiary education have the highest level of knowledge (47.9%), as compared with those with no education (10.1%). The 2005 survey results showed that misconceptions about HIV transmission are high in Sierra Leone. False beliefs vary by gender and residential stratum, with urban residents having fewer misconceptions than rural residents.

Koinadugu district had the highest prevalence (3%); and most of the respondents from this district neither knew their HIV status nor had any knowledge of a PLHIV. The survey concluded that in light of the high number of recent infections, the lack of knowledge, and the low condom use, prevention efforts, including educational messages, have to be urgently scaled up.

Situation Analysis of the Institution

The first sero-prevalence survey carried out within the military was in 2007. Results revealed a prevalence rate of 3.57%. The military over the years has put measures in place to halt the speed of the disease in the absence of a cure.

1.4 National response to the epidemic

The first step taken by the government in responding to the discovery of HIV in Sierra Leone was the formation of a National AIDS Committee in 1986. This committee was transformed into the National AIDS Control Programme (NACP) in 1988 to strengthen the HIV and AIDS prevention activities.

The main focus then was raising people's awareness of HIV/AIDS but preventive and control activities were not giving high priority, mainly because of internal conflict, inadequate resources and low political commitment and advocacy.

The situation however changed in 2001 when the government recognized that HIV and AIDS was a developmental problem. In 2001, the government of Sierra Leone appointed a cabinet Sub-committee under the leadership of the Minister of Information and Broadcasting.

The Cabinet Sub-Committee collaborative partnership, mostly with the expanded UN Theme Group on HIV and AIDS, the World Bank and the US Government to establish structures that would strengthen the national response to HIV and AIDS.

Through this collaborative partnership, mostly with the expanded UN Theme Group on HIV and AIDS, a national Policy was drafted in 2001. Government also collaborated with the US centre for Disease Control and Prevention (CDC) to conduct a national HIV Sero – Prevalence and Behavioral Survey in 2002 which provided a relatively clear status of the HIV and AIDS situation in the Country. There was renewed interest and awareness leading to heightened activities to respond to the HIV and AIDS epidemic.

The increasing interest of development partners to work with the Government in addressing HIV and AIDS and the exigencies of coordination resulted in the establishment of the National AIDS Council (NAC) and its Secretariat (NAS) under the office of the President in 2002 for the overall policy and coordination of HIV and AIDS related national response.

District AIDS Committee (DAC) have been established in all as extensions of NAC to district level to enhance the coordination of HIV and AIDS activities. The Ministry of Health and Sanitation (MOHS) established in October 2002 the AIDS Response Group (ARG) as the health sectors technical arm with four major areas of focus: surveillance, prevention, care and capacity building. Combating HIV and AIDS is considered a major step towards poverty reduction. The National AIDS Council (NAC) chaired by the President is the highest strategic body in the national response.

The National AIDS Secretariat (NAS) coordinates the implementation of policies agreed upon by the NAC by involving key Ministries, local councils, the private sector, and civil society in the design, planning, implementation, monitoring and evaluation of programmes. Over 300 agencies and organizations are engaged in HIV and AIDS activities (UNAIDS 2005) especially IEC/BCC leading to increased awareness on HIV and AIDS throughout the country.

The end of the decade-long war has provided the country with a socio-political environment for implementing a comprehensive multi-sectoral programme to combat the HIV epidemic including free treatment with ARVs.

1.5 Institutional Response

Initial reaction was the establishment of the RSLAF HIV and AIDS department in 2002. Subsequent successes include:

- Developed and produced HIV and AIDS policy for RSLAF (which is supposed to be revised every two years).
- Trained 210 HIV and AIDS Peer Educators (with yearly refreshers training) across the military
- Trained 60 HIV and AIDS counselors (with yearly refreshers training)
- Trained 40 training officers as HIV and AIDS trainer of trainees
- Trained teachers of Secondary and Primary Schools within the Military Barracks on HIV and AIDS Prevention among school going children
- Trained 40 Nurses working in the Military Hospital on the nursing of HIV and AIDS clients
- Trained 8 Lab Technicians on modern HIV testing techniques
- Trained doctors in the management of HIV and AIDS
- Formed 26 HIV and AIDS Peer Educator committees within the RSLAF with a mechanism to monitor their activities quarterly.
- RSLAF HIV and AIDS Program now has an association of People Living With HIV and AIDS (PLHIVs) with a membership of One hundred (100) service personnel.
- Retreat and training for PLHIVs with emphasis on HIV and AIDS
- Held series of HIV and AIDS Advocacy and Sensitization workshops for Senior military commanders
- Established a treatment centre at 34 Military Hospital for PLHIVs with a highly trained staff.
- Renovation of the RSLAF Laboratory with modern equipments

1.6 Gaps in the response

Despite the responses, the military does not have a comprehensive approach in responding to the epidemic. In addition to the limited financial support, they are faced with a lot of challenges in curbing the spread of HIV. This implementation will be only met by the implementation of the appropriate policies.

