ENLISTING THE ARMED FORCES TO PROTECT REPRODUCTIVE HEALTH AND RIGHTS:

LESSONS LEARNED FROM NINE COUNTRIES

TECHNICAL REPORT

Technical Support Division
Culture, Gender and Human Rights Branch

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FOREWORD

UNFPA has been at the forefront of involving men in reproductive and sexual health for decades, and especially since the International Conference on Population and Development (ICPD, 1994). Over the years, we have learned a great deal about how to positively engage men to take charge of their own reproductive and sexual well-being and support that of their partners. One of the fundamental lessons is to reach out to men where they are rather than expect them to seek out reproductive and sexual health information and services.

Employment-based programmes have been one of the most successful ways of doing this. Drawing on pre-Cairo successes with employment-based population and family life education programmes, UNFPA has worked in several countries with a major employer – the military – to introduce, expand and enhance reproductive and sexual health information and services.

The enormous human, social and economic toll of HIV/AIDS and the increased awareness of women's vulnerability to gender-based violence, have given greater urgency to this approach. Many countries have planned or are now implementing projects targeting men in uniform as a way to promote HIV prevention, engage men as partners in gender equity and the reduction of gender-based violence and improve their own and their partners' reproductive health status and protect their rights.

To map out what can be done in future interventions related to reproductive health and gender equity within this key institution, this publication draws lessons from nine country case studies and a global review of emerging programming and policy issues for enlisting the armed forces in reproductive health, including preventing HIV/AIDS and promoting gender equity. It starts by summarizing key lessons from the nine countries. This is followed by an introduction, a synopsis of each case study, and a comparative analysis drawn from the country findings. The comparative analysis examines what works in successful programmes, what does not and what is left out. It also identifies remaining challenges and opportunities. Finally, we outline global changes in the military context relevant to future programming.

I trust that this review will stimulate debate, future programming and increased funding to enlist armed forces as critical partners in both peacetime and conflict situations in our national and international efforts to promote reproductive health and rights and gender equity.

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ABREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communications (Formerly IEC: Information, Education and Communication)
CST	Country Technical Services Team
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICMH	International Centre for Migration and Health
KAP	Knowledge, Attitudes and Practices
PLWA	People Living with AIDS
RH	Reproductive Health
RSH	Reproductive and Sexual Health
RR	Reproductive Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAps	Sector Wide Approaches
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDPKO	United Nations Department of Peacekeeping Operations
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
VCCT	Voluntary and Confidential Counselling and Testing
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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EXECUTIVE SUMMARY OF KEY FINDINGS AND LESSONS

Background

This comparative study of country experiences across regions was undertaken as part of a UNFPA interregional project 'Improving Gender Perspective, Reproductive Health and HIV/AIDS Prevention through Stronger Partnership with the Military' (project number INT/01/PM3). It was conducted by UNFPA's Technical Support Division, with generous support from the Swedish International Development Agency and through collaboration with the UNFPA Technical Assistance Programme regional advisors, country offices and national consultants.

Its purpose is to inform future programming by identifying effective approaches for working with men in the uniformed services in reproductive and sexual health from a gender perspective. Although UNFPA has long cooperated with the military in the areas of family planning and family life education, its growing cooperation with an institution that operates in unique political and social contexts – in times of peace or conflict – has not been well documented. Experience sharing is needed to scale-up or sustain effective interventions and guide future programming. Cross-regional exchange of experiences is expected to enhance UNFPA's practical knowledge and leadership role in an area where it clearly has a comparative advantage regarding gender issues, reproductive health/reproductive rights promotion, and the fight against HIV/AIDS. Equipped with practical insights into the implementation process, UNFPA offices and their national partners should be able to improve existing programmes or introduce new ones.

To compare implementation strategies in the military that integrate reproductive and sexual health and gender issues, we established a conceptual framework to review the nature of the partnership; the extent and quality of reproductive health services and information, including for HIV/AIDS prevention; and gender mainstreaming.

Country experiences are from: Benin, Botswana, Madagascar and Namibia in Africa; Ecuador, Nicaragua and Paraguay in Latin America; Mongolia in Asia; and Ukraine in Eastern Europe.

The case studies focused on institutional changes, rather than actual impact on epidemiology and behaviour. They sought to identify the range of implementation approaches used so far, their commonalities and differences. A common query was: What is working and needs to be continued or expanded? What is not working and needs a new more strategic approach? And finally, what has not been addressed at all?

The main lessons follow:

Institutional opportunities and challenges for the partnership

Selecting a strategic focus for the partnership between donors and armed forces

The projects reviewed fell in three broad categories, focusing on:

- Prevention of HIV and other sexually transmitted infections in Botswana Mongolia and Namibia;
- Improvement of armed forces' reproductive health service delivery capacity in Benin; Ecuador, and Madagascar;
- Educating military personnel about population and reproductive health issues, in Botswana and Ecuador, and integrating reproductive and sexual health services and education in Nicaragua and Paraguay.

The review examined if and how the origin of the project – including its funding source, and whether it derived from earlier projects – affected the attention given to gender issues, quality of care and broader reproductive health messages as well as the project's prospects for scaling-up and institutionalization.

Since most of the projects studied did not conduct a needs assessment at the outset, strategic design decisions, such as the selection of priority beneficiary groups, depend on the degree of verticality of the intervention and preferences of donors, rather than on actual needs.

In peacetime, a larger difference in the focus of the reproductive and sexual health interventions with the armed forces seems to account from donor's interests rather than country-specific development context and lessons learned from experience. Another is the visibility of the HIV/AIDS epidemic in the country.

Donors may need to show short-term results, and hence, take a vertical approach. However, in order to implement the comprehensive ICPD vision, projects with the military should attempt to expand from the vertical and short-term programmatic approaches to HIV/AIDS prevention -favoured by many large donors- and encompass all components of reproductive health, including quality of care, reproductive rights, and gender-based violence, and mainstream gender in laws and codes of conducts.

Most projects supported by HIV-focused funds, such as UNAIDS, tend to address HIV prevention in a rather vertical and medical manner; much less attention is given to other reproductive health components such as family planning, maternal and child health, and gender perspectives. Even though these projects focus on prevention, critical components such as voluntary counselling and testing (VCT), sustainable condom provision and

education on gender sensitive relations, seem to have been an after-thought, and the reproductive health services component is limited.

Moreover, many of the surveyed HIV-only projects focus on educating young male soldiers and conscripts, but leave out higher-level officers, service providers, permanent staff, female staff, and civilian populations.

On the other hand, the broader reproductive health projects, which stem from former family planning or population education activities, try to address larger concerns and take a more comprehensive approach to reproductive health. When these projects contributed to building a reproductive health infrastructure, they tended to focus more on service delivery and less on education for behaviour change. However, the addition of an HIV prevention component – especially provision of condoms – is often an after-thought. Most projects on rehabilitation of reproductive health services encompass service providers, families of permanent staff and in some cases, surrounding civilian populations. They tend to overlook the needs of young recruits.

Who to work with inside the institution?

Most projects favour one department over others, often either the health or training departments, but rarely both.

Because the choice of a lead department is critical to the success of a project, a thorough understanding of military structure and its culture is essential to effectively channel support to project activities.

A major challenge to integration and coordination among departments comes from the organizational structure of the military itself, which is typically compartmentalized and hierarchical. Advocacy at the highest level possible, to promote the benefits of working across departments or divisions, is needed. Mid-level health officers will rarely have the clout to influence activities outside of their own department – orders from above are needed to make this happen.

Choosing the lead department to implement a project is a key strategic decision. This decision affects not only the overall focus and strategies of the intervention – for instance, the balance between education and service provision – but also the prospects for institutionalization and expansion.

Unfortunately, the choice of the department often reflects the history of the project and its previous entry points, rather than a well thought-out strategy. The choice of lead departments to manage the project is not always based on a feasibility study and knowledge of the military structure.

Different departments have different comparative advantages. Health departments, for instance, afford access to the military health service delivery infrastructure and can

facilitate reproductive health service delivery. However, since they are often staffed primarily by women, health departments tend not to have a great deal of clout throughout the institution as a whole. Thus, health interventions may not permeate pre-service and in-service training of officers and soldiers.

Training departments, on the other hand, offer access to strong training infrastructures, including military academies and in-service training programmes. Their participation is critical to the institutionalization of projects. However, working with the training department alone may be counterproductive if it creates an unmet demand for information and reproductive health commodities and services. Social welfare, recreation and communications divisions can reach and influence military personnel in other dimensions of their day-to-day life, which can facilitate and reinforce attitudinal and behaviour changes.

Ideally, the health and training departments should work together in leading these types of projects. An integrated approach is recommended for implementing projects with a broad reproductive health perspective that incorporates gender issues. This might include working with several departments at once, including health, training, recreation, communications and social welfare.

Another common flaw in projects reviewed is a lack of coordination of efforts among departments within the military, especially health and education, military academies and various other arms of the organization.

Cooperation between the military and other public agencies in health, education and youth is growing in the context of national responses to HIV/AIDS, but is still minimal. Similarly, lack of coordination among donor-funded military projects is endemic.

The hierarchical military structure seems to limit the amount of integration and lateral communication that can occur among the different elements of a reproductive health programme. For instance, even in projects where courses on reproductive health have been institutionalized and required in all units, little interaction between trainers and service providers was reported.

The importance of collaboration with other social sectors, including civil society

The military sector should be invited to contribute to population and development committees and task forces, including national AIDS commissions, poverty reduction task forces, multi-sectoral coalitions on reproductive health and gender-based violence, including SWAps, at national and decentralized levels.

Civil society organizations have a valuable and welcome role in integrating reproductive health programming into the military arena. One could encourage further use of civil society organizations for technical assistance.

Collaboration with other government agencies with experience or mandates in reproductive health and HIV/AIDS prevention and promotion of human security (such as health, education or interior security forces) is quite uneven and happens more easily at decentralized levels.

On the other hand – and contrary to the perception of military organizations having a 'closed' approach to outsiders – the military in many countries studied appear quite receptive to technical cooperation from civil society organizations in the areas of reproductive health, gender and population issues. Contributions from civil society have been particularly welcome in curriculum development, training of trainers, and behaviour change communication. Key challenges for this kind of collaboration rest on increasing transparency to promote human rights-based programming, and sharing information and evaluation data.

Building human capacity to address reproductive health, HIV and gender equity

A workplace that presents specific cultural and policy challenges

The hierarchical organization of the military, coupled with a predominantly masculine culture poses specific policy challenges for furthering the values and longer-term perspectives embodied in the ICPD vision.

However, military leaders are quite interested in collaborating on reproductive health issues, including family planning and HIV/AIDS, and, to a much lesser extent, depending on the context, on maternal health and gender-based violence issues.

The political will to introduce reproductive and sexual health into the military arena is present and should be leveraged. This commitment seems to stem from the military elites' sense of social responsibility for the health of their workforce or a desire to assist civilian populations in crisis. In any case, their concern serves as a valuable entry point for collaborating in reproductive and sexual health and for introducing gender perspectives.

However, one should not underestimate the policy advocacy efforts needed to change policies. Policies that address family leave, length of deployment, housing and accommodations, recreation and recourse to sexual services work, condom policies, place and role of women, and treatment of staff living with AIDS, need to be reconsidered as these issues contribute to risky behaviours and environments, and perpetuate gender inequality.

First of all, the hierarchical, authoritarian and masculine military culture in some respects clashes with many of ICPD's principles of individual empowerment. For example, military institutions tend to condone risk-taking behaviours and are known more for

enforcing conformity to stereotypical norms of virility than for tolerance of more gender sensitive attitudes and practices.

Although the HIV/AIDS pandemic is forcing some military leaders to deal with the sexual health and the social and psychological needs of soldiers, the tendency has been to ignore or deny these issues. Many military officers avoid discussing soldiers' needs for recreation, companionship and power, and the possibility of resorting to sex workers or same-sex sex partners, drug or substance abuse, stigma and discrimination, gender-based violence, and domestic violence in times of stress.

Consequently, voluntary counselling and testing, care for people living with AIDS and reproductive rights issues are weak, if not completely missing, components of the military projects reviewed.

There is even less consensus about addressing the reproductive and sexual health needs of female partners and female staff as well as other aspects of gender equity such as sexual harassment, domestic violence and gender-based violence in the codes of conduct.

Thus, a major challenge remains as to how to creatively and effectively deal with the apparent clash between military culture and ICPD values.

Training human resources

Training and capacity building in reproductive health are prerequisites to institutionalization of reproductive health and reproductive rights. Tapping the military's well-established training and health infrastructure, and establishing a core group of trainers and providers in reproductive health and HIV, emerged as two successful strategies in this regard. However, monitoring mechanisms to introduce lasting changes, after initial training of trainers, are weak.

More emphasis needs to be placed on institutionalization of capacity building. Since military organizations have tremendous resources and longevity, projects that become institutionalized within them can be transformational.

Toward this end, the initial project agreement with the military should include plans for:

- Conducting needs assessments of instructors and providers
- Integrating curricula on reproductive health, including HIV/AIDS and gender and human rights issues, in military academies
- Scaling it up to all bases and divisions, and
- Adopting clear monitoring and evaluation mechanisms.

Training in reproductive and sexual health was being well integrated into the military curriculum in four of the nine countries studied – Ecuador, Nicaragua, Paraguay and Ukraine.

However, training activities are inadequate in most of the other projects reviewed. Except when it is included in academic training, on-the-job training is a short, one-time event, and refresher training is deficient. Special attention needs to be given to maintaining training activities, especially since military personnel move around frequently.

When the project is implemented in a top-down manner, training of trainers tends to follow a fairly standard cascade approach. When the project is geographically focused, local workshops are more inclusive of all personnel and ranks.

Institutionalization requires a long time frame and formal structures for monitoring and evaluation. For that reason, projects that can show tangible results will have better prospects for institutionalization. However, few projects among those reviewed had conducted knowledge, attitudes and practices (KAP) surveys to measure impact of educational activities on trainers, service providers and young soldiers. Attitudes, beliefs, and behaviour are not regularly assessed and consequently, changes are difficult to gauge, except anecdotally.

Behaviour change communication strategies

Content and participatory process

Participatory educational and communication methodologies, including peer education, are known to be more effective for behaviour change in confined environments such as prisons and military bases, but their adoption may be at odds with traditional military approaches.

Military teaching methodologies tend to be didactic and focus on knowledge transfer. Attitudes, beliefs, and behaviour are not regularly assessed and changes are difficult to gauge, except anecdotally.

Messages and topics for discussions focus on imparting biomedical knowledge of family planning, HIV transmission, maternal and child health, and human anatomy. More rarely do they address lifestyle, gender and ethical issues, or deal with feelings, beliefs and life skills including communication, empathy, stress management and conflict resolution. Some projects, however, used innovative approaches such as peer education schemes, use of supportive lieutenants as role models, incentives for peer promoters, community-based distribution of condoms, and alliances with local social marketing schemes for condom procurement and revolving funds. A few of the projects reviewed (notably, Botswana, Mongolia and Nicaragua) incorporated participatory methods with some success.

Few projects among those reviewed had conducted knowledge, beliefs, attitudes and practices surveys to measure impact of educational activities on trainers, service providers and young soldiers.

Providing reproductive health services, including HIV/AIDS prevention

Range and quality of services

Reproductive health services offered on the base vary between regions, and quality of care is not much of a concern. Forecasting and meeting the needs in reproductive health commodities was found to be weak as well.

More attention should be given to quality of care issues in reproductive health, the integration of HIV into a reproductive health framework, and to the needs of permanent staff, including female contractual staff and family members.

In Africa and Latin America, health services tend to be more comprehensive and include reproductive health services for families and civilians, while in Asia and Europe, they may be limited to first aid care of young conscripts. Most health personnel in the military are female (and contractual) staff.

In general, the reproductive health needs of permanent staff, including officers, and contractual staff, are neglected at several levels. Accessibility to civilians and military families depends on the location of bases and differs from country to country. Civilians tend to be excluded from training and from receiving reproductive and sexual health services, including consciousness-raising workshops that aim to change attitudes and behaviours and provide information about rights and obligations.

In general, the services provided through military clinics at the primary level do not meet the standards established by the ICPD. In particular, the counselling skills of health providers in the areas of sexuality and reproduction, and conditions for privacy and confidentiality of counselling and testing for sexually transmitted diseases, including HIV, are deficient. Private counselling, including confidential VCT, is lacking, except in high HIV prevalence countries. Sexually transmitted infections (STIs) are managed through a syndromic treatment approach.

Forecasting the needs for and distribution of family planning methods, male and female condoms, HIV/STI tests or drugs were found equally weak. Because of the observed deficiencies in availability of services, including tests, drugs and condoms, a demand is more easily created for condom use than satisfied and enforced.

Recurring weaknesses in condom programming

Condom programming, in many projects, consists mainly of condom promotion. There is an urgent need to promote a culture of consistent condom use for dual protection, complemented by readily accessible and affordable male and female condoms so the people can act on the information they receive. Strategic moments to organize campaigns, such as leave and demobilization, should be seized.

Reproductive health projects cannot assume that condoms will be procured in a sustainable manner. None of the projects studied had adopted a satisfactory procurement system for condoms.

The military needs to strengthen its sense of ownership of reproductive health commodity security matters and increase its capacity in terms of condom procurement and distribution, using a marketing perspective that includes equal attention to clients' needs and preferences, pricing, placement and distribution.

Condom use was well promoted in most projects reviewed, although there is no data to support evidence of condom use.

Timely, affordable and user-friendly access to condoms, however, needs more emphasis. Organizing access to condoms for both permanent staff and conscripts was found to be deficient. Systems for procuring reproductive health commodities are better handled in projects that included family planning and maternal and child health service delivery components.

Very few projects – with the exception of Benin, which is installing automatic condom dispensers – take user perspectives into account when planning distribution. Some military divisions hand out condoms as a matter of course to soldiers taking off on leave.

The main challenge is that, in both reproductive health services and HIV-only projects, neither the military leaders nor the donors consider condom distribution a priority or a responsibility, although they could take full advantage of peer distributors, on-base health units, and collaboration with local health authorities.

Confusion about HIV testing

There is a need to clarify testing policies for peacekeepers, and other staff and recruits. HIV testing needs to remain voluntary and be accompanied with proper counselling, and policies of right to work, access to care, treatment of people living with AIDS and social welfare.

VCT is rare. However, hidden and compulsory HIV screening and testing of young recruits is being conducted by the military in a number of countries through blood donation schemes.

Clearly, the cost of treatment and retraining are major financial concerns of the military of resource-poor countries, and affects how persons living with AIDS are dealt with. In that regard, policies differ significantly between young recruits and permanent staff.

It does not help that the UN position is also unclear with regards HIV testing. WHO and UNAIDS emphasize that mandatory HIV testing risks violating basic rights to privacy, and freedom from socio-economic and political discrimination. They also assert that mandatory testing fails to prevent HIV transmission. DPKO does not require mandatory testing from troop-contributing countries and advocates for Voluntary Counselling and Testing (VCT). However, a person who has an active disease, including AIDS, cannot be deployed to a peacekeeping mission. Joining the international peacekeeping forces is a lucrative source of income for the armed forces of developing countries; in this context, troop-contributing countries sometimes interpret VCT and future peacekeepers are compelled to carry out 'voluntarily' undergo testing.

