

**THE INDONESIAN MILITARY RESPONSE TO HIV/AIDS:
A FOCUS IN THE UNITED NATIONS PEACEKEEPING
OPERATIONS**

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THE INDONESIAN MILITARY RESPONSE TO HIV/AIDS:
A FOCUS IN THE UNITED NATIONS PEACEKEEPING OPERATIONS

A thesis submitted in partial fulfilment of the requirement for the degree of
Master of Public Health

by

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Table of contents

Table of contents.....	i
List of Tables, Figures and Boxes	iii
List of Abbreviations	iv
Acknowledgements.....	vi
Abstract.....	vii
Introduction	1
Chapter 1: Background information of Indonesia	2
1.1. Geography and demography.....	2
1.2. Health status.....	2
1.3. Economy	2
1.4. Indonesian Armed Forces and its Kontingen Garuda	3
1.4.1. The Indonesian Armed Forces	3
1.4.2. Kontingen Garuda.....	3
Chapter 2: Problem statement, objectives, and methodology	5
2.1. Problem statement.....	5
2.2. Study questions.....	6
2.3. Thesis objectives	7
2.3.1. General objectives	7
2.3.2. Specific objectives	7
2.4. Methodology	7
2.4.1. Study design	7
2.4.2. Study method	7
2.5. Study limitation	8
Chapter 3: United Nations Peacekeeping Operation	9
3.1. Peacekeeping Operation	9
3.2. HIV testing policy in UNDPKO	12
3.3. HIV/AIDS intervention for peacekeepers	13
3.3.1. HIV/AIDS Awareness card	14
3.3.2. Strategic Action Package	16
Chapter 4: Indonesian's HIV military programme in relation with Peacekeeping Operation	18
4.1. Indonesians in peacekeeping operation	18
4.2. HIV testing policy in TNI	18
4.2.1. Pre-deployment HIV testing	19
4.2.2. Post-deployment HIV testing	19
4.3. HIV prevention programme in TNI	20
4.3.1. HIV/AIDS peer leaders programme	20
4.3.2. HIV services in TNI	21
4.4. HIV prevention programme targeting Indonesian peacekeepers..	21
4.5. Ethical issues on HIV/AIDS in TNI	23
Chapter 5: Risky sexual behaviour among Indonesian peacekeepers	24
5.1. Knowledge of HIV among TNI personnel.....	24
5.2. Sexually Transmitted Infections issues among Indonesian peacekeepers	27
5.3. HIV incidence among TNI personnel	29

5.4. HIV incidence among Indonesian peacekeepers.....	29
Chapter 6: Discussion.....	31
Chapter 7: Conclusions and Recommendations.....	35
References:.....	36
Annexes	41
Annex 1: Framework (Andersen’s behavioural model).....	41
Annex 2: Referral military hospitals for HIV/AIDS cases in Indonesia .	42
Annex 3: Peer leader training schedule in TNI.....	43

List of Tables, Figures and Boxes

Table

Table 1. Current peacekeeping operation and the HIV prevalence of host Countries	10
Table 2. Top ten TCC and levels of HIV infection	10
Table 3. Risky sexual behaviour among TNI personnel	28
Table 4. The result of HIV testing among Indonesian peacekeepers	30

Figure

Figure 1. Source of HIV training in the mission area	15
Figure 2. Comprehensive knowledge of HIV among peacekeepers in Liberia	15
Figure 3. Knowledge level about HIV prevention (BSS 2003)	24
Figure 4. Right perception about HIV/AIDS (BSS 2003)	25
Figure 5. Comprehensive knowledge level about HIV prevention and right perception about HIV/AIDS (BSS 2003).....	26
Figure 6. Knowledge level about HIV prevention (IBSS 2007)	26
Figure 7. Comprehensive knowledge level about HIV prevention and right perception about HIV/AIDS (IBSS 2007)	27
Figure 8. HIV incidence in TNI	29

Box

Box 1. Six key points of the Indonesian achievement in peacekeeping operation	3
Box 2. HIV/AIDS policy in UNDPKO.....	13

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CD4	Cluster of differentiation 4
CHG	Commission on HIV/AIDS and Governance in Africa
CMA	Civil-Military to combat HIV/AIDS
DFID	the United Kingdom Department for International Development
DHAPP	Department of Defence HIV/AIDS Prevention Program
DoD	Department of Defence of the United States
ELISA	Enzyme-linked immunoabsorbent assay
FmedO	Force Medical Officer
FHI	Family Health International
FSW	Female Sex Workers
HBsAg	Hepatitis B serum antigen
HIV	Human Immunodeficiency Virus
HRM	High Risk Men
ICES	International Centre for Ethnic Studies
IDU	Injecting Drug User
ISS	Institute for Security Studies
MONUC	<i>Mission del 'Organisation des Nations Unies en Republique Democratique du Congo/United Nations Organisation/Mission in the Democratic Republic of Congo</i>
MSM	Men who have Sex with Men
NAC	National AIDS Commission
PKO	Peacekeeping Operation
PL	Peer Leaders
PLHIV	People Living with HIV
Puskes (Ind.)	<i>Pusat Kesehatan/Health Centre</i>
RTC	Regional Training Centre
SAP	Strategic Action Package
SGOT	Serum Glutamic-Oxalocetic Transaminase
SGPT	Serum Glutamic-Pyruvic Transaminase
STIs	Sexually Transmitted Infections
TNI (Ind.)	<i>Tentara Nasional Indonesia/the Indonesian Armed Forces</i>
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAMSIL	United Nations Mission in Sierra Leone
UNDPKO	United Nations Department of Peacekeeping Operations
UNIFIL	United Nations Force Interim in Lebanon
UNGASS	United Nations General Assembly on HIV/AIDS
UNDPKO	United Nations Department of Peacekeeping Operations
UNPKO	United Nations Peacekeeping Operations
UNSC	United Nations Security Council
UNTAC	United Nations Transitional Authority in Cambodia
USPACOM	United States Pacific Command