1.7 Challenges

To mitigate the impact of HIV and AIDS in the military, joint action on a variety of fronts is needed. Principal among these are;

- Ensure that all service personnel and their dependants know how to prevent the infection
- Reduce and potentially stop the spread of HIV from mother to child
- Provide life prolonging treatment to entitled infected personnel and dependants to assure continuity in service
- Mobilize necessary resources to battle against AIDS
- Empower service persons with HIV and AIDS related information and other resources for behavioral change
- Promote research on vulnerability of service personnel to HIV and AIDS and STIs.

Rationale of the policy

Uniformed services, including peacekeepers, frequent rank among the population groups most affected by sexual transmitted infections (STIs), including HIV. Military personnel are two to five times more likely to contract STIs than the civilian population and, during conflict, this factor can increase significantly. However, soldiers may also become important agents for behavioral change in preventing the spread of HIV within the military and beyond. If equipped with the right information, knowledge and tools, the military can achieve lower HIV prevalence rates than the civilian population.

Goal

The RSLAF policy is therefore formulated to guide commanders and service personnel and other welfare agencies to combat the spread of HIV and AIDS.

This Policy shall be known as the "Republic of Sierra Leone Armed Forces HIV and AIDS Policy, 2010".

10 Objectives

1. To increase access to information on HIV.

2. To promote the rights of infected and affected persons to quality care and support services.

3. To promote health care training and develop support service to all RSLAF personnel and to assure universal precaution in health delivery system.

4. To promote voluntary confidential counseling and testing (VCCT) amongst service persons and their dependants.

5. To prevent mother to child transmission (MTCT) through screening of wives of service personnel during pregnancy and ensure safe delivery and safe motherhood practices.

6. To increase the participation of people living with HIV and AIDS in HIV prevention programmes.

GENERAL PRINCIPLES

2.1 HIV/AIDS Screening

The directorate of defence medical services of the RSLAF shall request HIV test for any service personnel for reasons of fitness for duty. However random HIV screening shall only be conducted with informed consent of the service personnel or dependants.

2.2 Confidentiality

Medical records of HIV and AIDS patients and all information about their treatment shall be kept under lock and key. Any information about the health of any patient shall only be communicated with the dependants/other persons only with the consent of the patient. RSLAF however deserves the right to use such information for prudent management decisions.

2.3 Informing the Employer

No service personnel is under any obligation to divulge his/her status to RSLAF command where such test was done outside the military health care system. However, service personnel are encouraged to be open about HIV status to their commanders who will treat such information with confidentiality to guide management's decisions.

2.4 Protection of Employee

Service personnel tested HIV positive whilst in service will maintain their job, as long as their fitness can permit.
Furthermore, commanders shall assign such service personnel to light duty or within the services based upon the individuals level of physical fitness and capability.

2.5 Access to Services

Peer education will be promoted to increase behavioral change communication (BCC) at the work place. Infected persons shall also be encouraged to become open about their HIV status and to serve as peer counselors at the work place so that PLHIVs will become part of the solution to HIV problem.

Consequently an association of PLHIV will be formed to fight stigma against HIV and AIDS and advocate for support of the affected. RSLAF shall make available in strategic locations free and adequate supplies of condoms, leaflets on HIV and AIDS and quality service to treat the opportunistic infections associated with HIV and AIDS.

Anti Retroviral Therapy (ART): - Anti Retroviral therapy will be commenced for any service personnel or dependant free of cost if CD4 count is below 350. Co-trimoxazole (Septrin) will however be commenced on all HIV positive patients (no matter the CD4 count) to prevent against opportunistic infections.

2.6 Reasonable Changes in Employment

Service persons tested positive need shorter shift lengths and postings guided by availability of quality health care and social services their place of work.

2.7 International Operation

The Joint Medical Unit, a Sub-structure of the coordinating committee, shall work with the Joint Force Comd (JFC), to ensure that no HIV positive case goes on international mission. Pre and post HIV testing shall be conducted for all personnel in the deployment and withdrawal for border patrol operations and peace missions.

2.8 Data bank

A data bank for affected and infected personnel will be established and maintained by the coordinating committee. In-theatre infections should be treated, repatriated and counseled before joining parent unit on the advice of the CC (Coordinating Committee).

Commanders should demonstrate leadership role in monitoring and supervision of counselors and peer educators under command.

2.9 Nutrition

Proper nutrition in the treatment of HIV is crucial. The military will collaborate with partners to see that PLHIVs are been provided with appropriate diet while on medication.

2.10 Contingency

First aid services shall be regularly provided to service personnel in order to promote safe handling of blood and blood products.

2.16 Administration and Enforcement

This policy shall seek to establish standards for the prevention of HIV, care and support for the infected and affected and treatment incase of Anti-Retroviral Therapy. Also such standards and protocols shall comply with best practice criteria and the RSLAF medical ethics. Guidelines, standards and protocols shall only come into force through the approval of the RSLAF AIDS Council.

2.12 Strategies for implementation

This policy shall engage the following implementation strategies in order to increase impact of its coordination response.

Advocacy and Social Mobilization-Advocacy and social mobilization will be strengthened through the use of counselors and peer educators for HIV prevention, care and support of infected and affected persons.