Addressing gender issues

Unmet women's needs in reproductive health

Most of the projects exhibited a gender bias, and met the needs of men more fully than those of women. Though this can be attributed, in part, to the fact that the targeted beneficiaries were predominantly men, gender perspectives need to be better integrated into projects.

Women in the military need a voice, equal access to opportunities and equal protection by laws. Gender perspectives need to be better integrated into project design and monitoring and in codes of conduct.

Most military organizations do not address such issues as power in sexual relations, nor do they challenge the dominant model of masculinity, which does not discourage men from having multiple partners. Thus, the key prevention messages the reproductive and sexual health projects promote are often at odds with military attitudes.

In the cases reviewed, this translates into reproductive health and HIV/AIDS prevention projects that inadequately meet gender equity needs in the following manner:

- Projects work with men in isolation from women's groups [on base or civilians].
- Women staff, contractual personnel and family members are not included as beneficiaries for access to information, services and rules that promote safe sexual relations.

- Projects assume that: women do not need STI testing and treatment, nor other reproductive health services; they do not have easy access to reproductive health services, including maternal health, family planning, emergency contraception, emergency obstetrics, and HIV post-exposure prophylaxis.
- Condom promotion aims only at changing risky behaviours with so-called 'risk groups' such as sex workers.
- Condom promotion exploits traditional gender roles to promote condom use.
- HIV prevention education describes HIV transmission using the medical model but leaves out the element of gender relations.
- No gender specific counselling services are offered.
- Men are not specifically involved as gender equitable partners in reproductive health and HIV.

Enforcing changes in codes of conducts

The ICPD principles of women's empowerment, partnering with men and rights-based approaches to the elimination of gender-based violence, could be promoted as a foundation to inspire the revision of military codes of conduct and labour policies, to address relations with civilian populations, safer lifestyles, and clarify ethical, legal and constitutional aspects of reproductive health, HIV prevention and care, and gender relations.

Codes of conduct are often overlooked as powerful avenues for promoting and enforcing acceptable standards of behaviour. However, in the codes reviewed, gender issues and partnership between men and women are neglected. And in the labour policies, reproductive health needs and related rights of women in the workforce and female family members seem to have been left out.

Examples of gender equity needs that are not addressed in military policies include:

- Staffing policies, including those of service providers, that address equal career opportunit;
- Inclusion of women in the creation of training curricula on lifestyles and reproductive health/HIV, so as to reduce gender stereotyping;
- Safe spaces for debating about masculinities, sexuality, violence, and risk cultures;
- Code of conducts and military courts that incorporate gender-based violence and other safety concerns;
- Equal access to external in-service training resources, including women's participation in in-service training workshops, as trainers and trainees.

New behavioural and ethical policies are rarely codified, except for peacekeeping personnel who need to abide by DPKO recommended rules of conduct, and in countries on their way to democratization, where the army is redefining its societal role and social responsibility in development and protection of human rights.

Despite these limitations, the formal, top-down structure of military institutions suggests that the written codes of conduct may be a powerful place to affect change. However, codes of conducts are under-utilized for promoting and enforcing new standards guiding ethical behaviour, gender equity, and social responsibility. Changing the code in most cases will require buy-in from the highest military and governmental levels.

Tapping political will

Advocacy needs to be addressed systematically

Political will at the highest level of national leadership is critical to successful projects with the military. It is a prerequisite for getting buy-ins from the other departments and military base officers. Nevertheless, efforts to gain high-level support are often overlooked, poorly organized or not sustained. Having personal access to military leaders is a definite advantage in this regard.

Advocacy efforts that appeal to the self-interest of the military, such as keeping its workforce in good health, or enhancing its humanitarian role in emergencies, tend to be more successful than convincing it to accept to address more general cultural, societal and ethical concerns.

In all nine cases studied, the military leadership expressed strong commitment to protect its staff against the risks of sexually transmitted infections, including HIV, through education and condom use, and to consider the positive societal effects of turning young men into responsible fathers.

This interest can be nurtured through advocacy efforts, by enlisting military participation in national population commissions and HIV/AIDS theme groups, and in response to humanitarian crisis.

Wives of high commanders and female officers can also be tapped as advocates, as they often play a ‘first lady’ leadership role at garrison level. They often take the lead in organizing spouses’ associations and committees, and in initiating counselling and training of female personnel and spouses on family separation issues, gender-based violence and reproductive health concerns. They also seem to be better listeners to the needs of young soldiers and of people living with AIDS.

However, it is easy to underestimate the time and effort required to achieve solid commitment of senior staff. This involves ongoing advocacy to raise awareness about the relevance of reproductive health, HIV/AIDS and gender equity issues to the military.

The challenge is also to translate the current level of interest into long-term, widespread and coordinated institutional changes in resource allocation, training, family policies, services and conduct codes, and in carefully raising gender and rights issues in ways that

do not cause a defensive reaction. An effective strategy in this regard is to promote pilot project activities and make them visible among the highest military ranks.

There is no consensus within the armed forces and among donors about roles codes of conducts can play in enforcing behaviour change and protection and respect of women or powerless groups.

Advocacy needs to address a number of issues, among them:

- Collaboration among key military departments, including the academies and other ministries, to manage the reproductive health/HIV/GBV projects; and acceptance of technical assistance from civil society organizations that are knowledgeable about specific reproductive health, gender and human rights related topics;

- Mobilization of internal resources for sustained training and provision of reproductive health commodities, including condoms;

- Broadening leaders' understanding of reproductive health and HIV issues, not only in terms of prevalence and medical consequences, but also in terms of family life and gender relation issues, interactions with civilian populations, gender-based violence, and poverty;

- Integration of reproductive and sexual health and gender equity curricula into military academies and in-service training;

- Accessibility and quality of reproductive health care improvements, including privacy and confidentiality in counselling, HIV ethics and status of people living with AIDS;

- Reliable and user-friendly condom procurement, including female condoms;

- Policy changes in housing that prevent occurrence of sexual abuse; leave policies that include easier communication with spouses and partners; gender equitable staffing policies that also apply to medical personnel; and amending the codes of conduct so that they enforce training standards and correspond to promoted norms.

Experience exchange and knowledge sharing

Armed forces seem very keen to know more about successful experiences in other countries and regions. Taking stock at the national level is also valuable in terms of knowledge sharing, spreading word of successful and innovative programming ideas, and expanding projects to include other groups, such as national police.

National conferences of military implementing units help build understanding, support and enthusiasm for reproductive health projects. They also serve to promote innovative and successful initiatives such as:

- Peer group discussions, in addition to training sessions;
- Peer-based condom distribution;
- Training and rewarding of peer educators;
- Using officers as role models to demystify readiness to condom use;
- Organizing recreational activities and contests with a theme on reproductive health or HIV;
- Establishing recreational corners or rooms and counselling facilities to talk about safer sexuality and relationships among same ranks, between ranks and with female partners.

Mobilizing more resources

From donors

In general, the funding allocated to projects was too small to accomplish or sustain project goals. In particular, resources for materials and commodities were inadequate, leaving projects without adequate funding for replenishment of training materials and procurement of condoms to meet increased demand.

Unlike many other 'higher risk target groups', the military is seldom considered an appropriate recipient of donor support for implementation of reproductive health and HIV prevention programmes. The CivSil Military Alliance very rightly has alerted donors that they must understand the urgency of greater external support for the defence establishment to scale up prevention efforts, or risk losing the progress that has been made thus far. In this regard, UNFPA has a definite comparative advantage, based on its partnership experience with this sector and for consistently advocating for comprehensive, long-term approaches.

The UNFPA projects begin fairly modestly in terms of size and scope and scale up progressively. Projects from other donors, such as USAID, tend to be much larger but more limited in time and scope (for instance, by tackling HIV/AIDS as a vertical issue, separate from reproductive health and gender).

Overall, project designs did not address the issues of institutionalization and sustainability of reproductive health, particularly re-supply of commodities and educational materials, and equipment maintenance.

Approaches to make reproductive and sexual health projects financially viable and sustainable are needed. One potential avenue is for the military to publicize their efforts on behalf of civilian populations and their staff. Such efforts may attract funding from other donors, and affect national budgetary decisions. Another strategy is to build

capacity of the military in fundraising, and in preparing joint proposals with ministries of health and education.

Recommended next steps for donors

To-date, UNFPA has taken an important, and to some extent, leading role with respect to reproductive health, HIV/AIDS prevention and gender issues in relationship to the military. The magnitude of the challenge before the United Nations and the international community as a whole nevertheless calls for far more concerted and consolidated action.

The findings of this assessment lead us to recommend the following specific initiatives:

- Preparation and diffusion of programming guidelines on reproductive health and HIV/AIDS prevention, gender equity promotion and prevention of gender-based violence within the military, and between the military and civilian sectors and communities;

- Adaptation of these guidelines to the specific needs and characteristics of different military forces and groups, including the needs of women as staff, spouses, service contractors and neighbours;

- Strategies to ensure reliable procurement of reproductive health commodities, including supplies and re-supply of condoms, reproductive health supplies and culturally adapted educational materials;

- Preparation and implementation of a series of KAP surveys that can be used in all military forces and provide the basis for behavioural surveillance, and for inter-country evaluation of progress and exchange of experiences with a view to facilitating resource mobilization;

- Preparation of additional case studies that describe the ways in which HIV/AIDS prevention and prevention of gender violence is taken up by different military forces, especially in low prevalence countries such as Senegal and Morocco, and in conflict and emergency situations, providing special attention to ‘good practices’;

- Organization of a series of knowledge sharing regional and inter-regional workshops and seminars that will help strengthen collaboration between different military forces, and enhance military civilian relationships;

- Preparation over the next five years of annual reports on all of the above and inclusion of additional information that would be useful to military forces in planning and preparing their work in these areas.

INTRODUCTION

Rationale for the study

The armed forces are central to the good governance of a country, not merely in terms of their defence role but also as a development agent. Military leaders are increasingly aware that they do not serve in isolation and that some attention has to be given to the well-being of their personnel, military families and to civilians with whom the military comes into contact.

Armed forces also play an important humanitarian role. Recent emergencies – for example drought and fires in Mongolia, earthquakes in Turkey, hurricanes in Central America – all involved large scale operations by the armed forces of those countries.

Furthermore, armies may be involved in local and regional conflicts or may be involved in international peacekeeping operations. Especially in countries whose armed services are augmented by conscript soldiers, the military reach large sections of the population not otherwise easily accessible[1].

Although UNFPA has long cooperated with this institution in the areas of family planning and family life education, its growing cooperation with an institution that operates in unique political and social contexts – in times of peace or conflict – has not been well documented. Experience sharing is needed to scale-up or sustain effective interventions and guide future programming.

Comparing experiences of different countries in partnering with the military to involve men in reproductive health, including HIV/AIDS and gender-based violence, with a gender perspective, is useful because:

- Reproductive health goals, including HIV prevention, require men to be part of the solution.
- The army is a male-dominated institution that reaches large cohorts of men at a young age.
- There is a clash between a male-dominant hierarchical and often aggressive institution and the introduction of content related to democratizing and equalizing gender relations.
- Armies are undergoing demographic and socio-economic changes that impact on their vulnerabilities and readiness to address reproductive health, HIV and gender issues.
- The HIV/AIDS epidemic is getting worse, including in the military.
- The army is mandated to work as partners in HIV/AIDS prevention and in eliminating gender-based violence by international agreements.
- The army is a strong and important public institution, with expedient training programmes, medical infrastructures and disciplinary rules.

[1] Curran, L. 2001. 'HIV Prevention in the Army of the Ukraine'. Draft. UNAIDS Best Practice Case Study. Kiev, Ukraine.

- Donors are starting to support efforts to improve the reproductive health and HIV situations but lack knowledge on how to best use their resources.
- Armies are eager to learn from each other's strategies beyond their regions.

This comparative study of country experiences across regions was undertaken as part of a UNFPA interregional project 'Improving Gender Perspective, Reproductive Health and HIV/AIDS Prevention through Stronger Partnership with the Military' (project number INT/01/PM3). It was conducted by UNFPA's Technical Support Division, with generous support from the Swedish International Development Agency and through collaboration with the UNFPA Technical Assistance Programme regional advisors, country offices and national consultants.

Its purpose is to inform future programming by identifying effective approaches for working with men in the military and uniformed services in reproductive and sexual health from a gender perspective. Cross-regional exchange of experiences is expected to enhance UNFPA's practical knowledge and leadership role in an area where it clearly has a comparative advantage regarding gender issues, reproductive health/reproductive rights promotion, and the fight against HIV/AIDS. Equipped with practical insights into the implementation process, UNFPA offices and their national partners would be able to improve existing programmes or introduce new ones.

The ICPD vision: Benefits of partnering with men in the military

Guided by the ICPD principles, the analysis framework is based on a conviction that partnering with men in the military can help achieve the following results[2]:

- *Increase* the likelihood that both men and women will make informed, safe and consensual decisions regarding sexuality and reproduction;
- *Reduce* men's vulnerabilities by altering their attitudes, beliefs and practices regarding risk-taking;
- *Inculcate* men's respect for human rights entitlements that relate to reproductive and sexual health;
- *Encourage* gender equity and promote freedom from gender-based violence;
- *Enlist* young men as allies in gender equity and reproductive and sexual health;
- *Enhance* perceived value of the girl child; and
- *Produce* reproductive health improvements for everyone such as:
    - Reducing sexually transmitted infections, including HIV/AIDS;
    - Offering greater choice of family planning methods;
    - Reducing unwanted pregnancies and increasing preparedness for safe motherhood;
    - Avoiding harmful practices, such as female genital cutting, early or forced marriage, and sex-selected abortions;

[2] UNFPA. 2002. 'It Takes Two: Partnering with Men in Reproductive and Sexual Health'. Programme Advisory Note. New York: UNFPA.

- Reducing violence, especially violence against women and other intimate partners.

Conceptual Framework

To compare implementation strategies in the military that integrate reproductive and sexual health and gender issues, we established a conceptual framework to review the nature of the partnership; the extent and quality of reproductive health services and information, including for HIV/AIDS prevention; and gender mainstreaming. The framework contains the following categories that are analyzed cross-sectionally:

- Historical entry points for the projects (focus of projects: RH or HIV/AIDS or both)
- Cross-sectoral collaboration (among armed force units; with other public agencies; with civil society; and with donors)
- Human capacity strategies (who is trained in what topics, and how)
- Behaviour change communication strategies (audiences; content and participatory process)
- Reproductive health service delivery strategies (including integration of HIV/AIDS prevention, counselling and condom programming)
- Promotion of gender equality (mainstreamed, scattered or left out)
- Institutionalization and prospects for expansion (vertical project approach or institutionalized; origins of resources)

The case studies focused on institutional changes, rather than actual impact on epidemiology and behaviour. They sought to identify the range of implementation approaches used so far, their commonalities and differences. A common query was: What is working and needs to be continued or expanded? What is not working and needs a new more strategic approach? And finally, what has not been addressed at all?

Methodology: Where and how?

The selection of countries was based on anecdotal knowledge of success stories and the willingness of the UNFPA Representative to accommodate the fact-finding mission. We also tried to include as much variety of regions and approaches as possible.

Experiences are from: Benin, Botswana, Madagascar and Namibia in Africa; Ecuador, Nicaragua and Paraguay in Latin America; Mongolia in Asia; and Ukraine in Eastern Europe.

The study gathered qualitative data, using rapid assessment methods, including secondary data, in-depth interviews, and focus group discussions. Based on a common data collection protocol and case study structure, local consultants conducted desk reviews prior to the fieldwork by local and international consultants. In-depth interviews included key stakeholders such as army project leaders, health providers, trainers and other armed

forces units (academies, training schools, etc.), donors and NGOs providing technical assistance, and representatives of government ministries involved in the project, among others. Focus group discussions were held with recruits, wives of military personnel, local leaders, men and women from communities surrounding army bases.

Limitations of the study

Scope of inquiry: HIV/AIDS is one of several topics that the case studies considered, not their sole focus. HIV/AIDS was addressed within the context of reproductive health, and most of the cases studies included HIV prevention among a number of reproductive health topics covered. This was intentional since UNFPA addresses HIV/AIDS as a reproductive health issue fully integrated into reproductive health programming. The intent of these case studies was to document how reproductive health programming in the military evolves, what its strengths and weaknesses are and what aspects need strengthening.

The focus here was on peacetime programmes. However, the same methodology for analyzing contexts and programming strategies could be applied to document conflict and peacekeeping situations, as well as post-conflict demobilization.

Findings: Indicators of behaviour change in the detailed case studies are rarely available because most of the projects did not conduct base-line studies and only reported anecdotal behavioural changes. UNFPA reviewers were also not always able to adequately assess the educational materials. Often they were available only in local languages and had not been evaluated.

Issues of same-sex behaviour and sexual harassment are not fully addressed. The challenge was to find the window of opportunity to discuss these topics because taboos associated with sexuality are very strong in the countries studied, and even more so in the military. Few, if any, military officers would acknowledge the fact that such practices exist. The same holds true, in general, for sexual harassment.

A corresponding challenge is to broaden the understanding of what gender means in the context of the military, to go beyond attitudinal and cultural changes and to address the policy and programming issues that may compound vulnerabilities or inequities.

SUMMARIES OF COUNTRY CASE STUDIES

The following countries were studied in this project:

- Benin
- Botswana
- Ecuador
- Madagascar
- Mongolia
- Namibia
- Nicaragua
- Paraguay
- Ukraine

The full text of the case studies is available from the UNFPA Intranet and Internet, and can be made available upon requests to: Technical Support Division, UNFPA New York, provided due mention to the source is given.

Send queries to: lrose@unfpa.org

BENIN:
Providing Reproductive Health Services in the Department of Health of the Armed Forces

Contributors: **Michèle Burger**, International Consultant
Dr. Jean Sehonou, National Consultant

Fieldwork: October 2002
Project Name: 'Providing Reproductive Health Services in the Department of Health of the Armed Forces'
Duration: The first phase July 1999 through December 2003 focused on increasing the use of reproductive health services in five targeted military health centres. The second phase focused on strengthening these health centres and the management of logistics skills of the Armed Forces
Budget: Government of Benin, $900,000[3], including in-kind contributions; UNFPA $800,000.
Partners: Regional Centre for Development and Health (CREDESA), the Training and Research Centre on Population (CEFORP) and the Research Centre on Human Reproduction and Demography (CERRHUD)
Beneficiaries: Young men and women in uniformed services, military wives and civilians

Summary

Though still at an early stage in its evolution, this project demonstrates what can be achieved when the Ministry of Defence, the Ministry of Public Health and the Armed Forces work together. Their cooperation initiated the integration of national standards for reproductive and sexual health into the Armed Forces' health care systems. The project is also exemplary in terms of the support it has garnered throughout the military and for its close monitoring and supervision. Like several other projects reviewed in this book, it builds on the idea that the military can be positive force for social change during times of peace.