VCT
VCCT
WHO

Voluntary Counselling and Testing
Voluntary and Confidential Counselling and Testing
World Health Organisation

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Abstract

Background: The HIV epidemic continues to rise in Indonesian military. Military personnel are at increased risk of getting HIV infection due to their mobility and nature of work. To defend the country from any threats is the main duty of the military service. Besides that, Indonesia also participates to United Nations Peacekeeping Operations since 1957. In 1993 seven Indonesian peacekeepers returned from a mission with HIV. It was the first HIV reported-case in military. A survey carried out in 2003 showed that the knowledge of HIV among the soldiers is low. Since then, Indonesian military initiated the HIV prevention programme for its personnel, ten years after HIV-finding among Indonesian peacekeepers. The compulsory HIV testing as a part of military policy which started in 2003 finds HIV-positive cases among peacekeepers. The trend shows that the epidemic of HIV keeps on growing in Indonesian peacekeepers.

Study methods: The thesis is mainly used the primary data from Indonesian military headquarters. Most of the data are unpublished. A literature review was done to support the data analysis. The sources for the literature review were available at the KIT library and by searching from the internet.

Result: One HIV case in military personnel was reported to the Indonesian military health centre in 2000. The same number case was reported in 2001, and in 2002 there were 2 cases. The HIV case rose into 23 in 2003 and keeps going up. The Democratic Republic on Congo is the destination of peacekeepers since 2003. Later on, in 2006 up to now Indonesia sends peacekeepers to Lebanon as well. The HIV cases among Indonesian peacekeepers show the similar pattern to Indonesian soldiers in general. In post-deployment test after peacekeeping operation accomplished, 1 HIV case in both 2005 and 2006 found to be 2 in 2007 and 4 in 2008. While HIV issues among peacekeepers need to be addressed, the HIV epidemic among soldier posted in Papua Island may not be underestimated. This situation is reflected by a result survey in 2007, showing that HIV prevalence among soldiers in Papua Island is the highest, which is 1.2%, compared to 0.1-0.3% in other military-bases.

Conclusion: The HIV epidemic in Indonesian military keeps rising. The military has the HIV prevention programme in which the sustainability of this programme should be ensured by the Chief of Indonesian military. Emphatic approach from the high-rank officers in military is also needed to reduce stigma and discrimination issues surrounding personnel living with HIV/AIDS.

Keywords: HIV, AIDS, military, peacekeeping

Word count: 11,189

Introduction

Working in the military hospital as a medical doctor for 2.5 years was my duty before I decided to follow this course. My last position was the Head of Outpatient department in Air Force hospital in Surabaya, East Java province, Indonesia. I joined the Indonesian Armed Forces in 2005, and first Lieutenant is my rank now. My interest in HIV/AIDS started up in 2007 after attending a HIV training in one military hospital. The HIV epidemic in Indonesian military was presented during the training, showing the rising number. It made me aware that HIV epidemic in military should be taken into consideration.

In practice, there are several challenges that should be dealt with. The challenge is not limited to the financial sustainability of any HIV programme conducted in military only, but also in any other requirements. Stigma and discrimination towards the military personnel living with HIV/AIDS needs to be addressed as well. Another important remark is the HIV epidemic that may show differences between the peacekeepers, soldiers in general, and soldiers posted in Papua. This thesis is dedicated to understand better how HIV prevention programme being practiced by Indonesian military, particularly in terms of its participation in the United Nations Peacekeeping Operations.

Chapter 1: Background information of Indonesia

1.1. Geography and demography

Indonesia is the largest archipelago in the world with a total of 17,508 islands in a 5,120 km range of area (TNI in Brief, 2008). With 228 million inhabitants in 2007 (Statistic of Indonesia, 2008) Indonesia is the fourth most populous country in the world. Those huge size of lands and number of people have created various ethnic groups and local languages. To unite the diversity in Indonesia, Bahasa Indonesia has served as the lingua franca of Indonesian people.

1.2. Health status

Indonesian has life expectancy rate at 66.18 years. People living in Jakarta and Yogyakarta have the highest life expectancy rate, which is 72 years. Infant mortality rate is 43.50/1,000 live births, meanwhile maternal mortality rate is 307/100,000 live births. In general hospital, diarrhoea and gastroenteritis is the most prevalent infectious diseases (8.5%), followed by typhoid and paratyphoid fever, and dengue hemorrhagic fever (MoH, 2009).

Indonesia is considered a low level epidemic country with national HIV prevalence of 0.2% (NAC, 2007). There are approximately 193,000 people living with HIV (PLHIV). Out of this number, 46 % are injecting drug users (IDUs), 5% are female sex workers, whilst 14 % are sex workers' clients. This figure is an indication that HIV in Indonesia is generally concentrated among high-risk populations. The main transmission of HIV in Indonesia is through the use of contaminated injecting drug equipment and unprotected sex.

In Papua, which population represents 1 % of the total population of Indonesia, the HIV epidemic behaves differently. Papua is considered to have a generalized epidemic. The main transmission is unprotected sex. In 2006, a population-based survey in Papua province showed an estimated number of adult HIV prevalence of 2.4 % (NAC, 2007).

1.3. Economy

Indonesia has GDP (purchasing power parity): US\$ 935 billion (2006 est.) and GDP - per capita (PPP): US\$ 3,800 (2006 est.) (Popdev, 2007). The regional minimum wage differs from one province to another. The average wage is US\$ 100/month. In some remote areas, primary school teachers will have an income of less than US\$ 100/month. In a middle-level private company, a 5-year working accountant collects US\$ 260/month. An engineer's income is US\$ 330/month (SWA, 2006). And a foreigner who teaches English as his/her native language in a private English course can earn US\$ 800 – 1,500/month.

The salary of the Indonesian Armed Forces' (*Tentara Nasional Indonesia/TNI*) officer starts from around US\$ 300/month. Compared to the salaries from the various occupations above, the salary of TNI is can be seen as an average income in Indonesia.