2.13 Information, Education and Communication (IEC)

A comprehensive IEC strategy shall be developed and strengthened. It will aim at delivering appropriate technically correct and up-to-date information on HIV/AIDS/STIs and rights on the infected and affected persons. This proposed strategy shall be consistent with existing resources and the national HIV/AIDS policy and its response through NAS.

2.14 Capacity Development

A capacity development strategy shall be implemented at organizational, managerial and technical levels to enhance effectiveness and efficiency at the command and operational levels for implementation of this policy.

2.15 Voluntary Confidential Counseling and Testing (VCCT)

These services shall be extended to all Bdes/Units to enhance access to early diagnosis, counseling, support and elimination of the social stigma surrounding HIV and AIDS.

Also the Director of Defence Medical Services shall ensure that all field and operation commanders understand this policy and work toward its realization without any obstruction. Consequently all service persons and dependants are required to enforce its implementation at individual, family and community levels.

2.16 Monitoring and Evaluation

Monitoring and Evaluation shall be an integral part of any HIV and AIDS interventions in order to provide the necessary data that can inform planning and programming. This policy shall incorporate into its implementation structure an M&E department, which is directly answerable to the Director of Defence Medical Services.

2.17 Coordination

Effective coordination strategy shall be developed and streamlined to enhance effective involvement of all key stakeholders. This will ensure maximum use of resources provided guidance, set standards of achievement that are sensitive to gender equality and equity and effective links to other existing policies and programmes. Formation of association of PLHIV to conduct advocacy against stigma shall be encouraged

2.18 Implementation

MOD shall implement this policy through the Directorate of Defence Medical Services using the approach that allows mainstreaming of HIV and AIDS into other operational activities. Hence the infection shall cease to be treated wholly as a medical problem but a development problem with social, economic and security dimensions. However, the implementation of the policy remains the business of RSLAF HIV and AIDS council.

2.19 Human and Financial Resources

The services of Military personnel shall be utilized as part of their normal military duty. However, should the services of a technical nature arise a consultant or contractor will be hired.

2.20 Logistics

The RSLAF HIV and AIDS council should endeavor to provide the necessary logistics towards the implementation of this policy.

2.21 Funds

Fifteen percent of the government of Sierra Leone allocations to Defence Medical Services shall be utilized for HIV/AIDS prevention and impact mitigation. Ten percent shall be used on prevention and 5% on care and treatment. RSLAF HIV and AIDS programme shall endeavor to mobilize resources from donors to augment GoSL/RSLAF resources. (NAS, US/DoD, DFID, UNFPA, USAIDS etc).

2.22 HIV and AIDS and the respect for Human rights

Partnership shall be established with organizations engaged in HIV and AIDS prevention and control in order to allow sharing of experience and technical know-how. Best practices shall be encouraged to impact on the RSLAF HIV and AIDS response

2.23 LIVING WITH HIV/AIDS AND THE RESPECT FOR HUMAN RIGHTS

The RSLAF will respect the human right of those living with HIV/AIDS and their dependants and assist in the destigmatization of all affected persons in line with the National HIV and AIDS policy. It is a crime to knowingly infect another person with HIV. The RSLAF HIV and AIDS policy also considers this act a punishable offence and will therefore institute disciplinary action against service personnel who willfully infects another person with HIV.

Disciplinary action will also be taken against any medical or health care worker who cause the spread of HIV by gross negligent, discharge of his/her duties (such as the reuse of dirty needles, syringes, blood transfusion etc)

Conclusion

The mode of development of service personnel in the Armed Forces to areas far remote from their spouses is one of the main predisposing factors responsible for the high incidence of STIs including HIV/AIDS in the RSLAF. The low level of knowledge of HIV/AIDS and the use of condoms among troops as demonstrated in the KABP Survey of 2002 have also contributed to the high incidence of the disease.

The ongoing sensitization campaign in the RSLAF to mitigate the impact of the disease, and the fight against social stigma and discrimination of the people living with HIV/AIDS in the RSLAF should be intensified with sustainable momentum.

The Defence Medical Services has accomplished its role as a policy maker by formulating this document, to regulate the implementation of all RSLAF HIV and AIDS programme but the Joint Medical Unit HIV/AIDS committee members are tasked with the responsibility to carry out the implementation. To effect this implementation, the committee members and other stakeholders need the full cooperation and total support of all commanders.

Apart from the commitment on preventive and control aspect of this disease, the policy also makes provision for service personnel living with HIV/AIDS as follows:

Provision of appropriate development within the service based on personal level of physical fitness and capacity. Provision of free voluntary confidential counseling and testing with access to appropriate medical treatment.

The policy also assures HIV/AIDS service personnel that they will not be dismissed from service as a result of their HIV/AIDS statusThe policy also advocate for disciplinary action to be taken against service personnel who willfully infect other personnel with HIV. The same will apply to any medical or health care worker who cause the spread of HIV among service personnel by gross negligence during the discharge of his/her duties ie. The re-use of dirty needle and syringes, the transfusion of HIV infected blood or unscreened blood etc.