In spite of a well-developed health system, Benin's infant and maternal mortality rates remain unacceptably high. And because polygamy and extramarital affairs are common, the country is vulnerable to HIV/AIDS. This project aims to address these issues by providing reproductive health services in military health clinics (called maternities). Initially, five of these clinics were rehabilitated and supplied, staff was trained, and health standards were rigorously applied.

Midwives, most of whom are civilians trained and paid with support from UNFPA, play a central role in the project's delivery of reproductive health services. To make the project

[3] Unless otherwise noted, costs are given in US dollars.

sustainable, many of the civilian midwives will need to be replaced by military ones, and some of the civilian midwives will need to sell condoms to sustain their income. Although the project initiated some random discussion groups and outreach activities on reproductive health, this study found a high unmet demand for more information on gender issues, counselling for men and sensitization of men to such issues as gender, couple communication, condom use and gender-based violence.

Lessons from Benin

The coordination and cooperation between the Armed Forces, the Ministry of Health and UNFPA is exemplary. The Armed Forces readily accepted the national health system's management tools.

A commission is now studying how to institutionalize collaboration between the Ministry of Health and the Ministry of Defence to formalize training of personnel and integrate statistics from the Armed Forces into the national health data. Under the proposal being considered, the Ministry of Health would also take on the responsibility of managing medical equipment of the military. This intra-departmental collaboration is critical to sustainability and institutionalization.

This project relied heavily on midwives for reproductive health service provision, based on a dubious assumption that they are best placed to provide information and counselling in broader areas of reproductive health. Before making this assumption, one should ensure that midwives, like any other providers, are equipped and willing to take on other responsibilities besides those that come under their vocation.

Ensuring continuity and delivery of quality services in the military, whose personnel can be mobilized on a day's notice, can be challenging. More training of trainers, and the initiation of peer education are ways to address this challenge and help institutionalize project achievements.

In terms of commodity management, automatic condom dispensers are or will be available in the garrisons covered by the project. The managerial follow-up, consisting of quarterly supervisory visits, was excellent. The project merits closer study so that other similar ones can benefit from the experiences and tools developed in Benin.

An important unmet need identified by this study is to 'sensitize the men'. Requested themes include couple communication, gender and gender-based violence.

BOTSWANA:
Reproductive Health for Youth at the Workplace

Contributors:	**Helen Jackson**, HIV/AIDS/STI Adviser, UNFPA Country Technical Support Team, Harare, Zimbabwe **Joseph Pitso**, National Consultant, Botswana University
Fieldwork:	December 2001
Project name:	'Reproductive Health for Youth at the Workplace' (BOT/98/P05)
Duration:	1998-2002 (builds on two earlier projects)
Partners:	Botswana Defence Forces, Occupational Health Unit of the Ministry of Health, National AIDS Coordination Agency, African Youth Alliance. Linkages with UNDP AIDS in the Workplace Project; Men, Sex and AIDS Project and external agencies such as the Botswana Network of AIDS Support Organizations (BONASO)
Budget:	UNFPA had allocated $196,000 in direct funding for the project for five years, but in order to stay within annual ceilings was unable to meet this goal or to provide funds beyond 2000. During the first two years, $39,200 was allocated to the project per year, but actual expenditure was reportedly lower, and the government is absorbing some of the cost. The Ministry of Health now pays the salaries for the programme implementers within the Occupational Health Unit.
Primary Beneficiaries:	Young men in the uniformed services (including military, police, immigration and prison services), their families and sex partners.

Summary

This project is a good example of cooperation between the Ministry of Health and the Botswana Defence Force. It also extends a strategy used in an earlier employment-based family welfare initiative to a different thematic area, HIV prevention. The project aims to train cadres of 'worker educators and distributors' to provide peer education and counselling, distribute contraceptives and provide referrals for treatment of sexually transmitted infections.

This project targets young men (age 18 to 30) in the Botswana Armed Forces, who spend extensive periods away from home in an active sexual culture where HIV is rampant. The urgency associated with preventing HIV/AIDS in this country provides an entry point for raising awareness about other aspects of reproductive health and rights to a group with generally low gender sensitivity and a high incidence of gender-based violence. Because the Botswana military is a highly regarded group, changes in their attitudes and behaviour could be highly influential for the general population.

The long-term strategy of this project is for each military camp to have an HIV/AIDS committee, including counsellors and peer educators. Their primary task will be to promote condom use and provide accurate information about HIV and other sexually transmitted infections. Toward this end, the project plans included considerable training and capacity-building activities, but various factors delayed their implementation. The project had two key achievements at the time of this review. One was a series of one-day sensitization workshop involving senior and mid-level personnel. The workshops covered a broad range of issues that affect family life, from safe motherhood to teenage problems and substance abuse. They have generally been well received. The project also conducted a needs assessment that focused on sociocultural attitudes, values, beliefs and practices around gender, sex, sexuality, contraception, HIV/AIDS and sexually transmitted infections. The results of this assessment were used to design peer education and group discussions.

Lessons from Botswana

Reaching and convincing top personnel that reproductive health is a military concern is a time-consuming but critical activity because it increases motivation and assures wider participation.

A needs assessment at the outset is a crucial step that can inform project design and improve results. This should involve in-depth key informant interviews as well as focus group discussion with direct beneficiaries.

Building on previous initiatives with the military calls for increased donor coordination, especially when the same unit of government agencies, such as in this case, the Occupational Unit of the Ministry of Health, is involved.

A single-focus, prescriptive approach to HIV prevention has limitations: the wider link with gender, reproductive and sexual health concerns is lost, and people become inured to and depressed by discussions of HIV/AIDS alone. Conversely, young people have high interest in sex and sexuality, and an inclusive focus allows HIV/AIDS to be raised more effectively.

Moving from vertical focus on family planning or HIV/AIDS prevention to a wider reproductive health and gender perspective is not straightforward and requires careful preparation. This can include, for instance, advocacy seminars with top leaders and mid-level trainers and service providers, sustained communication between health and social welfare units of the military and access to reproductive health commodities.

Condom programming and educational initiatives are interdependent. Behaviour change communication that promotes the use of condoms is more likely to succeed if condoms are readily available.

ECUADOR:
Strengthening Maternal Health (Phase I) and Sexual and Reproductive Health for the Armed Forces and the National Police (Phase II)

Contributors: **Pedro Garzón Castaneda**, Former Advisor in non-formal education, Country Technical Services Team for Latin America and the Caribbean;
Humberto Vaquero, National Consultant
Translated by Michèle Burger

Fieldwork: August 2001
Project: 'Strengthening Maternal Health' (Phase I) and 'Sexual and Reproductive Health for the Armed Forces and the National Police' (Phase II)
Duration: Phase I (1995-1998) focused on reproductive health services while Phase II (1999-2001) added education in military schools and experimental educational activities with conscripts
Funding: UNFPA contributed $195,385. The Armed Forces contribution was estimated at $2,700,000 (salaries for doctors, paramedics and maintenance of health centres, their infrastructure and financing some commodities).
Partners: UNFPA, Health Department, Department of Education and Military Training.
Primary Beneficiaries: Spouses and families of military personnel, conscripts

Summary

This project is a good example of using a specific reproductive health problem – in this case, high rates of maternal mortality and cancer among women – as an effective entry point for introducing broader interventions. While the project initially targeted the spouses and families of the military, it strategically used the military health structure as a cost-effective way to reach them, and then to broaden its reach to involve men working in the armed forces

The first phase of the project, 'Strengthening Maternal Health,' integrated reproductive and sexual health services into the existing military health infrastructure. It improved technical knowledge of health care providers, introduced quality of care standards, and raised awareness of reproductive health issues among women. This phase also offered a broad range of preventative services, including earlier diagnosis of cervical and breast cancers, and provided information and condoms to conscripts.

The second phase, 'Reproductive and Sexual Health for the Armed Forces and National Police' (1999 to 2001) introduced an education component that targeted young students

in the military schools. It included gender equality in the curriculum and trained providers in the subject. This phase also added a well-received parent education programme ('school for parents') that included discussion of self-esteem, psychological and biological changes during adolescence, and conflict resolution.

The project succeeded in incorporating integrated reproductive health themes, with an emphasis on gender equality, into training. Another major accomplishment was the integration of sexuality and love into the military training curriculum, using existing materials developed by other UNFPA-supported projects for the Ministry of Education, and using participatory teaching methods with adolescents and youth to stimulate their attendance and interest in these themes. Finally, introducing reproductive heath into the curriculum at military schools was an important initial step in institutionalizing the project.

The fact that a whole range of reproductive health services, including vasectomy, was offered to men helped break down barriers and taboos about adopting such new methods. Consequently, there was a significant increase in the demand for vasectomies, a rare occurrence in a country where discussing this topic is often taboo. A decrease in fertility rate among beneficiaries was also reported.

Lessons from Ecuador

More support and advocacy at the highest military ranks and among commanders of military bases would provide the project with a more solid political and institutional foundation. Similarly, better intra-departmental collaboration and communication would increase the success of such projects and foster their institutionalization.

In a military context where high turnover is common, training must be offered on an ongoing basis to be effective. Furthermore, training capacity should be institutionalized to reduce the reliance on external consultants.

Participatory teaching methods such as drama, games, the use of audiovisuals and written exercises (composing letters, for example) stimulate attendance and classroom discussion and generate interest in reproductive health issues. In addition, the use of existing educational materials and sharing lessons learned from other sexuality education projects carried out by, in this instance, the Ministry of Education, help reduce cost and redundancy.

Expanding the range of reproductive health services beyond family planning can help to expand the client base and encourage men's health-seeking behaviour.

Look to the specific needs of the region (in this case, high unmet demand for contraceptives, and high cancer rates for women) as a way to find effective entry points into the area of reproductive and sexual health.

Ensuring sustained supplies of reproductive health commodities, including condoms, is

critical aspect of such projects. Sending youth recruits and officers to purchase condoms in commercial pharmacies is not a viable strategy.

The concept of gender equality can be learned even in a traditionally male dominated institution such as the Armed Forces. However, gender equality remains an abstract notion if it is detached from issues of reproductive and sexual health and rights.

A viable strategy for institutionalizing such a project is to integrate education in reproductive and sexual health into training academies for officers, non-ranking officers and conscripts, rather than limiting it to students in military schools.

Monitoring and evaluation are vital to the project design. This requires determining, at the outset, supervisory responsibilities, evaluation indicators and clear directions for collecting the required information and the type of analysis required. Financial and human resources should be budgeted for these activities.

MADAGASCAR:
Introduction of Reproductive Health Services in Military Health System

Contributors: **Michèle Burger**, International Consultant/UNFPA, and
Dr. Jean de Dieu Marie Rakotomanga, National Consultant.

Fieldwork: November 2001
Project name: Introduction of Reproductive Health Services in Military Health System
Duration: A six-month pilot was initiated in 1998 in one area. This was then expanded to include 19 sites in three provinces.
Funding: The cost of this 28-month project was US $379,589, with $99,589 contributed by the government and $280,000 by UNFPA.
Partners: The Central Office of Health Services for the Armed Services has primary responsibility for the project. However, UNFPA and the Ministry of Health helped design the project. Local NGOs, including SAF (health department of the Jesus Christ Church) and SALFA (health department of the Lutheran Church), provided management training. FISA, the local affiliate of the International Family Planning Federation, trained providers in behaviour change communication and quality of care.
Primary Beneficiaries: Members of the armed forces, volunteers as well as career personnel, their families and people from surrounding communities, especially civilians in isolated rural areas.

Summary

Like several other of the projects reviewed in this book, this one advances an expanded role for military as a force to promote its country's social and economic development. The project worked initially from a somewhat narrow health perspective. Thus, it did not fully address human rights, reproductive rights and gender equity themes embraced by ICPD. They have been put off for later consideration.

Entry points were HIV prevention and increased access to reproductive health services in remote areas. Although the prevalence of HIV in Madagascar is under 1 per cent, the rate of other sexually transmitted infections is high, which makes the country vulnerable to an AIDS epidemic. In response, the Government has mounted a concerted effort to combat the disease. Arising as part of that effort, this project takes advantage of the military health infrastructure to prevent sexually transmitted diseases and to expand reproductive health services to underserved rural areas.

Implementation took place gradually: A successful six-month pilot was expanded to 19 sites, with hopes to eventually institutionalize reproductive health services within the military health infrastructure. Major activities include:

- Initiating behaviour change communication –through health centres, community outreach by health providers, and associations of military wives – to increase the demand for reproductive health services
- Expanding accessibility to such services by increasing the number of community-based service sites
- Improving the quality of care provided in clinics and health centres by upgrading facilities and equipment, providing training in managerial as well as clinical skills, and training regional coordinators in monitoring and supervision

Although the project was in the early stages of implementation at the time the study was made, it had already garnered considerable support and plans are in place to expand it nationwide. Because the military budget is limited, additional funds will likely be needed in order for this to occur.

Lessons from Madagascar

Although creating a cadre of trainers is a good way of institutionalizing reproductive health, their training needs to be ongoing, rather than a one-time event.

Behaviour change communication materials should be translated or available in illustrated versions for clients who are semi-literate.

Quality reproductive and sexual health services can only be provided in properly equipped facilities that are appropriately staffed. If women are uncomfortable with male health providers, the Armed Forces and the Government should assure that women providers could be assigned to military health centres.

The monitoring and evaluation components were weak and not clearly spelled out in the project plan. Human and financial resources should be allocated to developing management systems and assuring adequate supervision. Record keeping needs strengthening and some effort should be made to coordinate standards with those established by the Ministry of Health.

Gender was considered as an add-on component that comes later rather than as an integral element of project design. Mainstreaming gender at design stage would assure that gender issues are integrated from the outset.

MONGOLIA:
Peer Education among Young Recruits of the Mongolian Armed Force

Contributors : **Sylvie I. Cohen,** UNFPA New York;
Dr. Tumurbaatar Luvsansambuu, Mongol Vision Public Health Organization, Ulan Bator

Fieldwork: September 2002
Project name: 'Peer Education among Young Recruits of the Mongolian Armed Force'
Duration: 1998- present
Funding: Totally $8,000 from UNDP for 1998 and 1999. One year funding of Funding for 2000-2002 in the amount of $20,000 by GTZ, UNICEF and National AIDS Foundation.
Partners: Mongol Vision (a national public health NGO), Administrative and Training, and Health Departments of the General Staff
Beneficiaries: Personnel from 10 military units in and around Ulan Bator, Nalaikh and Tuv aimags
Project Name Gal Golomt – Family
Duration: January 2001- Present
Funding: Total, $15,000 funded by GTZ
Partners: Gal Golomt; Administrative and Training Departments of the Border Troops
Beneficiaries: Border troops in Ulan Bator City and Dornogovi, Selenge aimags

Summary

Unlike the other cases reviewed in this book, this one looks at two similar projects, both implemented by national NGOs. Both projects demonstrated excellent partnership between civil society and the military.

The entry point for each project is prevention of HIV/AIDS, which is still uncommon in Mongolia but rapidly increasing, especially along its borders. Innovative approaches included the addition of peer education and a condom revolving fund managed by each base to address the lack of supplies.

Partly because the NGOs carefully built support for the initiatives early on, the military has been very receptive to their ideas and has shown considerable commitment to the projects. For example, the military leadership has organized tests and competitions among units about their newly acquired knowledge of reproductive health at the end of each year, and sponsored meetings about reproductive health and HIV on the occasion of the World AIDS Day celebration, during which peer educators were honoured and received awards. They also established 'reproductive health meeting rooms' in the barracks to allow peer educators to meet young recruits informally.

The education of young recruits in HIV/AIDS prevention and a few aspects of reproductive health has been accomplished. Next steps are to increase the number of capable trainers, improve condom procurement and promotion mechanisms, expand the quality and scope of reproductive and sexual health services, and institutionalize a stronger gender equity agenda. Plans to broaden the focus are based on the idea that educating young recruits to become gender equitable, knowledgeable and caring fathers will have a powerful multiplier effect for society as a whole. UNFPA will support these next efforts as member of the HIV theme group and contributor to the national HIV strategy.

Lessons from Mongolia

Advocacy to engage key decision-makers in the plans early on are a prerequisite for reproductive health projects that target 'closed' institutions such as the army forces and police. Similarly, in a hierarchical organization, military leaders at a higher level in the chain of command are best positioned to introduce the activities that will be implemented to unit level officers.

Peer education among military conscripts can be a popular and effective way to 'bring home' socially beneficial information in a sprawling, sparsely populated country with a poor communications infrastructure. However, continuous refresher training of trainers and appropriate supplies of educational materials are needed to do this successfully.

The range of educational needs – from officers to illiterate recruits – should be taken into account, as well as the reproductive health service delivery needs of women personnel.

Promoting condom use, without also making condoms accessible, is ineffectual. Providing commodities, including condoms, should be a key element of the project design. In cases where the military cannot afford to purchase condoms, innovative ways to finance them can be explored.

Monitoring and evaluation is integral to project design and implementation. These activities measure changes resulting from such projects and inform needed adjustments.

Voluntary counselling and testing (VCT) raise issues of privacy and confidentiality. Furthermore, counselling skills of health providers need to be strengthened. This applies particularly to countries where the emphasis of public health systems has been on curative rather than preventive care.

Given the focus on prevention of sexually transmitted infections and HIV, gender issues – including gender equality, gender-based violence, reproductive rights, masculinity and men's sexuality – and sexual health needs are themes relevant to reproductive health that should be integrated into such a project.

Education is not sufficient to change attitudes and behaviours. Adjusting policies such as the Code of Conduct helps promote cultural change.

NAMIBIA:
Male Involvement in Sexual and Reproductive Health

Contributors:	**Dr. Akinyele Dairo,** Technical Officer, UNFPA, New York; **Captain Anne-Mary Shigwedha,** National Consultant, Namibia
Fieldwork:	November 2001
Project name:	'Male involvement in sexual and reproductive health'
Duration:	Phase 1: 1997-2001, Phase 2: 2002-2005
Funding:	$689,627 from UNFPA through a Trust Fund from Government of Luxemburg. In-kind contributions (health infrastructure, personnel) from Government of Namibia
Partners:	Namibia Defence Force, Namibia Ministry of Health and Social Services, Margaret Sanger Center International (technical assistance).
Primary Beneficiaries:	Military and police personnel (primarily near the Oshakati military base); Evangelical Lutheran Church in Namibia; soccer teams and male nurses in the Northwest region.

Summary

Unlike the other studies in this book, this project had a regional, rather than strictly military, focus. It worked with five different groups of men, including military and police personnel, in the Northwest region of Namibia, one of the countries hardest hit by the HIV/AIDS epidemic. Although the country has passed a progressive National Gender Policy, in reality unequal power relations are culturally entrenched. Men tend to be decision-makers on issues that affect women's reproductive health, even though they are poorly informed on these issues.