1.4. Indonesian Armed Forces and its Kontingen Garuda

1.4.1. The Indonesian Armed Forces

The Republic Indonesia proclaimed its independence on 17th August, 1945. In order to keep its independence, Indonesia installed a defence power which called the Indonesian Armed Forces, *Tentara Nasional Indonesia* (TNI). TNI was established on 5 October 1945, under the leadership of General Sudirman (Rabasa and Haseman, 2002) .TNI consists of three main forces: the army, navy, and air force. According to the data from TNI headquarters (2009),the three forces combined have a total of 459,739 personnel. This number includes 57,991 civilians who work for the military. Personnel are being posted in military bases all over Indonesia and are rotated between bases.

The central government puts aside a relatively small amount in its budget for TNI; equivalent to 0.9 percent of GDP (Rieffel and Pramodawardani, 2007). As a result, TNI faces the difficulties in providing proper facilities for its personnel, such as housing.

1.4.2. Kontingen Garuda

TNI also dispatches it personnel to international missions. This group of soldiers is called "Kontingen Garuda". The Kontingen joins United Nations Peacekeeping Operations (UNPKO) on an annual basis.

The first involvement of TNI in UNPKO was in the Sinai, 1957. Indonesian success story with its Kontingen Garuda XII was on the mission of the *United Nations Transitional Authority in Cambodia* (UNTAC) in 1992-1993, the largest and highly cost UNPKO to date. These conflicts related to the Khmer Rouge (Red Khmer) which could not be solved nationally, requested the engagement of the Indonesian contingent to come to a viable solution (Haseman, 1996).

Cambodia and Indonesia have a long history together; ever since the ancient time there has been a relation between kingdoms on Java and in Cambodia. The similarity in culture and skin-colour and the willingness of Indonesian to learn the Cambodian language created a mutual relationship that could hardly be built by another contingent.

An Indonesian high-rank army officer who served as UNTAC military chief of staff summarized six key points of the Indonesian achievement in Cambodia which could be useful in the implementation of interventions by any other PKO. These key points are as mentioned in the box below:

Box 1: Six key points of the Indonesian achievement

1. Develop broad knowledge of the area operations, including geography, socio-economic conditions, culture, customs, and religion;
2. Maintain vigorous standards in selecting personnel and units, including psychological testing;
3. Require high standards of personal and unit discipline since

- soldiers routinely face situations requiring great restraint;
4. Besides English, key contingent leaders should master the language of the area and individual soldiers should have a basic vocabulary in both English and the local language;
 5. Train officers in negotiation techniques and other diplomatic skills;
 6. Ensure that civic action and humanitarian assistance are an integral part of military doctrine. While not always thought of as integral to peace operations, they proved successful in Cambodia and were the basis for winning popular support and thus cooperation from the various factions.

(Source: Haseman, 1996).

Other country destinations for UNPKO in which Indonesians are being involved are the Democratic Republic of Congo (DRC) and Lebanon. Kontingen Garuda is continuously joining MONUC (*Mission Del 'Organisation des Nations Unies en Republique Democratique du Congo/United Nations Organisation Mission in the Democratic Republic of Congo*) and UNIFIL (United Nations Interim Force in Lebanon).

Chapter 2: Problem statement, objectives, and methodology

2.1. Problem statement

For decades or even centuries, military institutions tried to provide information about the danger of prostitution, unsafe sex, and sexually transmitted infections (STIs) to their soldiers. Despite the absence of cure, at the time for syphilis (Bratt, 2002) and since 25 years for HIV, soldiers continue to practice unsafe sex. During this time, some military institutions have put efforts into protecting their soldiers from being infected with HIV by providing information, care, support, and treatment. Others did not and continue to deny the risk and presence of HIV among their personnel (Expert Panel, 2001).

Studies in many countries show that men and women in armed forces generally have a higher risk of contracting with HIV infection as compared to the civilian population (UNAIDS, 1998). This situation challenges the military institutions to introduce safe sex strategies in order to prevent STIs/HIV infections among their soldiers. In Asia, the military officers put HIV/AIDS into their consideration, by conducting "Asia-Pacific Military Medicine Conference". The 13th conference in 2003 was held in Bangkok, Thailand, and some military delegations figured out the HIV prevalence in their military population. Such as Cambodia 7.1% , India 0.77%, Thailand 0.7%, Vietnam 0.64%, and Philippines 0% (Military Report, 2003). HIV prevalence in TNI is considered to be confidential; as such we use the national prevalence of HIV in Indonesia, which is 0.2%. On estimation, there are 193,000 people living with HIV (NAC, 2007).

Fearless, fast-action, and aggressiveness are the characteristics of soldiers that being built upon during the military training. As a result, soldiers display risk-taking behaviour. This behaviour often infiltrates into daily activities, including having risky sex (UNAIDS, 1998). Being aware of these circumstances, military services start to provide STIs/HIV information to the soldiers. On the other hand, a study carried out by Nwokoji and Ajuwon (2004) showed that knowing about HIV/AIDS does not give the guarantee that soldiers also apply safe sexual behaviour.

Then soldiers are also mobile. Approximately 37,000 soldiers from 89 countries join the UNPKO (CSIS, 2002). This force owns a special call – a blue helmet (in UNPKO setting, the soldier wears a blue helmet). For TNI personnel, joining UNPKO is a part of duty. When they receive a call letter from the headquarters, it means that they have to be ready for any command. Nevertheless, there are various added values on it. For some of TNI personnel, joining UNPKO is attractive since it will give extra income for them, more than US\$ 1,000/month.

In a conflict country, the blue helmet soldiers have a good reputation. They have money, food, and security. This could attract local people to initiate sexual relationships with them. The peacekeepers face the reality

that during deployment social control can be weak. The culture and the customs on how to behave well, to which the peacekeepers hold tight while in their home country, may be much less.

Sometimes, peacekeepers are posted in host country where its HIV prevalence is higher than the HIV prevalence in their home country. Interaction between peacekeepers and local population may raise some problems. Women are generally a vulnerable group to experience sexual abuse in conflict setting, while some women residing in refugee camps are intentionally selling sex to peacekeepers in return for food. More than 30 girls living in refugee camp in DRC have been interviewed, about half of them selling sex to peacekeepers. One of them, a 13-year-old girl said, "It is easy for us to get to the UN soldiers. We climb through the fence when it is dark, sometimes once at night, sometimes more" (Milmo, 2004).

The host country claims peacekeepers to spread HIV to the local population, while the countries that send the peacekeepers are objected and accuse the local population infect their soldiers with HIV (Expert Panel, 2001).

In 1993, TNI has had seven soldiers returning from peacekeeping operations with HIV (Soeprapto et al, 1995). This should be an alarm for TNI to take HIV into serious consideration. However, action was only taken ten years later. TNI initiated a HIV programme in 2003, when the result of a behavioural surveillance survey showed that soldiers had low knowledge of HIV/AIDS.

Since TNI keeps on sending its soldiers to participate in peacekeeping operations and HIV positive cases continue to be found among the soldiers returning home, it is relevant to explore further whether the HIV prevention programme in TNI is sufficient to address the problem? And whether TNI puts in adequate efforts to protect its soldiers from getting STIs/HIV infection? What is the response of the soldiers? Do Indonesian peacekeepers have proper knowledge of STIs/HIV? And how do these peacekeepers behave in the mission, including their sexual behaviour? While the data about the knowledge level of STIs/HIV and risky sexual behaviours among Indonesian peacekeepers is scanty, a paper written by Essa, A. in the African Recovery (2001) believes that the major challenge in reducing HIV in peacekeepers remains in changing the attitudes leading to unsafe behaviours among soldiers.

2.2. Study questions

For more than 50 years Indonesia participates UNPKO by sending its Kontingen Garuda to conflict areas. Some areas have higher HIV prevalence than that of Indonesia. The military is perceived to be one of the high-risk populations, globally. This leads to the question how does TNI respond to this, being an organization which dispatches hundreds to

thousands of soldiers annually for UNPKO? The study questions are divided up between study questions describing the extent of STI/HIV being a health problem, existing knowledge on HIV/AIDS among personnel and the package that TNI offers to its soldiers in prevention, care and treatment

The study questions are as follows:

1. What is the policy and programme addressing HIV in UNPKO?
2. What is the HIV policy and programme in TNI, particularly for its peacekeepers? And how is the implementation?
3. How is the knowledge, attitude, and practice of TNI personnel in terms of sexual behaviour?

2.3. Thesis objectives

2.3.1. General objectives

To analyse the magnitude of HIV and STIs as public health problems among personnel joining UNPKO, and to analyse the current response from TNI to these problems (HIV-positive personnel who join UNPKO)

2.3.2. Specific objectives

1. To describe the policy and programme addressing HIV in UNPKO
2. To describe HIV policy and programme in TNI
3. To describe access to HIV prevention, care, support, and treatment for TNI personnel
4. To explore the risky sexual behaviour leading to STIs/HIV among TNI personnel
5. To give recommendations to policy maker in TNI for relevant interventions

2.4. Methodology

2.4.1. Study design

The design used in this thesis is literature review, using primary data from TNI headquarters.

In describing how HIV prevention programme is being implemented in Indonesian contingent joining UNPKO, the writer used the Andersen's behavioural model as the framework (see Annex 1). This framework is used to explain how the internal (HIV policy in TNI) and external environment (HIV policy in UNDPKO) is applied to the personnel in military services. This group possesses specific characteristics which may lead to high-risk behaviour. Furthermore, the framework aims to explore the interrelations between the various factors which may influence the comprehensive knowledge of STIs/HIV and/or sexual behaviour among Indonesian peacekeepers.

2.4.2. Study method

The thesis is based on primary data gained from TNI headquarters. The data which is being referred to in this thesis is reliable to the extent

that the author has received this directly by the officer in charge in TNI Health Centre (*Puskes TNI*), with the permission of Chief of TNI Health Centre (*Kapuskes TNI*) – the highest-rank officer in health corps in TNI. All data related to Indonesian peacekeepers were provided by the Head of Medical Operational Support *Puskes TNI* (*Kasubdisdukkesops Puskes TNI*), an officer who has the responsibility to collect and check all the medical data from peacekeeping operation (PKO).

In addition, a literature review was done to support the data analysis. The sources that were used for doing the literature review were the documentation on the subject available at the KIT library and by searching the internet (Pubmed and Google) for relevant documentation. The keywords that were used to search those databases were: HIV, AIDS, sexually transmitted infection, TNI, military, peacekeeping.

2.5. Study limitation

The published information, literature, and reports on HIV in TNI are scarce. Any results of studies and surveys conducted on HIV in TNI are the exclusive domain of policy makers in TNI. The data made available for this thesis was provided as an exception to that rule, on behalf of *Kapuskes TNI*. Information about HIV programme in TNI was collected from some senior working in military health centre, namely:

1. the head of the Department of Preventive Medicine *Puskes TNI* (*Kasubdis Kesprev Puskes TNI*),
2. the Head of Medical Operational Support *Puskes TNI* (*Kasubdisdukkesops Puskes TNI*),
3. a senior medical officer in the Department of Preventive Medicine in military hospital, and
4. a medical doctor who once was on duty in PKO in DRC.

The triangulation technique was used to compare the different sources of information and strengthen the argumentation in the thesis.

Chapter 3: United Nations Peacekeeping Operation

In this chapter the writer will describe United Peacekeeping Operation (UNPKO) and United Nations Department of Peacekeeping Operation (UNDPKO). UNPKO refers to the mission and UNDPKO means an institute in managing UNPKO. Later, two interventions designed by UNDPKO and Joint United Nations Programme on HIV/AIDS (UNAIDS) for peacekeepers will be discussed. These interventions are HIV awareness card and Strategic Action Package (SAP).