This project used a wide range of innovative communication channels and distribution outlets, such as local brew shops. Both trainers and trainees displayed good knowledge about reproductive anatomy, contraception, sexually transmitted diseases and women's needs during pregnancy and childbirth. This knowledge can be used as a basis for improved communication between men and their partners. The project also supported

- Creation of a training manual (with technical assistance provided by Margaret Sanger Center International)
- Training of 22 military officers (as well as 16 police officers, and 14 soccer coaches and managers) on a broad range of reproductive and sexual health issues
- Increasing the demand for and availability of condoms, including the distribution of over 140,000 condoms to local drinking establishments, police and armed forces.

Results attributed to the project include less gender-based violence, more requests for voluntary testing and counselling for HIV infection, and a much higher demand for condoms. Also, a decrease in the HIV prevalence among pregnant women was noted in

the project area over a two-year period. The regional focus forged new links between the military and civilian groups. The second phase will expand the geographic coverage of the project and the subjects covered and will also target NGOs and young people, including displaced adolescents.

Lessons from Namibia

While a focus on a local area helps forge partnership between the military and other sectors, full support of a project at the highest levels is also necessary for its full acceptance throughout the military structure.

Collaboration with other development partners, especially in training and other activities, is valuable, but should be carefully coordinated so as to avoid duplication of efforts.

A greater effort should be made to 'Namibiaize' the project. Newspapers, television and community radio in local languages can further build awareness of the project and the issues it addresses. Most Namibians listen to community radios in their local languages.

The project only targeted men, which provoked resentment among female providers because they were not included as either trainers or trainees. Furthermore, reproductive and sexual rights are not well understood. Some stakeholders view reproductive rights and gender equality as the "right of women being equal or taking authority from men."

Policy issues related to family separation are integral to mainstreaming gender in the military. Ignoring the need to accommodate family realities of career soldiers, strains family relationships and increases the likelihood of casual sexual relationships along with the transmission of HIV and other transmitted infections.

NICARAGUA:
Support for Sexual and Reproductive Health Services and Information, Education and Communication Activities of the Armed Forces

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Translated by Michèle Burger

Fieldwork: September-October 2001

Project Name: 'Support for Sexual and Reproductive Health Services and Information, Education and Communication Activities[4] of the Armed Forces in Nicaragua'

Project Duration: 1998-2001 (consolidates and scales up activities from two earlier projects).

Funding: UNFPA contributed $28,672. The military contributed about $52,459 in in-kind support.

Major Partners: The military, with technical and financial support from UNFPA, was responsible for carrying out all project activities. UNAIDS, UNDPA and about 10 various NGOs contributed technical assistance, especially to training activities.

Primary Beneficiaries: Military personnel, their families, civilians who work for the military or live in surrounding communities.

Summary

The Nicaragua project illustrates how reproductive and sexual health can be successfully institutionalized into the military context. The project dovetailed with efforts that the government is making to reduce unplanned pregnancies, particularly among adolescents, and to prevent sexually transmitted diseases. It benefited from the country's generally progressive health and social policies. It also built on two earlier UNFPA-supported projects that introduced reproductive and sexual health information, training and services into the military arena, and on the partnerships that were forged. This project, like its forerunners, advances an expanded role for the military as a collaborator in the country's social and economic development.

The project promoted the concept of sexual and reproductive health as a human right and introduced new perspectives about gender equality, machismo and violence against women. A major emphasis was building capacity through training – of teachers, trainers, health providers and 'health brigadiers' – in a wide range of topics related to population and reproductive and sexual health. Through coordination with other projects within the

[4] IEC is now referred to as 'behaviour change communication'.

UNFPA country programme, considerable technical expertise was leveraged in the production of training materials targeted to various levels.

The communication component focused on prevention of sexually transmitted infections, and knowledge in this area was significantly increased. The project also established information, counselling and contraceptive distribution centres in 13 locations, and improved the reproductive and sexual health services at many bases. Waiting rooms in health centres were refurbished to allow for informational videos on a range of reproductive and sexual health issues. Wide ranges of innovative behaviour change communication approaches were used, from drama and puppetry to informal chats and educational fairs bringing information about reproductive and sexual health to underserved areas. The project has enjoyed broad support from the military, and also improved relations between the military and neighbouring communities.

Lessons from Nicaragua

National policies, in this case the National Population Policy (1997), can serve as catalysts to encourage different members of society, such as the Armed Forces, to take action. The Nicaraguan population policy specifies the need to significantly increase men's participation in reproductive decision-making and family planning practices in a gender equitable manner. The Armed Forces embraced this policy by strengthening their sexual and reproductive health services and information, education and communication activities.

The military's participation in activities to enrich the lives of servicemen and their families over the long term improved esprit de corps and strengthened the military's role as an agent of social change. It also contributed to combat readiness by improving the health of its troops and its leaders.

Training was a key aspect of this project. Institutionalizing training requires implementing various strategies simultaneously. They include welcoming different organizations specializing in particular aspects of reproductive health to train various levels of personnel – from medical and paramedical staff to brigadiers – and setting up teaching teams. On-going training for technically skilled personnel and trained teachers is essential to maintain their skills and keep them up to date on changing trends.

Training brigadiers as health promoters can be a cost-effective method for transmitting knowledge about and promoting health since the military takes them to the most remote areas of the country.

Including gender in the curriculum helped opened up the discourse on gender equality. However, gender continued to be considered a women's issue and tended to be confused with offering women contraceptive choices and informing them about safer sex. Issues such as masculinity, prostitution, gender-based violence and power in sexual relations were not addressed. Consideration of fatherhood was limited to pregnancy prevention

rather than men sharing in children rearing and other domestic chores. Lastly, the training was not reinforced with policies that promote gender equality.

An organization cannot expect to change its culture if its leadership is not fully involved in this transformation. Significant changes in gender perspectives and related behaviour may require sustained discourse and more fundamental sociocultural transformation in a country and institution where machismo culture is still powerful.

Inter-sectoral coordination and collaboration within the Armed Forces is critical in integrating reproductive health services and behaviour change communication.

PARAGUAY:
Population and Development and Reproductive Health Education in the Armed Forces

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Translated in English by Michèle Burger

Fieldwork: August 2001
Project: PAR/97/P04 'Educación en Población y Desarrollo y Salud Reproductiva en las Fuerzas Armadas del Paraguay
Duration: 1997-2001
Funding : $471,240 allocated, only $206,418 was spent
Partners: UNFPA, Paraguay Armed Forces
Primary Beneficiaries: Military personnel (from officers to conscripts), their families and civilians living near military facilities

Summary

This project institutionalized the inclusion of population and reproductive health into the military educational system, with materials and teaching techniques adapted to many target groups. Its strategic foundation is the view that military service offers an excellent entry point to improve the lives of young men and a viable infrastructure with which to do so. This project, which was strongly supported by the Armed Forces, covered population and sustainable development, as well as range of reproductive health issues within UNFPA's mandate, including: sexuality, family planning, sexually transmitted infections, responsible parenthood, domestic violence, gender and rights. These last two concepts proved the most difficult to address within the military context.

Capacity was strengthened through the training of more than 1200 people, from high-level officers to doctors, nurses and civilian nursing students. The topics mentioned above became part of the military curriculum, reaching approximately 28,000 young and adult men per year. More targeting of communication to conscripts, many of whom are not well educated and speak Spanish as a second language, could enhance the project's impact. With additional training, some of the best conscripts have the potential to become health promoters within their own communities, and thus widen the project's impact.

The project also enhanced the quality and range of reproductive health services available to military men, their families and civilians living near military facilities. Some 12 military health centres in the interior of the country and five hospitals and clinics belonging to the army, air force and navy were rehabilitated. They were all stocked with modern contraceptives and some health providers received training. The project also initiated systematic distribution of condoms for men taking off on leave.

Lessons from Paraguay

A thorough understanding of military structure and culture is essential to effectively channel support to project activities. For instance, it is important to keep in mind the hierarchical, vertical organization of the military, and to realize that horizontal links and communication channels may not exist. Where cross-sectoral or intra-departmental cooperation is called for, projects need to facilitate lateral communication.

Building partnerships is crucial. In designing a project of national proportions, cooperation between relevant military departments, key government institutions and appropriate development agencies should be addressed. In this case, linking the project with the human rights division of the Armed Forces and with other relevant sectors would have been helpful.

All members of the Armed Forces could benefit from training. However, short-term superficial training that excludes gender, masculinities, gender equality and reproductive rights can reinforce stereotypes and shortchange students from fully learning about such complex issues.

If conscripts are intended beneficiaries, curricula and educational materials appropriate to their education levels and language skills should be used. Further, if the intent is to use conscripts to spread information about reproductive health to their communities, they need training and supervision. The military was receptive to learning about and using different teaching methodologies such as drama and puppetry.

Reproductive health services were not integrated and lacked a gender perspective. Sexually transmitted infections were not clearly linked to broader reproductive health and social issues such as gender, power in sexual relationships and reproductive rights. Dual protection was not promoted. Counselling did not routinely accompany testing for HIV.

One of the challenges was to let people know about the availability of free reproductive health services. Another was to address the particular needs of men and make space available to welcome them in what tend to be clinics that primarily serve women.

Gender is a somewhat abstract concept. However, when it is discussed more concretely, for instance, in relationship to gender-based violence and human rights, men seem to understand and accept the term.

UKRAINE:
HIV/AIDS Prevention in the Armed Forces

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Andrey Poshtaruk, UNFPA project coordinator

Fieldwork: November 2002
Project names: **'**HIV/AIDS/STD Prevention in the Armed Forces of Ukraine'; and 'HIV/AIDS/STI Prevention in Internal Defence Forces'
Duration: Pilot phase 2000-2001; Second phase 2002-2003
Partners: Ministry of Defence Main Educational Department, UNFPA, UNAIDS, and UNDP, Ministry of Internal Affairs of Ukraine, and Humanitarian Institute of the National Academy of Defence.
Budget: $85,000 for pilot funded by UNAIDS and UNDP with assistance from the British Council and the Canada-Ukraine Partner's Office. The budget included costs of international technical assistance, purchase of video equipment, communication kits for soldiers (posters, videotapes, booklets, and condoms for demonstration), and manuals.
$175,000 for second phase, from UNAIDS and UNFPA and $20,000 for the project with Internal Defence Forces (Police)
Primary Beneficiaries: Soldiers, their families and sex partners, and society at large.

Summary

The Ukraine case study adds the perspective of an Eastern Europe country experiencing an accelerated increase of HIV prevalence, while also dealing with deep changes in politics and gender dynamics, a unique set of risk factors, including substance and intravenous drug use, and a particularly committed head of state and military leadership. This high level commitment helped achieve institutionalization of HIV prevention education in the armed forces at an exceptionally quick pace.

With UNAIDS funding, UNFPA has collaborated with the military in a series of HIV prevention project since 2000. A one-year pilot project was renewed for an additional year and quickly expanded to cover all departments of the military. Using an adult education approach, its main feature was to prepare and institutionalize an HIV education curriculum in collaboration with the Defence Ministry's Main Educational Department responsible for pre-service and in-service training. A core group of psychologists were trained as trainers. Regularly scheduled classes on HIV prevention were scheduled for groups of young recruits and military cadets. Education of peacekeeping forces was included in the project, following the recommendation from UNAIDS' Humanitarian Unit.

The courses focus on HIV prevention with less emphasis on other reproductive health and gender relation issues. This was apparently the result of UNFPA's donor preference, something UNFPA would need to negotiate with respect to the ICPD's wider mandate on reproductive health, gender equity and empowerment, and human rights issues.

While the educational and condom promotion components are well developed, the weak links were service delivery, including voluntary counselling and testing, condom availability and meeting the reproductive health service needs of women in the military. Policy and funding of reproductive health service delivery, including HIV testing and access to condoms, needs to be addressed. Reproductive health needs of women personnel will constitute a second phase of the partnership, something UNFPA is well placed to support as well.

Lessons from Ukraine

The Ukraine is one of the first countries in the region to start educating its soldiers on HIV prevention and risk behaviours. Other Eastern European countries that are also experiencing rapid rises in HIV infection can greatly benefit from the Ukrainian project. A high-level regional conference involving top military personnel responsible for Armed Forces Policy could be convened to exchange ideas in this regard.

The armed forces clearly have both the organization and the command structure to implement a national programme of HIV prevention for their personnel. The main accomplishment of the project was to demonstrate that a system of HIV/AIDS prevention education should be inclusive – from the command level down to all military personnel.

Inter-sectoral coordination and collaboration is vital in reproductive health projects because they involve the disciplines of education and health. Although establishing the project in the Main Education Department of the Army helped institutionalize it in the general training programme, the medical personnel of the army were left out by this arrangement. The two approaches are complementary rather than parallel or sequential.

The military's leadership and soldier's receptiveness suggests an opportunity to widen the scope beyond HIV to include other reproductive health-related themes. These would include family life, gender issues, reproductive rights, drug abuse, sexual abuse, healthy and satisfying sexuality, and life planning.

To be more effective, training curricula and behaviour change communication methods also need to include peer education methods and encourage empathy for the plight of people living with AIDS. Peer education is a behaviour change communication approach that has been found quite successful in another project implemented in this country. Since discussions among peers about reproductive and sexual health issues "are actually happening", according to military commanders, the military should consider adopting this approach officially.

Condom programming is integral to education programs that aim to change behaviours. If the intent is to increase the use of condoms, they must be readily available on an on-going basis to soldiers and officers going on leave or leaving the base. As many young soldiers and officers do not have the ease of movement and financial means to purchase condoms, these should be provided free of charge. Creative means of subsidizing the availability of condoms should be considered in the project design.

As in many other countries, HIV testing policies need some clarification.

Gender equity issues are an integral aspect of reproductive and sexual health programming but were somewhat neglected in this project. For instance, the curriculum did not address women's needs, nor were women provided with training or health services.

COMPARATIVE ANALYSIS OF THE NINE UNFPA COUNTRY CASE STUDIES

National contexts

The national contexts of the countries we studied are obviously quite varied, even within regions. We chose countries where there were no major internal or external conflicts. Detailed information on major development and population, gender issues, including gender-based violence; reproductive health, including unmet needs; HIV prevalence and country response; the situation of young people; and the military structure, can be found in each case study.

Botswana and Namibia have high HIV prevalence, while the other countries have a low prevalence rate. Benin, Ecuador and Madagascar share high rates of maternal mortality; Nicaragua and Paraguay, similar to Mongolia and Ukraine, have a low HIV prevalence and increasing contraceptive prevalence in a weakened health infrastructure. Ukraine is unique with the prevalence of injecting drug use and its rapidly accelerating rate of new HIV infections.

Until the late 1990s, Mongolia and Ukraine had made considerable progress in gender equality, but this is being reversed with changes in the economy. New roles of the armies in emerging democracies in Latin American seem conducive for addressing human rights and gender equity education. Common issues relate to the vulnerabilities of young people.

Entry points for the projects

Project history and donors' interests, more than the development context, account for a large difference in the focus of interventions and implementation strategies in peacetime.

The emphasis of the interventions varies from country to country and with the duration of the project. Some focus on strengthening health service delivery systems – with a marked shift in focus since the Cairo Conference (ICPD, 1994) from family planning only to broader reproductive health. Others aim at building human capacity in family life education and reproductive health for behaviour change. More recently, projects address HIV prevention and, to a much lesser extent, gender-based violence.

Donors are often quite instrumental in shaping these orientations. In fact they are often more influential than the leaders of the country or national population and reproductive health needs. In Ecuador, Madagascar and Ukraine, however, the opposite was true: the military approached donors to fund military initiatives.

Most UNFPA-funded projects attempt to adopt a rather comprehensive approach to reproductive health services and education. For instance, in Ecuador, the focus was on maternal health, including family planning. The project was developed in response to a

request from the armed forces to UNFPA to improve the quality of maternal and reproductive health services available to the military, their families and veterans. In two other countries in this region, Nicaragua and Paraguay, a deliberate attempt was made to apply the ICPD vision.

The shifting role of the military in society is also quite apparent. In Benin, the reproductive health project was a direct result of reforms that encourage the armed forces to use its know-how in the country's development. The first phase covered the rehabilitation of health clinics and provided training in maternal health and family planning; the second phase strengthened the rehabilitated clinics' quality of care and HIV prevention capacity. Similarly, in Madagascar, the project's focus on health was a direct result of political reforms that encourage the armed forces to use its health infrastructure for improving HIV/AIDS/STI prevention and maternal health.

Nicaragua is another interesting case. Following its civil war, the military was encouraged to be a collaborator in the country's social and economic development. The Nicaragua project builds on two previous ones that developed a curriculum for officers and integrated reproductive and sexual health services and training for brigadiers, adopting a dual focus on health and education. Thus, reproductive and sexual health issues were framed with an emphasis on rights and gender equality.

In Paraguay, UNFPA and the military had similar ideas about involving the military in improving the lives and health of personnel, families and civilians in surrounding communities. Thus, the project focused on educating military personnel on a comprehensive range of population and reproductive health issues. This idea converged with the military's interest in using its infrastructure to improve the lives of its personnel.

In Botswana, current activities are a continuation of a former 'Population, Family Welfare Education and Services at the Workplace' project that provided population education to young workers from 1994 to 1997. Its focus shifted to HIV/AIDS prevention after the Ministry of Health received support from another donor for HIV education and prevention and persuaded the military to join in. In Namibia, the project focused on men's reproductive health within a specific locale. Men in soccer clubs, male members of the Evangelical Lutheran Church, male nurses, and men in the police and the army were all targeted.

In two countries, Mongolia and Ukraine, where the primary international donors were mostly interested in HIV/AIDS prevention, interventions were more vertical and limited to education. In Mongolia, as the military saw rates of STIs increase among its personnel, it focused on educating young male recruits on preventing sexually transmitted diseases, including HIV, with some limited discussion of family planning, safe motherhood and family life. Similarly in Ukraine, with UNAIDS funding, UNFPA has collaborated with the military in a series of HIV prevention education projects since 2000, following rapidly increasing rates of HIV/AIDS within the armed forces and among civilians.

The choice of a lead department is critical to the success of a project.

Main military units involved in reproductive and sexual health projects range from health to training departments to military academies. Rarely is a coordinated approach taken. The choice of the lead department, however, does not seem to be the result of a clear institutional decision related to a department's capacity to lead or their understanding of reproductive health behavioural and ethical issues. This fragmentation results in a lack of synergy among the supply of reproductive and sexual health services and commodities, behaviour change education and policy change efforts.

Health departments of the military are often invited by donors to prepare reproductive health project proposals. Four countries with a reproductive health service component, Benin, Madagascar, Namibia, and Paraguay, used the military health department as their primary counterpart for managing project activities.

Interestingly, two countries, which focused rather vertically on HIV prevention education – Mongolia and Ukraine – only corresponded with the training departments. Establishing the Ukraine project in the Main Education Department helped institutionalize it in military cadets and soldiers' general training. The project demonstrated the benefit of HIV/AIDS prevention education efforts that include everyone from the command level down to all military personnel. However, the medical personnel were left out, even though they have a clear role to play in providing voluntary testing on request, STI treatments, counselling for those with HIV or other infections, and condom distribution. The two approaches should be complementary rather than parallel or sequential.