3.1. Peacekeeping Operation

United Nations was established in 1945. The first United Nations Peacekeeping Operation (UNPKO) was in 1948, after the Security Council approved the deployment of UN military observers to the Middle East. Recently, 20 PKO all over the world, involving approximately 130,000 authorized military, police, and civilian personnel are being managed by the Department of Peacekeeping Operations (DPKO) (UN, 2008). Indonesia is one of UN members since 28 September 1950 and has its first debut in UNPKO in 1957.

According to UNAIDS (2008a), uniformed services personnel are population at increased risk of exposure to HIV due to their mobility and occupational setting. UNPKO demands thousands of soldiers from UN member states. UNPKO creates huge mobility of uniformed personnel across the continents, including Indonesia. In the field, the contingent does not only interact with contingent from other countries, but they also interact with host population.

There will be soldiers from various TCCs in one location, who come from countries with different level of HIV prevalence and different level of knowledge of HIV/AIDS as shown in a HIV/AIDS Knowledge, Attitude, and Practice (KAP) survey conducted among military personnel (Bazergan, 2006).

The table below shows 7 out of 17 current peacekeeping operations (PKO), chosen from mission that involved minimal 9,000 uniformed services. The two right columns represent HIV prevalence in host population aged 15-49 years old and HIV prevalence among SW. While on duty, peacekeepers may have contact with general population, including SW. SW seek for peacekeepers as clients since they generally have more money than local clients (Sarin, 2003).

Table 1: Current UNPKO and levels of HIV infection in host countries

No.	PKO	Number of peacekeepers	Location (Host country)	% of adults (15-49) infected with HIV/AIDS	HIV prevalence among SW (%)
1	MONUC	18691	DRC	1.2-1.5	12.4
2	UNAMID	13532	Darfur	1.4	4.4
3	UNIFIL	12030	Lebanon	0.1	0.1
4	UNMIL	11406	Liberia	1.7	NA
5	UNMIS	9643	Sudan	1.4	4.4
6	MINUSTAH	9080	Haiti	2.2	NA
7	UNOCI	9026	Cote d'Ivoire	3.9	32

(Source: UNDPKO 2009 & UNAIDS 2008)

The HIV prevalence data in host countries and TCCs are taken from UNAIDS report (2008b).

While the table 1 contents of the data about HIV prevalence in host countries, the table 2 gives the number of HIV prevalence in countries where the UN peacekeepers come from.

Table 2: Top ten TCC and levels of HIV infection

No.	PKO	Number of peacekeepers	% of adults (15-49) infected with HIV/AIDS
1	Pakistan	10616	0.1
2	Bangladesh	9717	<0.1
3	India	9345	0.3
4	Nepal	3656	0.5
5	Jordan	3596	<0.2
6	Ghana	2932	1.9
7	Uruguay	2585	0.6
8	Nigeria	2539	3.1
9	Italy	2449	0.4
10	France	1943	0.4

(Source: UNDPKO 2009 & UNAIDS 2008)

From those two tables, we can see that the countries where PKO are taking place have disparity in HIV prevalence, from 0.1-3.9%. HIV prevalence among SW in those countries are also provided since one can expect peacekeepers may buy sex during the mission. Meanwhile, HIV prevalence in the countries from which the large number of peacekeepers come range from <0.1% to 3.1%, as figured out in the table 2. These two tables provide information about HIV prevalence in both host countries and TCCs. The factors that may contribute to the HIV epidemic in each country are not mentioned, let alone the correlation between HIV/AIDS and the presence of peacekeepers.

Until recently the HIV/AIDS epidemic was sometimes related to UN peacekeepers. For example, in the statement of the former US Ambassador to the UN when he attended the United Nations Security Council (UNSC) in January 2000, "I regret to say, that AIDS is being

spread, among other people, by peacekeepers”.

This concern points out that the incidence of HIV infection increases during UNPKO, as a result of UN peacekeepers’ behaviours. Some believe that UN peacekeepers from high HIV prevalence country transmit the HIV to host population. On the other hand, the countries that send peacekeepers accuse local people in host country with high HIV prevalence infect their soldiers, and then the peacekeepers return home with HIV-positive status (Expert Panel, 2001). A study conducted by Civil-Military to combat HIV/AIDS (CMA) among Nigerian soldiers returning from PKO in West Africa found that infection rates was twice higher than in the civilian population in Nigeria. The risk of HIV infection among soldiers got higher for each year spent in PKO, showing a link between deployment in conflict area and HIV transmission (Fleshman, 2001).

The studies carried out to investigate the correlation between peacekeepers, HIV/AIDS, and host population are hardly found. Due to lack of these studies, the debate about whether or not peacekeepers spread HIV during the mission and after returning home will keep going on.

One way of assessing the extent of the problem is through mandatory HIV testing of personnel in two instances: pre- and post-deployment. This may be the most reliable way to measure the risk of HIV among personnel. Obviously this poses questions around human rights and one’s freedom to opt or opt-out for HIV testing. This is the main objection to apply mandatory testing to peacekeeping personnel (Bazergan, 2004). Despite this, there are a few countries that apply this method (Fleshman, 2001), including Indonesia.

HIV prevalence in military personnel is generally higher than in the civilian population (UNAIDS, 1998). And military in African continent, the continent where most of UNPKO personnel dispatched, have high numbers of personnel living with HIV/AIDS. South African Defence Intelligence have found that HIV infection rate in Angolan-, the DRC-, and Malawi-armed forces were 50% in 1999. In Zimbabwean- and Zambian-military these figures were even higher, respectively 55% and 60% in 1998 (Bazergan, 2004). According to Commission on HIV/AIDS and Governance in Africa (2008), HIV prevalence above 5% is considered to reduce the operational capability of armies where “armies cannot operate at full capacity or be available for peacekeeping activities”. Infected military personnel will be unable to participate effectively in UNPKO (Chief UNAIDS, 2002). Furthermore, based on 2002 South African government figures, 7 out of 10 mortality cases in military were related to AIDS (CHG, 2008). In the situation where African military services are heavily hit by HIV infection, the burden of PKO in Africa will shift to non-African countries (Chief UNAIDS, 2002).

PKO is the most essential instrument for international conflict management. And it seems that PKO will remain so for couple of years ahead (Schmidl, 2000).

DPKO's chief medical officer noted in 2001, "We are huge movers of young people across borders and between contingents. Some come from non-endemic countries for deployment in endemic areas. Others come from endemic countries to non-endemic areas. It is a huge concern of ours that the legacy of the UN not be that of bringing the virus into the local environment. The legacy to the country providing the peacekeepers should not be to have them bring the HIV virus back home" (Fleshman, 2001).

Studies should be done to determine how peacekeepers behave in PKO; how they socialize with local people, how they relieve the stress and boredom, whether it is true that peacekeepers contribute significantly to the number of new HIV cases in host countries, etc. These studies are however complex and it may take a long time before the researchers can share results.

3.2. HIV testing policy in UNDPKO

DPKO policy related to HIV/AIDS issue among peacekeepers is offering voluntary and confidential counselling and testing (VCCT) to peacekeeping personnel. DPKO strongly encourages UN member states to provide VCCT for their troops and to strengthen HIV/AIDS education in national military training programme (Fleshman, 2001).

The DPKO HIV testing policy states clearly that "the sole medical criterion for the deployment and retention of a peacekeeper is fitness to perform peacekeeping duties during the term of deployment" (UNDPKO, 2005).

A HIV-positive personnel does not directly show low-quality performance on duty. It takes certain time for someone to develop AIDS for HIV to deteriorate the immune system. Based on personal's health status and human rights, "the HIV status of an individual is not itself considered an indication of fitness for deployment" (UNDPKO, 2005).

Regarding to the national HIV policy in each troop-contributing country (TCC), DPKO respects TCCs which practice HIV mandatory testing for pre- and post deployment PKO. Three out of the five permanent members of Security Council (a permanent council of the United Nations; responsible for preserving world peace): China, Russia, and the United States of America have national policies of mandatory pre-deployment screening for their military personnel. Meanwhile the United Kingdom and France apply voluntary testing, although for France there are some considerations follow (Bazergan, 2004).

Current HIV/AIDS policy in UNDPKO:

To address HIV issues among peacekeepers, UNDPKO has 4 points written in its HIV/AIDS policy as explained in the box below:

Box 2: HIV/AIDS policy in UNDPKO

D. HIV/AIDS

1. Many troop-contributing countries screen their military personnel for HIV infection prior to sending them on overseas assignments. The national policies regarding enlisting and employing HIV-positive individuals in the military vary.
2. In UN peacekeeping operations, HIV-positive individuals who do not show clinical manifestations of AIDS are not precluded from peacekeeping service. It is, however, recommended that such individuals should not be selected as treatment available within the mission area may not be adequate to meet their special requirements. Exposure to endemic infections and exhaustive immunization requirements may also be detrimental to their health. In addition to the individual's health concerns, there is also the risk of his or her transmitting HIV to medical personnel, fellow peacekeepers and sex workers in the mission area.
3. Should a known HIV-positive individual be deployed in a UN mission, his/her status should be made known to the FmedO (Force Medical Officer) and attending doctor, to ensure that proper medical precautions are taken and adequate medical care provided. This information should be kept strictly 'medical-in-confidence'.
4. Any individual who develops clinical AIDS or any of its complications should be repatriated to his home country for further treatment once the diagnosis has been made. The UN medical support system is not obliged, and does not have the resources, to manage this condition.

(Source: Expert Panel, 2001)

HIV/AIDS policy applied by UNDPKO clearly stated that HIV-positive personnel without any clinical manifestations of AIDS may join UNPKO. Later on in duty, if he/she develops any complications of AIDS, he/she will be sent back home. Under the same policy, UNDPKO recommends TCCs not to send HIV-positive personnel because the risk of transmitting HIV to medical personnel, other peacekeepers, and sex workers during the mission. In response to this, TCCs apply mandatory HIV testing, some do not. Since the decision to send or not to send HIV-positive personnel for peacekeeping is on the hand of TCC, not UNDPKO, sending HIV-positive personnel will remain to be a polemic at global level.

3.3. HIV/AIDS intervention for peacekeepers

Knowing that HIV is the problem should be addressed in the mission, UNDPKO in the collaboration with UNAIDS developed programme targeting peacekeepers. The intervention programme consists of HIV/AIDS Awareness card and Strategic Action Package (SAP). This

package is a more structured, long-term programme than the provision of the awareness card.

3.3.1. HIV/AIDS Awareness card

To provide HIV/AIDS information to peacekeeping personnel, WHO published an AIDS education booklet in 1995. A second edition of this booklet was published by the DPKO jointly with UNAIDS in 1998; a 50-page booklet entitled *Protect Yourself, and Those You Care About, Against HIV/AIDS* (Bratt, 2002).

The UNSC also pays attention to the importance of HIV/AIDS awareness among peacekeepers. Security Council Resolution 1308 of July 2000 recognized that “the HIV/AIDS pandemic is also exacerbated by conditions of violence and instability, which increase the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care. Also recognized “the need to incorporate HIV/AIDS prevention awareness skills and advice in aspects of the United Nations Department of Peacekeeping Operations’ training for peacekeeping personnel” (SC Resolution, 1308).