Health and training departments worked jointly, in Ecuador and Nicaragua, although coordination was not so smooth. The Botswana military let the Ministry of Health's Occupational Health Unit manage its campaign; this was an exception.

A thorough understanding of military structure and culture is essential to effectively channel support to project activities. For instance, it is important to keep in mind the hierarchical, vertical organization of the military, and to realize that horizontal links and communication channels may not exist. Where cross-sectoral or intra-departmental cooperation is called for, projects need to actively encourage lateral communication.

Health departments, often hosted under the auspices of logistics departments, rarely have the direct contact with military leaders that training departments do. They lack clout in influencing policies and training, since reproductive and sexual health issues are often perceived as falling in the purview of health departments. The considerable time and effort required to get solid commitment from senior staff outside health departments should not be underestimated.

Cross-sectoral collaboration

Collaboration with ministries of health*:* Collaboration between the military health departments and the national ministries of health varies from being non-existent to having

ad hoc local linkages to being systematic. While the armed forces health infrastructure and training in reproductive and sexual health and HIV prevention greatly contributes to public health efforts, this area requires more attention and willingness of the military to feel part of the national health policy and training standards.

In Madagascar, Mongolia and Ukraine, the military seemed to operate almost independently of other governmental departments, including the ministry of health. In these cases, the ministry of health does not retrain military medical doctors nor does the military share its epidemiological data. In Benin, Namibia and Paraguay, the military is occasionally involved in joint health fairs and vaccination campaigns with their respective ministries of health. In Paraguay and Namibia, colleagues of the Ministry of Health review the military's training materials.

Collaboration with public health services seems easier when the military project builds partnership with local civilian organizations at the outset. The collaboration seemed easier in Benin, Botswana, Ecuador and Nicaragua. In Botswana, the Ministry of Health's Occupational Health Unit and Family Health Unit took the initiative to reach out to the military. Benin was another successful case of collaboration between the ministries of health and defence to train medical personnel, integrate health statistics from the armed forces into the national health data, manage military medical equipment and adopt national standards of health care.

Collaboration with ministries of education*:* In Ecuador, collaboration between the Ministry of Education and the military's Institute of Social Security avoided duplication of educational materials on sexual health education. Here, military teachers were also able to establish contacts and share learning from other UNFPA-supported reproductive health projects. In addition, training teachers in schools for the military's children in reproductive and sexual health proved to be an effective way to implement the Ecuador Ministry of Education's policy requiring sexuality education in schools.

In Mongolia, the Ministry of Education got involved when growing numbers of illiterate young rural recruits convinced military commanders to invite schoolteachers to teach young recruits basic literacy skills.

Collaboration with NGOs*:* Training provided by professionals who do not belong to the military system is very valuable because it can increase motivation of military personnel to learn and bring in new perspectives. In Namibia, Margaret Sanger Center International and the UNFPA Country Support Technical Team provided technical assistance. Similarly in Benin, Madagascar, Mongolia, Nicaragua, and Paraguay, national NGOs were welcomed as technical assistants. The training of military personnel by civilians from NGOs seems to have gone smoothly with no significant problems. Most reports about this experience were positive.

Collaboration with NGOs is a sign of openness of the military leadership to improve its skills and use cutting-edge methodologies. As a result of donor funding, most projects rely on technical assistance from international NGOs. Collaborating with national NGOs

allows for more sustainable partnership with civil society, rather than relying on individual consultants and international partners.

In Botswana, collaboration with national NGOs was a major feature of the project. In Benin, NGOs provide training in both management and technical skill for reproductive health. Similarly, in Madagascar, health management organizations and family planning affiliates provided management training and trained providers in behaviour change communications and quality of care. In Mongolia, two national public health NGOs, developed the curriculum and training materials, and trained the military and border troop trainers. With a stronger focus on gender and rights in Nicaragua, many national NGOs serving on different specialized aspects of reproductive and sexual health and adolescent reproductive and sexual health, human rights, gender, including masculinity and violence, were enlisted to work with the military. Civil institutions, such as NGOs specializing in certain aspects of sexual and reproductive health, should continue to work in partnership with the military.

In conclusion, reproductive and sexual health programmes require an integrated approach among the different military departments that traditionally do not work together, and among national level agencies such as ministries of defence, health and education, and with civil society organizations.

The 'closed' and centralized hierarchical structure of the military can be a barrier to internal cooperation and horizontal informal health promotion strategies. The health and education departments must collaborate in capacity building and training. The logistics, maintenance and financial departments have to coordinate management of logistics and maintenance of health care facilities.

Human capacity strategies

In general, military organizations offer an excellent infrastructure for training in reproductive and sexual health at all levels, but need support in introducing new themes such as reproductive health and gender issues, including gender-based violence. Building an internal capacity to train on reproductive health and HIV is the main output sought out by projects.

This is achieved through development of new curriculum and teaching materials and by training military faculty, frontline trainers and medical staff. Projects differ regarding who provided technical assistance, who was trained first, whether needs assessment were conducted prior to curriculum and materials development, and how training sessions were organized. Training is provided primarily through workshops that last several days and include lectures, handouts as well as time to read and review the material distributed.

Good preparation to training is a prerequisite.

Prerequisite activities to training include sensitization of senior staff to achieve acceptability of the project, and rapid needs assessment and audience analysis to inform

training content and methods. This preparation should not be overlooked. Otherwise plans may be delayed, as was the case in Botswana.

Project leaders involved in the project should be oriented and trained, but this does not happen systematically. Training capacity should also be institutionalized so that the armed services do not have to rely on external consultants.

Assessing training needs at the outset, and regularly conducting sociocultural and operations research are crucial steps to making training more effective and improving knowledge, attitudes and practices. In Namibia, baseline sociocultural and operation research on reproductive and sexual health among project beneficiaries – including monitoring, assessment of interventions and related activities – boosted ongoing activities. In Benin, follow up, quarterly supervisory visits and coordination between UNFPA's National Advisor for reproductive health and the Project Coordinator of the armed forces provides an outstanding model for others to follow.

Mainstreaming gender and human rights into reproductive health and HIV prevention is complex. A short-term, superficial approach to training in these topics may ignore sensitive sociocultural issues like gender inequality, violence and masculinities, and reproductive and sexual rights. It can result in reinforcing stereotypes and stigmas or providing students with a partial understanding of such complex issues. Addressing these issues correctly would, in the long run, contribute to changing young men's attitudes and behaviours and their views toward the responsibilities of family life.

In Nicaragua – one of the model approaches with regard to gender training – new themes, such as adolescents, were superficially addressed and others, such as violence, were not considered a priority. Informants recommended that future training include substance abuse, violence, sexuality (including pleasure and impotence), and masculinity. To be more effective, gender and human rights perspectives may mean adding life skills such as conflict resolution and empathy for the plight of persons living with AIDS.

Instructors from within the military need training not only on new topics but also about the different ways people learn and change their attitudes and behaviour. Theatres and puppets are examples of teaching methods that are very popular among young men. In Ecuador, teachers appreciated training in these participatory methodologies, which helped them lead more animated classroom discussions. Workshops in Madagascar covered adult education/participatory education techniques, group consciousness raising and peer training.

It is not customary to include both health and education personnel in workshops. Paraguay was an exception, where workshops were directed to unit commanders, heads of education departments, company commanders, platoon commanders and auxiliaries, military doctors and nurses. Content was quite comprehensive, and the military subsequently assessed trainees' knowledge of sustainable development, population dynamics, cultural changes, differences between the sexes, sexuality and gender.

Technical assistance and capacity building are at the core of all programmes with the military.

Integrating reproductive and sexual health into the curriculum of military academies and appointing a high official of a training department to oversee the project, are elements that help institutionalize a project, as demonstrated in the Nicaragua and Ukraine projects.

Establishing the project in the Education Department of the Army in Ukraine helped institutionalize it in military cadets and soldiers' general training. The Nicaragua military presents a model of elaborate organizational structure for pre-service and in-service training. Local teaching teams in military units complement a central team. Reproductive and sexual health is now offered by the Military Medical Department. Cadets get even more advanced sexual health training, equivalent to Ph.D., while graduates of the Basic Training School are trained to serve as reproductive and sexual health 'brigadiers'. And reproductive and sexual health training is structured along grade levels according to military ranks.

Because of the usually high turnover among health care staff and officers, many professionals do not receive training. In addition, personnel and trainers at the central and local levels need on-going training to maintain their skills and remain current about reproductive and sexual health issues. In Benin, personnel can be mobilized on a day's notice and officers and medical personnel rotate often, challenging continuity and delivery of quality reproductive health services. Training should be ongoing and not a one-time event. Another recurring issue is the need to provide adequate training materials, handouts and teaching aids.

In conclusion, external technical assistance and capacity building is at the core of all programmes with the military. Indeed, training military personnel in reproductive and sexual health and gender and human rights issues during employment, deployment and demobilization, is a cost-effective way to provide technical assistance for country health programmes. Conversely, the military should be viewed as a contributor of technical assistance within its own institution, and to civilians.

Behaviour change communication strategies

Projects should embrace a more comprehensive approach to reproductive and sexual health and gender education, beyond STI/HIV biomedical information.

Messages and discussion topics tend to focus on imparting knowledge of family planning, HIV and maternal and child health, and narrowly focus on biomedical information related to STIs and HIV transmission and prevention methods. More rarely do they address lifestyle, gender relations and ethical issues, or emotions, beliefs and feelings of empathy. For instance, men could be encouraged to reflect on how they increase women's vulnerability to sexually transmitted infections, including HIV/AIDS.

A single-focus, prescriptive approach to HIV prevention has limitations: the wider links with gender inequality and reproductive and sexual health concerns are lost, and people may become inured to and depressed by discussions of HIV/AIDS alone. Generally, women officers feel that much more than information on human anatomy is needed. Young recruits need opportunities to reflect on gender issues, gender-based violence, communication skills with their partners, how to be a good father, and how to take care of the first baby and develop good family relations.

An important unmet need identified by this study is to 'sensitize the men'. Requested themes include gender equity, couple communication and violence against women. Information about reproductive and sexual health and rights can be integrated into young recruits' basic training to complement the health education they currently receive on such issues as proper hygiene and first aid, and prevention of sexually transmitted infections and HIV/AIDS.

Finally, integrating sexual and reproductive health in the military is more successful when these programmes consider the cultural values, norms and perspectives of the local communities to which members of the military belong, and address stress management, sexual harassment, men having sex with men, coercive sex within the armed forces, sexual violence, vulnerabilities, power imbalances, prejudices and fear, and empathy for people living with AIDS.

Project priorities should be based on needs assessment.

Authorities and military leaders agree that teaching reproductive and sexual health and gender relations can benefit everyone on the base, regardless of rank, not only young recruits. Permanent staff can become advocates and role models, thereby reinforcing changes in gender equitable attitudes, responsibilities and condom use.
However, most HIV prevention education projects tend to focus on young soldiers to the detriment of adult officers, permanent staff, and civilian populations.

In contrast, most reproductive health projects reviewed embrace permanent staff, their families and surrounding civilian populations. In Ecuador, reproductive and sexual health educational needs of permanent staff and their children were even favoured over those of young recruits. Interestingly, a parent education programme was added. However, the reproductive and sexual health content was not well integrated into the military academies.

Baseline sociocultural studies help raise awareness about masculinity, sexuality and reproduction, and contribute to the recognition that there are diverse perceptions about these issues among the different people in the military. Young conscripts come primarily from marginalized urban and rural areas where access to education about reproductive and sexual health, gender issues and prevention of sexually transmitted infections, is rare. It is also important to ensure conscripts have access to condoms.

In any case, if projects within the armed forces focus on conscripts as beneficiaries, the educational content and format of materials should be appropriate to their educational level and in their primary language. For instance in Mongolia and Paraguay most of the conscripts come from rural areas. Most are poorly educated and functionally illiterate, and the materials for this group should reflect this. Illiterate soldiers need materials that they can understand.

Priority stakeholders for training and behaviour change communication should not be donor driven. Project coordinators should consult instructors of conscripts on an on-going basis for direction when materials for army recruits and young men are produced. After all, they are the ones who have gained the confidence and trust of these young men to the extent that they are willing to discuss their reproductive and sexual behaviours. These instructors can be a rich source of information and often have developed creative ways to teach interesting materials.

Peer education gets good reviews. Using army discipline on sensitive issues is not a guarantee of success.

Changing the behaviour of others takes time and skills. Open discussion and exploration of complex feelings, attitudes, values and beliefs that inform sexual behaviours and create empathy have a greater chance of influencing gender relations and sexual activities than does simple information sharing.

Military personnel tend to respond to top-down instruction, in line with their own hierarchical work culture. According to standard military discipline, teaching methodologies can be fairly didactic. However, while authority can enforce attendance at meetings, it does not guarantee that those attending will benefit or comply in their private lives. To change reproductive and sexual health and gender relations, same-rank peer education seems a more popular and effective approach. In some countries (Botswana, Namibia, Nicaragua), participatory and informal methods such as peer education are being introduced with some success, although they are not systematically organized.

Participatory teaching methods with adolescents and youth stimulate their attendance and interest in educational activities. Likewise, content needs to have direct relevance to the lives, sexual experiences, needs and interests of the students. For instance, in Ecuador, students wanted to learn more about dating and communicating with family and partners. Because many young men engage in sex for pleasure and peer approval, this methodology is particularly well suited to uncovering attitudes related to sexuality and gender equity.

In Mongolia, a needs assessment study recommended experimenting with a peer education scheme among military conscripts. It was found to be a popular and effective way to ‘bring home’ socially beneficial information. Many peer educators expressed pride and enjoyment about their new roles and responsibilities and satisfaction about the support they received from their supervisors.

The projects in Nicaragua and Ecuador aimed to have recruits become peer educators when they returned to their communities after having completed their military service. However, taking on a role of social change agents among friends and families requires coaching. Regular back-up training of peer educators, supportive supervision and symbolic incentives could strengthen motivation and competence. Appropriate supplies of educational materials are needed.

Furthermore, careful selection of peer educators is necessary to ensure that trainees are motivated to undertake their roles effectively. Simply expecting that young recruits share their knowledge does not work. During home visits, conscripts rarely distribute materials they receive. In Botswana, peer promoters were represented in the HIV/AIDS committee at every military base. In Nicaragua, trained brigadiers were asked to promote sexual health inside the base and in the surrounding communities; they were successful as health promoters as long as they served in the army, thanks to good supervision and on-going training.

Peer education programs should be developed and/or strengthened so that trained military personnel who re-enter societies as civilians can serve as health agents. This is particularly applicable in the context of demobilization. On-going support and training can include discussion groups, counselling, organizing distribution of condoms, and setting up and conducting simple community-based surveillance programs[5].

Achieving measurable changes in knowledge, attitudes, beliefs and behaviours remains a challenge.

One of the challenges of the projects is to measure changes in knowledge, attitudes, beliefs and practices.

In Ecuador, the project made a noticeable difference in promoting and providing adequate information about the range of reproductive health services available to men, including vasectomy. Demand for vasectomy at the military hospital rose to almost 30 vasectomies per month – an extraordinary result, given that it occurred in a country where vasectomy is taboo.

Similar anecdotal evidence was found in Nicaragua, where sexual practices have changed, especially increased condom use among most members of the military. A high percentage of focus group participants reported using condoms in situations considered risky, like casual sexual relationships with sex workers. Health providers confirmed a high demand for condoms when soldiers go on leave. Nevertheless, there is still great pressure to have multiple sexual partners.

In Ukraine, a KAP study concluded that prevention education proved useful on changing knowledge and some attitudes. However, the study also concluded that knowing the risks

[5] Carballo, M., and J. Cillóniz. 2002. 'HIV/AIDS and Security'. Geneva: International Centre for Migration and Health.

of drug addiction and unsafe sexual practices proved insufficient to change everyday life and adopt a safe and responsible behaviour[6].

Any uniformed service initiating a reproductive and sexual health programme should carry out qualitative assessments to understand perception of risk and risky behaviours among military personnel and civilians. A baseline survey should include questions about accessibility to treatment of STIs, confidentiality when receiving such care, when and with whom men use condoms, what men do for recreation, and what they value. These assessments will not only help improve understanding about and contribute to developing strategies for HIV/AIDS and STI reduction and prevention; they will also provide an overall perspective of reproductive, sexual health and gender notions among men and women in the military.

This assessment is also vital for reviewing current military policies and developing a strategic plan that integrates a comprehensive reproductive and sexual health programme into the existing military health structure. Information obtained from these surveys could also help identify gaps in the codes of conduct that need to be addressed.

Consideration should also be given to involving HIV-positive people, including military personnel living with AIDS, to design approaches to reduce the spread of HIV/AIDS and to define audiences that should be targeted.

Reproductive health service delivery strategies

The constellation of reproductive health services provided by the military needs to be better defined.

In general, health services provided by the military are quite distinct from those provided by the Ministry of Health. Depending on the country and the location, the primary mission of the health services of the military is to maintain or improve the physical and mental health of military conscripts.

In some cases, needs of personnel and their families are also catered to. For instance, in rural areas of Benin, Madagascar and Paraguay, military health services are particularly important where the Ministry of Health has a weak presence. In Benin, Namibia and Paraguay, the military promoted activities initiated by the Ministry of Health, such as immunization campaigns.

Many of the focus groups recommended making the military health services more accessible to civilians. Given the limited resources in these countries, care should be given to ensure that the health services offered by the military do not duplicate others offered in the area to civilians. Several focus groups also mentioned the fact that services located inside military bases may discourage family members, who may live away from

[6] Vornyk, B. and A. Gudzovsky. 2001. 'Risk Behaviour of Military Personnel and Possibilities of Change: Comparative report'. UNFPA and Ministry of Defence of Ukraine.

the base, as well as neighbouring civilians, from using them. In Nicaragua, some talked about "taking the services out to the community."

Expanding the range of reproductive health services beyond family planning can help to expand the client base and encourage men's health-seeking behaviours, especially for prevention of sexually transmitted diseases. The armed forces should also consider whether it can realistically afford to continue providing services to civilians and how it can sustain these services in the absence of UNFPA support.

In all countries, the military health services offer STI treatment, and generally this is done using a syndromic management approach.[7] In general, however, counselling services are overlooked. Health care standards established by the ministries of health should apply to all health-related activities in military bases, including space to assure clients' confidentiality for screening and counselling. All reproductive and sexual health services should assure confidentiality. This will help remove the stigma surrounding testing and fosters the provision of quality VCT services.

Clearer policies on the minimum components for reproductive and sexual health care and their accessibility to staff, families and civilians also need to be defined. Women's health issues are rarely covered and permanent staff and their families are often required to seek health services from the closest provincial town, except in cases where military clinics and hospitals are open to families.

In the case of Ecuador, high unmet demand for contraceptives and high cervical cancer rates for women were effective entry points into the area of reproductive and sexual health. Ecuador was remarkably successful in meeting both genders' needs, by providing cervical cancer prevention and vasectomies at military hospitals. Because the projects in Benin, Ecuador and Madagascar focused on rehabilitating military maternities, staff, health providers and female clients were the centrepieces of these projects.

Calling military health centres 'maternities,' as is the case in Benin, rather than reproductive (and sexual) health centres, at a time when population programmes are progressively moving toward embracing men, may unknowingly reinforce existing gender stereotypes.

Service providers are often not equipped to counsel in reproductive and sexual health.

Quality reproductive and sexual health services can only be provided in properly equipped facilities that are appropriately staffed. In cases when services are offered to families, women may be uncomfortable with male health providers. The armed forces and the government should assure that women providers are assigned to military health centres. On the other hand, men may prefer discussing sexual health among peers, so

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[7] Curran, L. and M. Munywoki. 2002. *HIV/AIDS and Uniformed Services: Stocktaking of Activities in Kenya, Tanzania and Uganda*. UNAIDS Humanitarian Unit and the UNAIDS Inter-Country Team For Southern And Eastern Africa, p. 16.

staffing military health clinics with male counsellors should be considered. Typically, however, medical staff are contractual staff and predominantly female.

Young recruits are screened for sexually transmitted infections at the time of recruitment and regular health check-ups take place at the army base health unit. Very little education and individualized counselling take place during these routine sessions. Training in health education focuses on prevention of infections and first aid, sanitation and hygiene principles.

Health providers need additional training to acquire the skills required to communicate with clients about more personal problems and about their reproductive and sexual health needs. In fact, all health care providers need gender training and counselling skills, as issues related to gender come up frequently in their work with clients.

In general, condom programming is not addressed satisfactorily and remains uncoordinated with educational initiatives.

Condom promotion and provision is the most powerful tool in the war against HIV/AIDS and STIs. Teaching soldiers to use condoms is widely considered the most effective and inexpensive way to prevent the spread of sexually transmitted infections. But promoting condom use, without making condoms accessible, is ineffectual. Army leaders may well have overlooked the sexual activities of young conscripts, and the subsequent need to supply condoms to them. In order to build on the messages about prevention of sexually transmitted infections, both male and female condoms should be more available and accessible at all health facilities, youth centres and bars, especially in the rural areas. Sending young recruits and officers to purchase condoms in commercial pharmacies does not ensure timely access. Embarrassment and lack of financial resources keeps them from obtaining them.

Condoms were accessible in Benin and Madagascar, as well as in Ecuador, Nicaragua and Paraguay, even though supplies tended to dwindle when the project ended. In Benin, there are even plans to install automatic condom dispensaries to encourage and facilitate their purchase. Quite surprisingly, however, the projects that focused on HIV prevention education in Botswana, Mongolia and Ukraine did not have good in-base availability of condoms. This lack of comprehensive condom programming contrasts with success stories in Ethiopia and Thailand [see last chapter on Changing Contexts].

As many young soldiers and officers do not have the ease of movement and financial means to purchase condoms, these should be provided free of charge to soldiers going on leave and sold to officers leaving the base. This would add substantially to the cost of projects, but efforts should be made to obtain separate funding for this purpose. Provision of female condoms should also be considered a priority. In Namibia, most of those interviewed expressed willingness to use female condoms but said they were just not available.

In Mongolia, the military experimented somewhat successfully with a revolving fund for condom procurement and resupply. However, the purchasing power of young recruits is a problem: it is extremely low, just enough to buy a few cigarettes and soap and not sufficient for condoms, even at subsidized price. Only officers were able to purchase condoms.

Although the coordination of reproductive health information, services and commodities was generally impressive, improvements are needed to ensure a continuous supply of condoms to meet the increase in demand for them. This can be complex in countries where condoms are vulnerable to heat damage, or where deliveries to rural areas are constrained by poor roads.

It turns out that providing condoms is often considered to be beyond the financial means, and moreover, the responsibilities of the military. It is clear, however, that the military needs to do more to build its capacity in managing logistics and ensuring security of reproductive health commodities. The army may need to actively look for outside sources of funding for condoms and organize their procurement in a client-centred way. One of the ways the armed forces could show their commitment would be by institutionalizing reproductive and sexual health training and ensuring constant supplies of reproductive health commodities, including condoms and educational materials after a project ends.

International financial support and technical assistance in managing reproductive health commodity security are needed to assist military fundraising and programming efforts, including male and female condoms, STI drugs, and HIV and blood count tests. In addition, serious consideration should be given to including condoms in travel kits, having adequate supplies of STI drugs, and providing continued care to HIV-positive personnel at all levels of the armed forces.

Policy with regards HIV testing needs clarification.

HIV testing is one of the most controversial health-related issues in the military. To date, each country seems to decide on this matter. The issues are: Who is to be tested? Is it voluntary? Are tests results communicated to the subject? Are tests results confidential? If HIV positive, can soldiers stay at work?

The general aim today is not to implement mandatory HIV testing and screening, but to encourage informed consent from military staff and recruits and train reproductive and sexual health providers to conduct VCT. Decisions to conduct mandatory testing are influenced by enrolment in peacekeeping operations, demobilization, security of employment and support for the HIV-infected, and general safety. Counselling and HIV testing is sometimes described as ‘voluntary’ because the candidates for promotion or training abroad or peacekeeping service are volunteers and knowing that HIV negative status is a condition of selection[8].

[8] Curran and Munywoki 2002, p. 17.

In the nine countries we studied, all the military forces had different VCT policies. HIV testing was mandatory for all future peacekeepers and for new conscripts in Namibia, Ecuador, and Botswana. Young recruits are also screened during compulsory blood donations in countries such as Madagascar, Nicaragua and Ukraine because many military health departments have not integrated laboratory services into their health systems. Under these conditions, recruits do not always receive results of the tests and post-counselling, and they are usually dismissed if found positive.

Treatment of PLWAs is not uniform.

Military authorities who turn away HIV-positive recruits are increasingly faced with charges of discrimination. Recently, the African Consensus and Plan of Action (2000) claimed "armies must provide for soldiers who are living with HIV."

In four out of the nine countries we visited, the military seemed to be in a transition phase. They were willing to treat staff with HIV, but had not yet adopted clear policies with regard to testing, length of stay and access to family and pension benefits. In Namibia, for instance, the labour court ruled that exclusion from the military, solely based on sero-positive status, is discriminatory and breaches a section of the Labour Act of Namibia.[9] The court also stated that no person should be excluded from enlisting into the Namibia Defence Forces solely on the basis of such person's HIV status where such person is otherwise fit and healthy. All HIV- positive members receive full pay until they die. The military organizes and pays for funeral and pays pension to beneficiaries.

Similarly in Botswana, PLWAs are reassigned to less stressful work and retire with full benefits. In Ukraine, if mandatory blood donor screening of conscripts reveals sero-positive status, the soldier is put in quarantine until dismissal from military service. On the other hand, career soldiers are pensioned if they are ill, allowed to continue in the army until they became ill and then, receive a pension. Rulings such as these may contribute to the military's hesitancy to embrace universal testing.

Transparency and accountability of the military could be improved.

There seems to be consensus about the lack of surveillance information on HIV prevalence in the armed forces. Reasons for this are well known. Nevertheless, the military offers far better possibilities for information gathering as well as surveillance. Since the military is well-structured organization of people who are disciplined and eager to learn, a good logistical and well-planned base could provide surveillance practices relevant to designing interventions, monitoring changes and evaluating the impact of several interventions.[10]

[9] Section 107 of the Labour Law of Namibia, Labour Court Namibia, April 2000.

[10] Carballo and Cillóniz 2002.

Promotion of gender equity

Gender mainstreaming is not implemented.

Gender mainstreaming tends to be an add-on component rather than being integral to project design. Health providers consider gender in terms of providing more contraceptive choices to women and increasing the quality of services women receive. This suggests they perceive that gender is limited to women. Health-focused projects that lack a gender component should be reviewed by a gender advisor to find ways to address the issue at the outset and in all phases of the project.

Involving women alone, either as trainers, health service providers or clients, cannot achieve gender equity. Gender and sexual and reproductive health need to be mainstreamed in the academies and training centres for officers and non-ranking officers. Policy issues related to family separation are also integral part of gender mainstreaming in the military.

Findings from these studies clearly indicate that women's needs, including access to their rights, are not being fully met, regardless of whether they are personnel or family members. Women personnel are often not included in project activities, such as training; and they lack access to reproductive and sexual health services, and miss information about gender equality, risks involved in sexual relations, and gender-based violence.

While outstanding and deliberate efforts are made to increase awareness about gender equity and power imbalances among young recruits and the military cadres – as in Nicaragua and Paraguay, there is still a disconnect between condom promotion and a gender perspective. Safer sex behaviour is 'medicalized' through such messages: "Be careful not to have sex with any woman because you may contract an infection. Use a condom." Women are seen as the major culprits and sources of infection, which leaves power relationships between men and women and *machista* sexuality unchallenged.

Nevertheless, the willingness of the military, in Paraguay, for example, to address gender issues that could be considered counter to its culture, is admirable.

Undoubtedly, gender and reproductive and sexual rights were the themes that were most difficult to understand by all those involved. Gender can seem a very abstract concept, especially for students with little education. It will remain misunderstood unless training provides practical examples in focused group discussions. At all educational levels, gender must be linked to issues of equality in social institutions and also to masculinity.

Future activities should give greater emphasis to gender equality and reproductive rights education. The training curriculum for instructors in military academies could include these concepts. If the quality of education is not carefully monitored, teachers may relay partially correct concepts or even false ones that may result in unexpected consequences.

For instance, they may reinforce traditional gender stereotypes and encourage associated negative behaviours, such as stigmatising homosexuals or treating prostitutes violently.

Finally, an organization as the military cannot expect to change its culture if its leadership is not fully involved in this transformation. Significant changes in gender perspectives and related behaviour may require sustained discourse and more fundamental sociocultural transformation in a country and an institution where machismo culture is still powerful.

Gender-based violence is often denied.

The increasing scale and premeditated nature of wartime sexual violence and peacetime domestic violence has led to ever-increasing concerns over gender-based violence. In general, and except for female officers and female service providers, there is a denial among those interviewed that gender-based violence is an issue in their unit or in their institution.

In Paraguay, domestic violence in the military is addressed in education, training and service provision. In Botswana, domestic violence in the military is actively discouraged. However, when incidents do occur, they are considered beyond military jurisdiction and handled by civil authorities. In Benin, providers reported that gender-based violence exists among all classes and military ranks. Poor illiterate women were more likely to be the victims of such violence than women who have their own means and have the option of leaving their husbands. The consensus is that civilian and military men are violent because “they are all men after all.”

Violence is a fact of life for most women, since few are financially independent. Some men and women recognize that rape occurs in marriage, but is rarely reported. When women were asked what men can do to control or reduce the level of violence, the response was universally “we must be patient.” Most women have no choice and find ways to live with this kind of violence.

In that regard, a major limitation is the narrow focus of projects on the risks of getting sexually transmitted infections or preventing unwanted pregnancies. Most army personnel and officers have little knowledge of men’s broader sexuality and sexual health needs, and gender equity and reproductive rights issues. Notwithstanding, when gender is addressed in terms of violence, men are very receptive and understand it, especially since it is a very concrete ‘combat’ topic and is related to human rights.

Codes of conduct rarely address gender issues.

In the nine UNFPA case studies, the review looked at the extent to which codes of conducts mentioned gender equity, including protection over gender-based violence, concerns for safe and respectful behaviour, respect of HIV status and human rights of civilian populations. Except for Benin, countries in Latin America, and peacekeepers sent overseas, the codes of conduct of general staff did not refer specifically to respect of

gender equity and human rights, nor to the army's responsibility in reducing gender-based violence.

In Benin, general reference is made to equal opportunity to staff. However, women are not allowed to marry or have children before completing three years of service and men have to serve five years before they can marry. This code of conduct is also more specific about granting parents in the military with maternity leave (14 weeks) and paternity leave (three days). Sexual harassment is also severely punished. However, sexual relations, homosexuality, children outside of marriage and prostitution are not specifically addressed in the disciplinary rules.

In Mongolia, there is a general commitment to the human rights of conscripts with respect to their working conditions, but gender equity, sexual relations or sexual abuse and harassment are not addressed in the army rules. Sexual relations are not an open topic for discussion in the units. Nothing is mentioned about gender relations and how to communicate with women, either on the base or with civilians. In Botswana and Ukraine, any type of violence against vulnerable civilians such as women and children, is strongly discouraged. However, only peacekeepers are trained to apply the ten rules related to violence against women, and safe and respectful sexual conduct.

Advocacy at the highest level is needed to amend army codes of conduct to reflect and enforce new training on reproductive and sexual health and human rights of personnel and civilians. These should, specifically mention reproductive rights, sexual relations, rights of sex workers;, gender-based violence, including sexual harassment, and domestic violence.

Women's reproductive health and rights are not often addressed.

Family health, including family planning and safe motherhood (healthy pregnancies, pre- and post-natal care, and attended childbirth) continue to be neglected by the military, while HIV prevention is dealt with in a rather vertical and biomedical fashion.

HIV should be integrated in a wider gender perspective, and concerns for both female and male reproductive and sexual health should include the implementation of complete health-care services to military personnel and their families.

However, this is changing in armed forces that have recently embraced development into their scope of work. Meeting the needs of their families and civilians in nearby communities is becoming a priority. It is through this window that the military is becoming increasingly aware of reproductive health.

Moving from vertical focus on family planning or HIV/AIDS prevention to a wider reproductive health and gender perspective is not straightforward and requires careful preparation, such as advocacy seminars with top leaders and mid-level trainers and service providers, better communication between health and social welfare units of the military and access to reproductive health commodities.

Women are often not included as project beneficiaries.

Only three projects – in Benin, Ecuador and Madagascar – included spouses as project beneficiaries. In all the others, the practical health, educational and legal needs of women, spouses or personnel, in education and health services are neglected.

Too much focus on men can lead to resentment. In Botswana, female health service providers complained that the only beneficiaries were men. Some of the male beneficiaries also expressed a desire to have their spouses involved in the project.

In general, there is lack of a gender perspective in: addressing practical and strategic reproductive health needs of women personnel and equal access to external resources; incorporating gender-based violence in code of conducts; and talking about masculinities, sexuality, violence, sex workers, and risk cultures.

Institutionalization and prospects for expansion

The military sector has been slow in recognizing the relevance of sexual and reproductive heath to its personnel. It is only beginning to understand its exposure to HIV/AIDS, but still fails to recognize the AIDS pandemic as a cross-sectoral problem, fueled by poverty and gender inequality.

Until recently the military community was excluded from efforts to satisfy unmet reproductive and sexual health needs and to change social norms regarding gender equity and human rights.

However, the projects recently reviewed in the nine countries confirmed that the military offers an ideal setting that can readily be adapted for training, educating, managing, counselling and providing reproductive and sexual care for people at risk, and for modifying the social and policy conditions that encourage risk taking.

Reaching, convincing and motivating top personnel of military institutions that reproductive and sexual health is a military concern is essential. This is a time-consuming but critical activity because it increases motivation and assures wider participation. Once top officials are motivated, they can demand wide participation of their troops in workshops, discussions and talks on reproductive and sexual health and gender issues. Advocacy to engage key decision-makers in the plans early on is a prerequisite for reproductive health projects that target ‘closed’ institutions such as the armed forces and police.

Advocacy directed at mid-level officers is needed to make sure that unit commanders understand the value of reproductive health educational activities. Mid-level authorities in the armed forces should be constantly encouraged to carry out their role of systematically supporting project activities by officers who are at the higher level in the chain of command.

In the nine countries, there is definite interest in scaling up the projects.

- In Nicaragua, a decree calls on the military to implement the reproductive and sexual health programme in all units and created health military degrees in reproductive health.
- After adopting a curriculum for its academies, Ukraine is also on its way to expanding training of conscripts of all combat arms.
- Madagascar plans to expand the project throughout the country although the challenge remains to work successfully in remote areas.
- Benin intends is to rehabilitate all the military health centres once the first five have been strengthened.
- Botswana aims to eventually reach the entire Botswana Defence Forces and to upscale and duplicate intervention models that work such as 'Widening choices for adolescent youth' applied in civilian youth centres. New approaches such as better marketing of gains in male involvement, male-only clinics, or exclusive male hours will also be piloted.
- In Namibia and Mongolia, it remains to be seen whether the military is ready to expand project coverage to other bases and units.

Yet, the challenges of institutionalizing sexual and reproductive health within the military should not be underestimated. For instance, integrating the reproductive and sexual health curricula into the military academies is not enough if delivery of services and supplies, including educational materials and condoms, cease once the project is completed. Gender equality and reproductive rights need additional advocacy work. This requires action at the international and national levels.

Educating officers and conscripts is not necessarily sufficient to change behaviour. Codes of conduct must be amended. Building on the military's reputation for achieving compliance, a complementary policy approach might be to include gender relations, sexuality, violence against women and human rights education, along the UN peacekeeping operations rules, in official codes of conduct.

More frequent exchanges among countries undertaking similar projects can be encouraged. Advocacy is further needed to demonstrate the cost-effectivenss of prevention compared to treating sexually transmitted infections and HIV/AIDS. Some colonels have expressed interest in learning more about the experiences of other armed forces such as Thailand, regarding sexual health and provision of condoms. Study tours could be organized.

At the national level, military authorities must acknowledge their contribution to solving health, social, economic and legal problems in their countries and adopt unambiguous policies for addressing them, whether the problems involve HIV/AIDS, STIs, high maternal mortality and morbidity, gender-based violence, substance abuse or women rights. In Nicaragua, the military publicly supported and praised the project as a fundamental strategy. In this regard, high-ranking officials supported their project leaders. The military also used its press, radio and television to promote the project,

inform people of upcoming activities and air some aspects of the project. The military made available its entire communication structure to the National Forum on Reproductive Health, which it organized.

At global level, the United Nations, partners and donor government need to cooperate so that military policies reflect internationally recognized conventions. At a regional/sub-regional level, the coordination with inter-country teams, other co-sponsors and partners, as well as regional and sub-regional mechanisms must be emphasized.

In general, militaries of the Latin America region seem more advanced in debating human rights than those of other regions. In Ecuador, Nicaragua and Paraguay, the constitution requires human rights training of officers; some limited discussion of reproductive rights is also included for high-ranking military officials of Nicaragua and Paraguay. However, reproductive rights training are not yet reaching health service providers.

In Benin, soldiers attend courses on international human rights. These courses have become more important since Benin started participating in peacekeeping exercises. Specially trained officers in collaboration with the International Committee of the Red Cross teach them.

CHANGING CONTEXTS FOR PARTNERING WITH THE ARMED FORCES ON HIV AND GENDER ISSUES

This section provides a brief overview of the social, political and health contexts within which the armed forces worldwide currently operate, and which affect the possibilities to partner with them on reproductive and sexual health and gender equity issues.