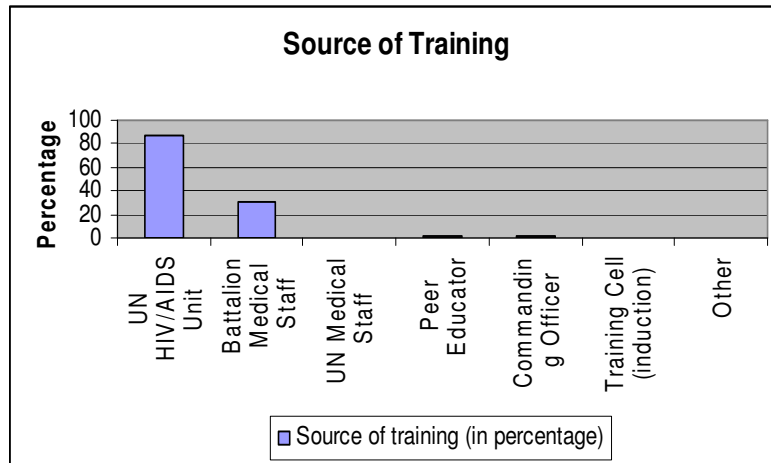
In one of the UNSC meetings on 19 January 2001, UNAIDS and DPKO agreed to develop HIV/AIDS Awareness card. The existing 50-page booklet about HIV/AIDS would be transformed into a pocket card (African Recovery, 2001). The HIV/AIDS Awareness card is plastic coated, contents of basic information about HIV/AIDS and codes of conduct that should be followed by personnel in PKO. This card is produced in 10 languages (the most spoken languages among peacekeepers) and has an inner condom pocket (UNAIDS, 2003). In TNI, this card is available in Bahasa Indonesia.

In May 2003, the Deputy Force Commander of MONUC Force Headquarters launched HIV/AIDS Awareness card in the South African base, Basoko, Kindu. In front of around 1,000 military personnel who represented Senegal, South Africa, Uruguay, and China, the Force Commander stressed the importance of HIV awareness among the soldiers and he suggested them to carry the card as a part of their uniforms. The Force Commander took HIV/AIDS issue into his consideration, regarding to the fact that despite of the success of UNPKO, many peacekeepers and their families suffered from HIV/AIDS and its consequences long after their participation in PKO (UNAIDS, 2003).

Keep the peacekeepers informed about HIV/AIDS in the mission is another challenge. A HIV/AIDS Knowledge, Attitude, and Practice (KAP) survey conducted among military personnel peacekeepers deployed in Liberia showed that contingents from many countries said that during the mission they gain HIV/AIDS information not from their official medical officer. This KAP survey which piloted by DPKO and UNAIDS in 2005 gave

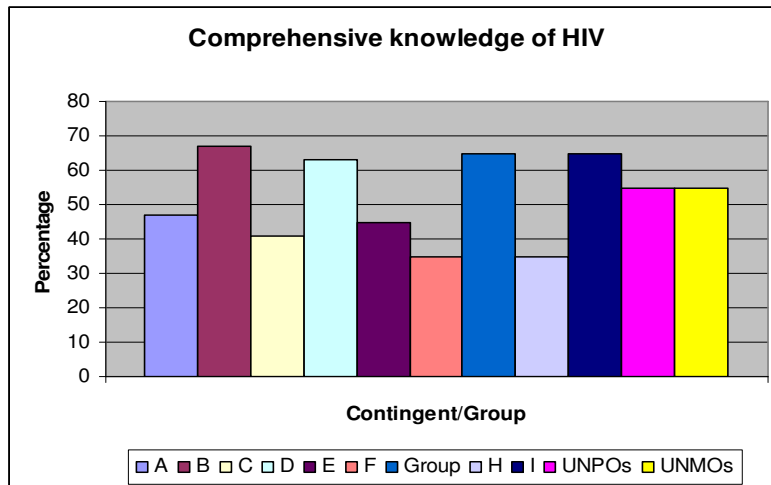
the fact that during deployment above 85% personnel said they received HIV training from UN HIV/AIDS unit. One third of personnel got HIV training from battalion medical staff, 2% from a commanding officer, and below 1% got the training from peer educator. Six hundreds and sixty seven peacekeepers from 8 TCCs: Nigeria, Namibia, Ghana, Sweden, Ireland, Philippines, Bangladesh, and Pakistan were involved in this survey (Bazergan, 2006).

Figure 1. : Source of HIV training in the mission area



(Source: Bazergan, 2006)

Figure 2 : Comprehensive knowledge of HIV among peacekeepers in Liberia



(Source: Bazergan, 2006)

The figure above shows that the comprehensive knowledge of HIV among peacekeepers dispatched in Liberia is above 30% , varies from 30% to 70%. This various number visualizes the difference of HIV/AIDS awareness level among soldiers. Do these peacekeepers get the HIV information merely from the awareness card, or do they gain the information from their own military services? However, to ensure that

peacekeepers will practice safe sexual behaviour, the comprehensive knowledge should be above 80%.

It is not conclusive whether the intervention programme by providing the awareness card is effective.

3.3.2. Strategic Action Package

According to Chief UNAIDS (2002), 45 countries were selected at a first phase of implementing Strategic Action Package (SAP) developed by UNAIDS. UNAIDS secretariat through the Office of AIDS and Security developed SAP in order to support member states in designing HIV interventions among uniformed services, particularly among young recruits. This package contains of (a) the UNAIDS generic guidelines on HIV/AIDS interventions, emphasised on young recruits, (b) programming guide for interventions, (c) training materials (e.g. stigma, gender, substance abuse).

Burundi is one example of some countries that can run this programme successfully. In Burundi, three cross sectoral ministries committed a partnership project to respond HIV/AIDS among young recruits. In military service, the Burundi army created a solidarity fund to support the treatment cost of soldiers living with HIV/AIDS, including their families (Chief UNAIDS, 2002).

Besides UN pilot project, there are some countries which have their own initiative to respond HIV/AIDS within militaries. In December 2000, the Ugandan President stated that the military has strict policy against the discrimination in HIV-positive soldiers. The President guarantees, infected personnel can continue their career in the military, given less stressful duty, until they were too ill to perform their duty (Fleshman, 2001).