Changing roles, demographics and socio-economics of national military forces

The military is one of the biggest employers in the world, and attracts young men between the ages of 18-24, those most threatened by the HIV/AIDS pandemic. Most personnel in the armed forces and police are young sexually active people, predominantly men, under the age of 24, and at the peak of their sexual lives. One of every six people are considered fit and of age for military service. Policies and practices concerning conscription vary considerably from country to country. In most cases the proportion of eligible people who are actually drawn into military service is small. In many countries, a large proportion of the nation's young adults spend one or more years in the military. At the end of this stage, most of them will return to civilian life and will potentially affect the communities they return to.

Military personnel have often been forced to move and separate from families and partners. In addition, politically unstable regions have seen large mobilizations of hundreds of thousands of soldiers, including peacekeeping contingents for long periods of time and often with little or no rotation. Indeed, all displaced people, including mobilized soldiers, have to cope with new situations and demands over which they may have little power of decision-making or choice. Displacement causes families to separate, disrupting social support networks. Feelings of loneliness and isolation offer conditions whereby new social networks and interactions are created. Under these circumstances, human interactions may turn into spontaneous, clandestine, or illegal – and often unprotected – sexual interactions.

Growing numbers of women military personnel call for new policies

Women traditionally have not been actively recruited into the forces, and even today there are restrictions on the type of role they can play in the military. Even when enlisted, women have been primarily assigned to administrative, medical, and logistical management positions. However, over the course of the years, changing attitudes about the rights and roles of women have affected the military sector as much as the civilian sector. In addition, changing roles and technologies of the military, falling rates of men volunteering to enlist, and a growing involvement in international peacekeeping has opened new opportunities for female participation within the military.

Policies such as equal opportunity have also compelled the military to reconsider enlisting women. The European Court of Justice, for example, has argued that men and women must have equal opportunity and rights in the army, and that women should be

able to serve under the same rules and regulations as men. However, although the European Court of Justice argues for equality of rights, it also states that in the case of certain functions, gender can be considered a determinant during deployment. Thus, today gender remains grounds for exclusion of women from combat duty in a number of countries.

Other countries, on the other hand, specifically include women in combat functions. Since 1993, for example, Eritrea has required all men and women aged 18 to 40 to do 18 months of national military service. Between 1998 and 1999 (the Eritrean liberation war) when 30,000 Eritrean soldiers were sent to the Eritrean-Ethiopian front[11], an estimated 30 per cent were women[12].

The increasing number of female military personnel is leading the military to re-examine their health policies and programmes. Family care plans are necessary for pregnant female personnel. Several countries also recognize gender differences between sexes by defending the right of women to bear children and have a family. Indeed, well-established policies need to address several issues regarding maternity care treatment facilities, post-partum care, uniform sizes and overseas assignments. Maternity and paternity leave within the military are also taken seriously and policies are beginning to reflect this. For instance, most NATO militaries presently offer entitlements for maternity leave, often including pre and post-natal care. Paternity leave is also included in various countries.

Dependants also need to be considered in the full integration of female military personnel, through, for instance, the creation of childcare services for children of military service personnel.

Yet, in spite of these changes, most military personnel continue to work in medical, administrative and management units (56 per cent of total female personnel in France[13]), and as contractual staff.

Military in national budgets: A privileged sector in developing countries

Military expenditures in developed countries declined over the last decade, while those in developing countries remained relatively static. Some developing countries in the Middle

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[11] Gilmore, I. 1999. 'Women hold the line in Africa's forgotten war.' Web site: http://denden.com/Conflict/media.

[12] Barth, E. 2002. 'Reintegration of Female Soldiers in Africa: A Comparative Study'. *PRIO (Internet Journal)*.

[13] In the Land Force, 8 out of 10 women work in these specific sectors, as compared to 6 out of 10 women in the Air Force. Women who engage in professional activities in this sector are, on average, older than other female personnel. Among women aged 35 years and under, 51 per cent work in the administrative or management sector. Among women aged 35 years or older, the proportion is 64 per cent. Source: DFP/OSD. 'Direction de personnel des armies'. Web site: http://www.defense.gouv.fr.

East, Asia and Africa are increasing their military spending. Military expenditures in developing countries account for 21 per cent of total global military expenditures in 1994.

In general, public spending on military in developing countries outpaces health funding. While industrialized countries tend to spend more on health and education and less on the military[14], in most developing countries, military expenditures have remained higher than both health and education expenditures, even though social spending has increased. Areas such as health and education are not getting the attention needed to achieve international development goals, while relatively high allocations are being made to the defence sector[15].

Military expenditures on HIV/AIDS prevention, just as on reproductive health and gender-based initiatives, are difficult to assess. Countries rarely report on this, and within the military, it is often considered to be a matter of security and not available to the public. In general, however, funding for HIV/AIDS prevention has been limited.

Increased attention to health vulnerabilities of military personnel

HIV/AIDS within the military constitutes a growing challenge to national security and certainly to the health and the day-to-day capacity of military personnel. Attention is increasingly being directed at the vulnerability of military personnel to HIV/AIDS and other sexually transmitted infections, as well as to the possible role military personnel could play in preventing HIV/AIDS within their ranks and in the civilian communities they come in contact with.

A number of factors have contributed to this. The first is the growing evidence that historically rates of sexually transmitted infections have always tended to be higher among military personnel than among civilians. The second is that in some countries HIV/AIDS has become the leading cause of death among men and women of military service age, and that within some military forces the disease has become a major threat.

HIV/AIDS in the military, however, must be seen against the backdrop of the larger and still growing pandemic. Since 1981 more than 60 million people have been infected with HIV, and by 2002 some 40 million people were thought to be living with HIV/AIDS. Such is the current pace of spread of the disease that over 5 million new HIV infections occurred in 2001– approximately 14,000 people a day. AIDS-related mortality rates have also risen and at least 25 million people have already died of AIDS, approximately 3 million of them in 2001 alone. In some parts of the world, women have proved more vulnerable than men. Overall 17.6 million of the HIV positive adults are estimated to be women. In 2001, 1.8 million women were infected with the virus and 1.1 million women died from AIDS-related complications.

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[14] Sivard, R.L. 1993. *World military and social expenditures*. Washington, D.C. Web site: http://www.unicef.org/sowc96/8mlitary.htm.

[15] Annex I offers a comparative table on military expenditures as a percentage of GDP in several developing countries. A comparison with both public and education expenditures is given.

Vulnerability to AIDS has nevertheless been highly discriminatory in terms of people and places, and some professions have been disproportionately affected by the disease. The military in sub-Saharan Africa and elsewhere has been especially affected. There may be a number of reasons for this. First, the age profile of the military is such that most military personnel are between 19 and 49 and likely to be at the height of their sexual careers.

The military sector, moreover, has traditionally been a male-dominated institution in which high-risk behaviour is part of the informal culture. To what extent the military has seen fit to train its personnel on health matters, and in particular on disease prevention, appears to vary considerably among countries. But for the most part, little emphasis in developing countries has been given to the prevention of sexually transmitted diseases and HIV/AIDS. Indeed attention to reproductive health matters in general has been relatively weak.

Because of its age and gender profile, and the lack of attention given to health protection, the military has been particularly exposed to sexually transmitted diseases. This vulnerability has been heightened when military personnel have been stationed away from their families and regular sexual partners, and there are data that now suggest that STI rates have at times increased by over 100 per cent during deployment to other action zones. Although there are signs of a growing awareness among senior military policy makers of the need to address the problem of HIV/AIDS and issues such as gender violence, studies nevertheless suggest that knowledge among military personnel about reproductive health, HIV/AIDS and human rights remains low.

A growing international commitment to peacekeeping has also meant larger numbers of military personnel being sent to countries that often have very high rates of HIV/AIDS in the civilian populations. This – coupled with the fact that peacekeepers share the same characteristics as all other military personnel in terms of youth, sexual risk-behaviour and loneliness when away from home – has meant their potentially high exposure to HIV/AIDS and STIs in general. Infrequent rotation and extended deployment in combat or insecure zones where stress is high may exacerbate vulnerability. UN Security Council Resolution 1308 recognized the danger of HIV/AIDS in the case of peacekeeping forces and called for peacekeepers to be made fully aware of the problem and their exposure vulnerability. It called for education and counselling, including the option of voluntary counselling and testing.

Military personnel are at increased risk of HIV infection because they are[16]:

- By and large, young sexually active people
- Often away from home on duty
- May be more inclined to take risks
- Engage in risky sex, often with commercial sex workers

[16] Curran and Munywoki 2002.

- Subject to high stress periods, interspersed with long periods of boredom
- Suffer occupational stress and relax by abusing alcohol and drugs
- Less subject to social controls whilst on leave
- Deployed where drugs are easily available

The spread of HIV can have far reaching consequences for the military. It may:

- Reduce military readiness
- Create gaps in key personnel
- Cause loss of skills and experience
- Affect teamwork as key workers are lost and positions replaced
- Cause loss of morale
- Affect the climate of trust between soldiers[17]

Unequal power relations between armed forces and civilians

In many countries military personnel (unless they are deployed elsewhere) are fully integrated within their local communities and often live with their families rather than in barracks. If deployed, their contact with the nearby communities is highly variable. In some cases, the role of the military may be one of aggression in which interaction with the civilian community assumes a particular character and is open to abuse. If deployment is for peaceful purposes, the interaction with the local community is likely to be far less abusive.

The latter part of the 20th century, especially the period that followed the wars in Bosnia and Rwanda, gave birth to a growing concern about the impact of conflicts on women and the role of war in the spread of HIV/AIDS and other sexually transmitted infections. The wars in Bosnia and Rwanda were characterized by, among other things, widespread rape and sexual abuse, and throughout the world the massive uprooting and displacement of civilian and military populations appeared to be associated with a growth in the vulnerability of people to sexually risky behaviours and related infections.

Social instability and masculinities are not the sole reasons for the spread of STIs and HIV/AIDS. Economic and social factors and poverty also contribute to the spread of HIV/AIDS among military personnel. In most countries, the military are paid less than the average civilian. However, in situations of internal or external conflict, they are often paid more than civilians in the areas they have been sent to secure, and thus may attract sex workers. In all circumstances, however, military personnel have traditionally attracted a sex industry, be it informal or formal, and military status, even under peacetime conditions, may lend itself to some degree of abusive or exploitative relationships with local communities and women.

In several countries, following pressure to downsize the military in order to cut costs and rationalize public expenditures, together with peace building efforts, the military has

[17] Ibid.

established a systematic way of demobilizing ex-combatants. This involves assembling large numbers of military personnel and training them in skills they can use as civilians. Post-conflict reconstruction and peace processes bring about an important activity of demobilization that is usually promoted and can be financed by external donors.

Demobilization of former combatants provides a unique opportunity to reach a captive and obedient audience eager to obtain information and services such as screening and treatment of STIs. Nowhere are the need and opportunity to raise awareness about HIV/AIDS, STIs and other reproductive health and gender issues greater than in the context of demobilization. The training and preparation of military personnel to enter into civilian life offers great possibilities for health and sexual behaviour achievements as well as new responsibilities. During cantonment and reinsertion when military personnel are routinely gathered together, they form a 'captive' audience that is not only disciplined but may also be eager to get information and instruction on what they can do as civilians. Ex-combatants are likely to want to establish a health record and participate in knowledge, attitudes, beliefs and practices surveys, since this is their first contact with health authorities.

Global agreements to involve the defence sector

The need for the military to give more attention to HIV/AIDS and social issues such as the rights of women and gender violence has not been lost on national policy makers. The African Development Forum of 2000 in Addis Ababa referred to the importance of the military in playing a 'leading role' in prevention of HIV/AIDS and violence against women and girls.

In 2000, the UN Security Council also adopted a Resolution (1325), specifically calling on "…all parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict." In 2001, two International Criminal Tribunals for Rwanda and the former Yugoslavia also began to demonstrate the extent to which the international community was willing to go in upholding the rights of civilian populations in times of war. Both tribunals handed down severe sentences on sexual violence committed against women during conflict using terms such as 'crimes of genocide' and 'crimes against humanity'.

In 2001 the UN again took up the issue of HIV/AIDS in the military. In its Declaration of the United Nations Special Sessions on HIV/AIDS, it recommended that by 2003 every country have national strategies and policies on HIV/AIDS education, prevention and training for military and uniformed services in general.

The African Consensus and Plan of Action of 2000 argues that "armies must provide for soldiers who are living with HIV" and virtually all armed forces worldwide do appear to provide care and support for military personnel with AIDS and their families. Most militaries keep HIV positive military personnel on active duty until medical indicators suggest they may be unfit for active duty, and at that time military personnel tend to be

medically retired with full benefits for themselves and their families. Care and treatment of HIV-infected military, however, can bring with it stigmatization, and much remains to be done to ensure that people with HIV/AIDS not only receive care and support but are also not excluded psychosocially.

Numerous conflicts worldwide and the growing international commitment to peacekeeping mean that larger numbers of military are being deployed to conflict and post-conflict situations. Thus, more soldiers are susceptible to STIs/HIV/AIDS. Since 1980, AIDS has been the main cause of death among peacekeepers.[18]

The UN Security Council Resolution 1308 is largely responsible for the military sector increasing education on HIV/AIDS and providing voluntary counselling and testing. This resolution recognized peacekeepers vulnerabilities to contracting HIV/AIDS and resolved to address this problem by requiring peacekeepers to be fully aware of their risk of exposure through education and counselling.

It has become increasingly apparent that women and young girls are especially vulnerable in war and conflict situations. This concern was addressed in a Co-operation Framework between UNAIDS and UNIFEM. It includes a provision that requires AIDS awareness and gender training of uniformed services involved in peacekeeping operations.

Shortly after this resolution passed, UNAIDS initiated a Co-operation Framework with UN Department of Peacekeeping Operations (DPKO) with the objective of introducing a comprehensive HIV/AIDS awareness campaign within DPKO personnel. The targeted population includes civilians as well as peacekeeper personnel and extends to humanitarian aid workers and host communities. This campaign promoted the introduction of the 'HIV/AIDS Awareness Card for Peacekeeping Operations'. This Awareness Card consists of a plastic card containing basic information about HIV/AIDS and the Code of Conduct that peacekeepers should follow. These cards were issued in 10 major languages and were distributed and tested in Sierra Leone. The cards are now distributed to all major UN peacekeeping operations.

[18] International Centre for Migration and Health and Tulane University's Payson Centre for International Development and Technology Transfer. 2000. 'Consultation on Population Movement, HIV/AIDS, Complex Emergencies and Reconstruction'. Kenya, 29-31 July 2000.

Military and human rights in Paraguay

The Statutes of Military Personnel[19] and the *Personnel Military Statutes* refer to conscientious duty and military honour that imposes a 'faultless' standard of moral and professional conduct on each member of the armed forces and implies a whole set of precepts. These include:

- Dignity and pride in service
- Rigorous adherence to procedures and compliance with orders
- Professional honesty and firmness of character
- Discretion in conduct and prudence in language
- Proper conduct, whether on duty or leave
- Discipline, respect and military decorum
- Self- sacrifice, including giving up one's life, when the interest of the Paraguayan nation demands it.

Armed forces personnel are also exempt from following any order that seriously violates fundamental human rights or undermines the constitutional system or legitimate constitutional entities. The Human Rights Division of the armed forces supposedly promotes some activities in this area, but researchers for this case study were not able to talk directly to those in charge of it.

The armed forces accept the existence of homosexuals[20] 'either due to habit or sickness,' but they do not allow them in barracks because it is believed their presence can be destabilizing. Since they realize this could raise charges of discrimination, they are beginning to use existing laws that excuse, temporarily, civilians who are ill or physically challenged from employment by the Auxiliary Services of the armed forces or Police Institutions.[21]

Personnel rules do not address sexual abuse. Military tribunals judge only military crimes and offences. Cases of premeditated actions subject to the penal or civil code are resolved through the regular judicial system. For instance, claims of sexual abuse are governed by the civil code. Child support is deducted from the salaries of those in the military who are delinquent in paying.

The personnel statutes do not address equal opportunity between men and women, based on the fact that until recently the military, which was originally considered to be a masculine institution, did not include women. Women with university degrees now have the right to join the military as career officers or non-commissioned officers. Some civilian women teach in the training centres. As of 2003 a small number of women, which will increase annually, will be able to join the ranks.

Opportunities for change and emerging good practices in prevention

Military personnel never live in isolation. They constantly interact with people in the communities they are deployed in and around, and most have families and partners with whom they maintain relationships and visit from time to time. When they retire or are

[19] The reorganization of the armed forces presented in 1996 is still being debated in Congress.
[20] The text uses the terms used by military personnel, as people who present behaviours considered, though stereotypical, effeminate.
[21] Article 43 of Law 569/75.

demobilized (as is occurring more and more as part of cost-cutting practices), and where there has been high exposure to HIV/AIDS and little education on prevention their return and social insertion in local communities can be fraught with risks for all concerned.

At the same time it is becoming increasingly evident that while in the military and even during the process of demobilization, there may be important opportunities and ways of reaching personnel with systematic training and education on HIV/AIDS, social responsibility and gender issues. Indeed the military arena may be able to provide one of the most unique settings for reaching people with information on these themes. This is because military personnel are a relatively captive audience while in the military and are used to receiving new information and in-service training and upgrading of skills education.

They are for the most part also highly disciplined and certainly more so than local non-military populations, so that instructions are more likely to be followed than is the case in non-military populations. At the same time, the emphasis given to maintaining an 'esprit de corps' that involves cohesion around selected and agreed-upon principles, may open doors to creating new cultures of health awareness and greater sensibilities and commitment to social issues.

A number of HIV/AIDS education and prevention programmes have already begun to demonstrate their effectiveness. In South Africa, for example, anti-AIDS campaigns have led to 95 per cent of soldiers agreeing to carry out voluntary testing for HIV; moreover, there has been a reported decline in rates of HIV infection among South African soldiers sent on international missions. In Uganda, HIV infection rates among the military have also dropped dramatically, from 25 per cent in 1990 to 13-14 per cent in the mid-1990s to below 8 per cent today. HIV rates in Uganda's military are now lower than in the civilian population.

Thailand has also seen its rates of HIV infection in the military fall significantly as a result of its rigorous implementation of an HIV/AIDS prevention strategy. The Royal Thai Army accepted early on the fact that the epidemic could pose a major threat to its personnel and to national security as a whole, and implemented a campaign that has had considerable success.

These successes have helped raise important questions about the role that the military and ex combatants could play in reproductive and sexual health promotion in the civilian community. In Bolivia, a programme on training and health promotion called the 'Sentinels of Health' was established in 1991 to prepare military conscripts for community work in disease prevention and health promotion. Training covers 50 basic health messages on home hygiene, nutrition, oral health, safe water and disposable waste, immunization, respiratory infections, oral rehydration, prenatal care, family planning, childhood growth and development and HIV/AIDS. More than 200,000 young men have taken part in the training and reach an estimated 35,000 to 40,000 people per year with health information and education.

The Peruvian army and police forces are also implementing a training programme on the theme of 'Sexual Health, Reproductive Health, Sexual Rights and Reproductive Rights'. One of the main goals of the programme is to teach the military and police members to see themselves as 'health-care agents' and to transmit their own knowledge and experiences. It emphasizes the role individuals can play in promoting responsible sexuality, gender equity, sexual health self-care, and reproductive health. Aimed at conscripts under the age of 20, the training is given by young graduates of the military academy. Paraguay also plans to insert these same courses to the curricula of all its military institutions in the belief that the programme will be beneficial to the armed forces and to civilians.

Bolivia military peer health educators

The 'Sentinels of Health' Programme incorporated in Bolivia during 1991 is one of the most effective programmes on using peers for training and health promotion in the military. For $3 per month per conscript, military conscripts were trained into peers in the fight against diseases, by becoming effective health communicators. A two-week Sentinels of Health training course teaches military conscripts, with the help of the 'Para la Vida' booklet produced by UNICEF, WHO and UNESCO, over 50 basic health messages (home hygiene, nutrition, oral health, safe water and disposable waste, immunization, respiratory infections, oral re-hydration). Prenatal care, family planning, and childhood growth and development are given great emphasis. Today, up to 200,000 young men have taken the training enabling the education of 35,000 to 40,000 people every year about health. This programme places male military conscripts in a position where they can play a fundamental role in the re-education of traditional rural Bolivian society about health and the rights of women and their reproductive rights.

Challenges for HIV prevention in the military

HIV testing

HIV/AIDS prevention in the military has not been without its difficulties, however. One of the most controversial health-related issues to emerge has been and continues to be the question of HIV testing. Military authorities are not only grappling with the circumstances under which testing should be conducted, but they are also concerned about the outcome of such tests and whether results should be released.

Those opposed to universal testing and screening have raised concerns about its reliability, its expense, and its implications for human rights and privacy. It has also been opposed on the grounds that it may have adverse effects on military staffing patterns. Advocates, on the other hand, claim it could help maintain the readiness of the military, strengthen national security, protect the military's investment in personnel training, enable better care of military personnel with HIV/AIDS, and facilitate better HIV/AIDS prevention and promotion. An Expert Panel on HIV Testing in UN Peacekeeping Operations in 2001 nevertheless reported that current UN policy embraces the principle of voluntary and confidential counselling and testing (VCCT).

Voluntary testing and counselling remains by far the most accepted approach but there have been a number of problems. They include the cost of long-term counselling; ensuring confidentiality within the military, especially with respect to commanding officers; the denial of selected postings based on HIV status; and confusion about the term 'voluntary' in the context of peacekeeping forces.

To date, only a few military forces have adopted mass testing or screening policies and for the most part the issue has remained controversial. What to do with those who are identified as HIV infected remains a major ethical, economic, clinical and public health concern. Some militaries prohibit foreign deployment of military personnel with HIV on the grounds that their health could be compromised further. Others do so on the grounds that compromised health has implications for efficacy of performance. On the whole, however, the issue remains unresolved and one of national jurisdiction. Thus even in international peacekeeping operations there remains the possibility of variance between national contingents.

UNAIDS is opposed to routine universal HIV testing. WHO is opposed to testing without consent. UNDPKO recommends that all nations supplying personnel for peacekeeping missions should test such personnel for HIV antibodies and not deploy those who test positive. The UN protocol recommends that only medically fit and HIV-negative armed forces should be dispatched on peacekeeping operations. Post-deployment testing rarely takes place.

'The Post Test Club & GIPA Project' in Uganda

The 'Nowadays' project consists of a support group for military personnel and their families who go through the process of VCT, regardless of their serostatus. Any individual testing negative receives education and support allowing them to remain negative and encouraging them to participate in advocacy for VCT. People living with HIV/AIDS receive on-going support with specific emphasis on the concept of positive living and quality of life. They are also encouraged to participate in HIV prevention and AIDS care programmes and recreational activities.

Some of the main objectives of this Club are to raise a voice and lobby to obtain improved care and support from the Army authorities. They are also trying to create networks and partnerships with other support organizations and become actively involved in HIV prevention and AIDS care activities. In the near future, child and orphan care initiatives will be initiated together with the creation of a platform for sharing experiences.

The Uganda People's Defence Forces programme shows that it is possible to live with HIV/AIDS within the military. This programme has gained important reduction levels of stigma and discrimination, building up confidence, hope and keeping up the professionalism at an adequate grade. From the Uganda's programme we can conclude that military populations require more comprehensive programmes on HIV/AIDS that explore all aspects of vulnerability, and take into account care and support issues.

Condoms

In addition to VCT, condom promotion and provision is seen as one of the most powerful tools in preventing HIV/AIDS and STIs. But in some countries there have been problems translating this knowledge into action within the military. Financial implications have been one of the more important constraints together with the fact that, to-date insufficient attention has been given to training on personal reproductive and sexual health. Many countries feel that distribution of condoms is not in itself sufficient.

Successful condom initiatives, however, have been reported. In Thailand, which was one of the first countries to recognize the problem of HIV/AIDS as a national security problem, the '100 per cent Condom Programme' was initially designed to reduce STI and HIV infection rates among brothel-based sex workers, injecting drug users and men having sex with men. With time this condom initiative, which also includes intensive education and information, was extended to military recruits. A study carried out in 1996 in the Royal Thai Army showed a decline in HIV prevalence rates from 12.5 per cent in 1993 to 6.7 per cent in 1995. In addition the study also highlighted a sustained and significant change in behaviour and in "safe sex' understanding.

Condom programming Ethiopia

With regards to condom promotion and distribution, the Ethiopian military, whose high priority is HIV/AIDS prevention and control, began interventions during the demobilization of troops after the Eritrea-Ethiopia border conflict. It purchased 17 million condoms from the Ethiopia Social Marketing Programme (ESMP), while conducting training programmes on HIV awareness and on proper and consistent use of condoms for military personnel.[22]

Policies governing military life, including family relations

Every country has a code of conduct that its military is obliged to follow. The code sets out standards of behaviour and values expected of all service personnel regardless of rank, status and gender. These include moral principles that guide the soldier under difficult circumstances, such as being taken prisoner. Army rules also include how to communicate with other ranks and with civilian populations, and whether military personnel can engage in political life.

Other national policy issues, which have gained general agreement include: recruitment, incapacity, periodic assessment, surveillance and monitoring, prevention, counselling, care, research and resource allocation. [23]

[22] USAID, AIDSCAP, USAID, 2000.
[23] Healthlink Worldwide and Panos London. 2002. 'Combat AIDS: HIV and the World's Armed Forces'.

The African Military Code of Conduct

Several African countries (namely Benin, Burkina Faso, Cameroon, Central African Republic, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Liberia, Libya, Mali, Niger, Nigeria, Republic of Congo, Senegal, Sierra Leone and Togo) have adopted a draft code of conduct for military and armed forces, which aims to recognize laws and regulations that will dictate relationship between civilians and the military, the armed forces and security forces, armed/security forces and human rights, international humanitarian law and the implementation of the code of conduct.[24]

This African Military Code of Conduct specifically stipulates that personnel of armed and security forces must abstain at all times from murder, any cruel, inhuman or degrading treatment such as torture, corporal punishment, *rape* and mutilation, hostage taking, collective punishments or any other acts that harm the physical and/or psychological integrity and well-being of individuals. Accepted in Lome, the draft is being submitted to the African Union for consideration by its council of ministers and head of states and government summit. After its adoption it will be implemented in military academies, barracks and other institutions. Focus is given on the active participation and partnership of civilian populations.

Human rights issues

As the military increasingly becomes responsible for the security of civilians, it should familiarize itself with human rights principles to assure that its members will not violate them and will be able to protect civilians whose rights are abused. The right to life, gender and individual equality, security of the person, equal protection under the law, general freedom, and prohibition of torture and other cruel and inhumane acts are a few of those principles. To promote, protect, respect and facilitate the rights of all conflict-affected populations is also the responsibility of the national military, which should respond to it by educating its members effectively and firmly.

Responding to this, various changes within the human rights field have recently taken place. The Vienna Declaration adopted by the World Conference on Human Rights in 1993 and the Beijing Platform of Action adopted by the Fourth World Conference on Women in 1995 states that victims should be properly redressed and that the perpetrators should be punished. The International Tribunal on War Crimes is one of the instruments implemented to recognize and prosecute as a legitimate crime any act of violence. Established by the United Nations in the early 1990s, this tribunal tried war crimes committed in the former Yugoslavia and Rwanda. In addition, other tribunals, such as the 2000 Women's International War Crimes Tribunal (also known as the Tokyo Tribunal), which focuses on Japanese[25] Military Sexual Slavery, have been set up. This tribunal addresses the sexual slavery forced on 'comfort women' by Japan's military occupation before the Second World War. The tribunal recognizes the active role that uniformed

[24] Ocnus.net. 31 May 2002. 'African Military Code of Conduct'. Web site: http://www.ocnus.net/artman/publish/printer_643.shtml.

[25] Victimized countries included China, Democratic People's Republic of Korea, Indonesia, Japan, Malaysia, Philippines, Republic of Korea, Taiwan Province of China and Timor-Leste.

services have played in reproductive, sexual and gender rights violations and emphasizes the long physical and psychological suffering endured by victimized women.

In addition to military courts and the Tribunal on War Crimes, codes of conduct have also become major instruments for setting standards of behaviour and values expected of the military regardless of rank, gender or sexual orientations. As well as defining the right to a private life, and principles of respectful personal behaviour, these codes emphasize moral guidance for personnel in difficult situations.

Unresolved gender issues with the military

In addition to HIV/AIDS-related issues, the question of gender violence has also assumed high priority in many military forces. Although they account for a small proportion of the armed forces, female military personnel may be especially vulnerable to gender equity violations and violence. Lower status female personnel or contractual staff may be at particular risk because armies are predominately male and the organization is hierarchical.

Furthermore, the severity and seriousness of physical aggression by military men against their wives and partners is much greater than that by civilian men. A National Family Violence Survey carried out in 1985 within the US Army reported that one in three military spouses were victims of mild to moderate forms of domestic violence, and found that domestic violence in the military is as much as two times higher than among civilians. A major ‘zero tolerance’ programme and a Family Advocacy Programme that emphasized reproductive rights followed the survey and appears to have been highly successful in preventing gender discrimination and violence. In Uruguay where the Army Health Service Unit reported that over half of all the women in the military had been verbally harassed by comrades and a third had been exposed to domestic violence, a nationwide training programme was started for health care staff so they would be in a better position to identify and counsel both victims and perpetrators.

In Belgium the General Military Staff has a training programme that has produced over a hundred highly qualified counselors who work with military personnel in all the forces. In addition, an independent service has been started to resolve complaints of sexual harassment, mobbing, discrimination and violent or disrespectful behavior. An earlier survey found that 54 per cent of military women had been faced with sexually disrespectful remarks and 22 per cent claimed they have received sexual propositions linked with threats or abuse of power.

Gender equity in the armed forces of Norway is being approached through a Strategic Plan for Gender Equality in the Armed Forces, which addresses proficiency enhancement, recruitment, family policy, and real career opportunities for women. In addition, the Norwegian military has taken up a strong gender/sexual harassment policy that outlines in detail what actions will be taken in cases of sexual violence, rape and sexual/gender harassment of all kinds.

Conclusion

In summary, there is growing evidence of military forces taking up the theme of gender-based violence, and working with their personnel to reduce violence against women of all kinds, both during peacetime and during periods of war. Recent actions in Africa to establish codes of conduct for military personnel represent an important step forward, indicative of what may emerge in the future. Similarly, actions taken in other parts of the world, for example, in the US, Belgium and Norway, to prevent sexual harassment within the military, provide examples of how women's rights, reproductive rights and indeed human rights are beginning to assume an important position in the culture of the military.

Despite the challenge that these issues constitute, there is growing evidence that the military sector presents a unique opportunity for reproductive health promotion and HIV/AIDS prevention. Within the military, the discipline, accessibility and willingness to be trained means that in all countries a relatively large group of sexually active men and women can be reached with HIV/AIDS prevention strategies and actions. Although many countries have still not taken decisions to build on this opportunity, there is evidence that more and more countries are becoming more aware of the opportunity and are beginning to allocate appropriate resources and energies to this.

Well documented examples of how military personnel can be trained to work effectively with the communities they live in and become active agents of health promotion including HIV/AIDS prevention, is likely to increase this interest.

CONCLUSION: THE MILITARY INSTITUTION AS SOCIAL CHANGE AGENT

A set of military and civil-military 'best practices' is now emerging that includes education for the prevention of STIs and HIV, condom promotion and provision, voluntary HIV testing and counselling, reproductive health services, and partnering with men. However, other reproductive and sexual health needs, gender and human rights issues, including promotion of gender equity and elimination of gender-based violence, are not systematically addressed.

Any plan of action to introduce reproductive and sexual health into the military health system should also consider the wide-ranging cultural and ethnic diversities and educational levels among military personnel.

Latin America is not yet addressing the problem of HIV/AIDS, as this issue still has less visibility there, whereas countries of this region are addressing gender equity and human rights issues more so than in other regions. The Nicaraguan model comes closest to addressing all issues within reproductive and sexual health and human rights perspectives.

Uniformed services are a highly organized setting, encompassing a large and disciplined population. Indeed, much can be done by building on the strengths of military culture, discipline, teamwork, command structures and institutional frameworks and readily adapting them for training, education and medical care. The military culture encourages teamwork and requires following orders from higher ranking officers, not only with respect to the preparation of new recruits, but also with respect to on-going readiness and continuous training of existing personnel.

This predisposition was found to be conducive to introducing and promoting preventive health measures that protect military personnel and civilians with whom they come into contact. Most military establishments have well developed educational and health infrastructures. Since training is such a dominant part of the military service, most military forces already have cadres of trainers and training facilities. This capacity can be directed towards a training of new and existing crew to the principles and practice of reproductive and sexual health at time of entering the uniformed forces and, as an on-going awareness programme, repeated at different stages in the military. This would enable an effective, rapid and cost-effective adaptation of services for reproductive and sexual health promotion within the uniformed services. In some countries, the military also has a communication network, including its own press, that could be used to raise awareness about such reproductive and sexual health issues as HIV/AIDS, human rights, gender equity and gender-based violence.

The army health systems could also offer comprehensive coverage that includes reproductive and sexual health services and counselling to members, their families and civilians in surrounding communities. However, therapeutic materials, drugs, condom provision, education and training programmes are very expensive, and more money coming from donors is needed in order to achieve all the objectives.

Consideration should also be given to involving HIV-positive and military personnel living with AIDS in designing approaches to reduce the spread of HIV/AIDS, and in defining audiences that should be targeted. Peer education programmes should be developed and/or strengthened so that trained military personnel who re-enter societies as civilians can serve as health agents. This is particularly applicable in the context of demobilization.

Hence, emphasis should be placed on the active role military personnel as agents of health and change. This, in turn could greatly reduce risk-taking behaviour, reproductive and sexual rights violations and improve the image of the military forces, while strengthening the self-esteem of military personnel themselves.

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Annex
A comparison of military, education and health expenditures in developing countries

COUNTRY	Military expenditures in US dollars	Military expenditures (% of GDP)	Public Expenditure on Education (% of GNP)	Public Expenditure on Health (% of GDP)	Total Expenditure on Health (% of GDP)
Ecuador	US$720 million (FY98)	3.4% (FY98)	3% (FY90)	2.6% (FY95) 1.7% (FY00)	4.7% (FY95) 3.6%
Cameroon	US$118.6million (FY00/01)	1.4% (FY98/99)	3% (FY99)	0.7% (FY95) 1% (FY00)	3.9% (FY95) 5% (FY00)
Central African Republic	US$29 million (FY96)	2.2% (FY96)	2% (FY99)	1.9% (FY95) 2% (FY00)	2.7% (FY95) 3% (FY00)
Democratic Republic of The Congo	US$250 million (FY97)	4.6% (FY97)	NA%	NA%	NA%
Angola	US$1.2 billion (FY97)	22% (FY99)	5% (FY95)	NA%	NA%
Cambodia	US$112 million (FY01 est.)	3% (FY01 est.)	6% (FY99)	0.4% (FY95) 0.9% (FY00)	6.5% (FY95) 6.9% (FY00)
Colombia	US$ 3 billion (FY00)	3.4% (FY00)	3% (FY90)	3.5% (FY95) 5.2% (FY00)	6.8% (FY95) 9.4% (FY00)
Ethiopia	US$138 million (FY98/99)	2.5% (FY98/99)	4% (FY99)	1.3% (FY95) 1.2% (FY00)	3.8% (FY95) 4.1% (FY00)
Ghana	US$53 million (FY99)	0.7% (FY99)	4% (FY99)	1.5% (FY95) 1.7% (FY00)	3.9% (FY95) 4.7% (FY00)
Kenya	US$197 million (FY98/99)	1.9% (FY98/99)	7% (FY99)	2.4% (FY95) 2.4% (FY00)	7.7% (FY95) 7.8% (FY00)
Lesotho	US$34 million (FY99)	NA%	10% (FY99)	3.4% (FY95)	NA%
Namibia	US$104.4 million (FY01)	2.6% (FY97/98)	8% (FY99)	4% (FY95) 3.3% (FY00)	7.5% (FY95) 7% (FY00)
Nicaragua	US$26 million (FY98)	1.2% (FY98)	5% (FY99)	9.1% (FY95) 8.5% (FY00)	13% (FY95) 12.5% (FY00)
Nigeria	US$360 million (FY00)	10% (FY00)	1% (FY90)	0.6% (FY95) 0.8% (FY00)	2.6% (FY95) 2.8% (FY00)
Peru	US$1 billion (FY00)	1.9% (FY00)	3% (FY99)	2.5% (FY95) 2.4% (FY00)	5.6% (FY95) 6.2% (FY00)
Senegal	US$68 million (FY97)	1.4% (FY97)	4% (FY99)	2.5% (FY95) 2.6% (FY00)	4.6% (FY95) 4.5% (FY00)
South Africa	US$2 billion (FY00/01)	1.5% (FY99/00)	6% (FY99)	2.9% (FY95) 3.3% (FY00)	6.6% (FY95) 7.2% (FY00)
Thailand	US$1.775 billion (FY00)	1.4% (FY00)	5% (FY99)	1.3% (FY95) 1.9% (FY00)	5.1% (FY95) 6% (FY00)
Uganda	US$95 million (FY98/99)	1.9% (FY98/99)	2% (FY99)	1.6% (FY95) 1.9% (FY00)	4.8% (FY95) 5.9% (FY00)

Ukraine	US$500 million (FY99)	1.4% (FY99)	5% (FY99)	4.9% (FY95) 2.9% (FY00)	5.8% (FY95) 4.4% (FY00)
Venezuela	US$934 million (FY99)	0.9% (FY99)	3% (FY90)	2.4% (FY95) 2.6% (FY00)	4% (FY95) 4.2% (FY00)
Zimbabwe	US$127 million (FY99/00)	3.1% (FY99/00)	12% (FY99)	2.4% (FY95) 3% (FY00)	5.8% (FY95) 8.1% (FY00)

Source: The World Fact book 2001, The Worldbank statistics: **http://genderstats.worldbank.org** and http://devdata.worldbank.org/hnpstats/