Some African countries start to provide HIV education for the military. In February 2001, Burkina Faso's defence and health ministers had a meeting with high-rank armed forces officers in order to make an agreement on an action plans against HIV/AIDS in the armed forces. Five points in the plan of actions are: "(a) reducing the rate of new infections among soldiers by 5% annually through educational and preventive measures; (b) ensuring that new recruits are HIV-negative; (c) voluntary, anonymous and confidential testing of military personnel; (d) counselling and the provision of generic medications to ill soldiers; (e) social and economic assistance to the families and survivors of ill soldiers" (Fleshman, 2001).

Learning from those intervention experiences, SAP seems to be more effective in preventing uniformed personnel from contracting with HIV infection. It allows the comprehensive programme implemented rather than a limited, short term intervention. In addition, when the country leaders, including high-rank armed forces officer take action and support HIV prevention programme in the military seems to be successful and

more sustainable. Increase of safer behaviour among military personnel also impact to broader community, including SW and other peer or colleagues in living environment.

After reviewing how UNDPKO and UNAIDS work together to produce general HIV/AIDS policy for peacekeepers, and looking back at some countries which start to apply HIV/AIDS policy in their militaries, in the next chapter we will take a look at HIV/AIDS policy being implemented in Indonesia.

Chapter 4: Indonesian's HIV military programme in relation with Peacekeeping Operation

Indonesia takes part as a troop-contributing country (TCC) in PKO for more than 50 years. As many other TCCs, Indonesia also experienced from having its peacekeepers returning with HIV positive status. This chapter will discuss the participation of Indonesia in PKO. What is HIV policy and programme in TNI, particularly in its peacekeepers? Ethical issue around HIV is also address here as it seems to be a problem in TNI.

4.1. Indonesians in peacekeeping operation

Over a half century Indonesia participates in UNPKO. UNTAC is the biggest and most costly UNPKO, where Indonesian military gained success (Haseman, 1996) but must face the fact that 7 soldiers returned with HIV-positive (Soeprapto et al, 1995).

During UNTAC, thousands peacekeepers from 21 troop-contributing countries (TCCs) were posted in Cambodia. Seven from 1,929 peacekeepers from Indonesia were found to have positive results on HIV-test post-deployment after participating UNTAC in 1992-1993. HIV-test used Pasteur enzyme-linked immunoabsorbent assay (ELISA). Twice positive results with ELISA were confirmed by western blot. A collaboration study held by researchers from Indonesia and the United States of America concluded that Indonesian peacekeepers returned with HIV-positive were likely to acquire HIV infection during deployment in Cambodia. Six out of seven found to be subtype E. meanwhile among other Indonesian risk groups, subtype B is the most common HIV-1 subtype (Soeprapto, 1995). In Cambodia, subtype E is predominate, seems that it has correlation with epidemics in neighbouring Thailand, the likely source of HIV spread into Cambodia (Weniger, 1994).

4.2. HIV testing policy in TNI

TNI has policy to test its personnel who will be dispatched to UNPKO and to Papua pre- and post-deployment. In 2007 45,830 HIV test kits were provided for TNI. Approximately 80% of these kits were used for pre- and post-deployment UNPKO, internal deployment to Papua, new recruits, and health examination (DHAPP, 2007).

It is written in HIV/AIDS Guidelines in TNI (*Petunjuk Pelaksanaan Penanggulangan HIV/AIDS di Lingkungan TNI*), signed by the TNI Chief of Commander in 2004. HIV testing is mentioned for: 1). personnel who will be sent for mission (pre- and post-deployment test), altogether with other medical examination; 2). for post-deployment, HIV-test should be done three times, early after arrival, 3 and 6 months later; 3). recruitments for military personnel and civil servants working in military. Another point in this policy is that personnel living with HIV have access to TNI health service freely.

According to the Regulation of the President of the Republic Indonesia Number 75 Year 2006, the Chief of TNI is one of the National AIDS Commission's (NAC) members. "Controlling, monitoring and evaluating the implementation of activities for prevention and management of the response to AIDS", is under the duty of NAC; including the implementation of HIV activities in military.

It means that HIV prevention programme in military should be in the agenda of the Chief of TNI. HIV among soldiers needs to be taken into consideration since the result of Integrated Biological-Behavioural Survey (IBBS) in 2007 showed that soldiers serving in Papua have HIV prevalence at 1.2%, higher than the national prevalence.

While the HIV epidemic among soldiers in Papua calls for attention, the HIV case finding in pre- and post-deployment test for peacekeepers also needs to be thought about. It will be explored further in the following part.

4.2.1. Pre-deployment HIV testing

TNI personnel should follow several tests before the deployment in PKO, including health examination. Health examination is done in 2 phases. Personnel who do not pass the first phase can not follow the further test. The policy on health examination is based on Permenkes RI Nomor 518/Menkes/Per/VI/2008 on 6th June 2008 (Dukkes TNI, 2009).

Health examination phase 1:

- a. Physical and dental examination
- b. Laboratory examination: 1). routine blood and urine, 2).SGOT and SGPT, 3). HBsAg, 4).ureum, 5).creatinine

Health examination phase 2:

- a. Thorax röntgen
- b. Electrocardiography (ECG)
- c. Laboratory examination: 1). malaria, 2). narcotics, 3). uric acid, 4). fasting blood glucose, 5). bilirubin, 6). cholesterol, 7). triglyceride, 8). HIV
- d. Psychiatric

4.2.2. Post-deployment HIV testing

When peacekeepers have got their mission accomplished and arrive back in Indonesia, they will be quarantined right away for one day to get post medical examination including HIV-test. Any personnel who found to have positive result will be referred to RSPAD for counselling and CD4-test. HIV testing is one item from this following test:

- a. Physical and dental examination
- b. Laboratory examination: 1). routine blood and urine, 2). SGOT and SGPT, 3). HBsAg, 4). ureum, 5). creatinine, 6). malaria, 7). narcotics, 8).

- uric acid, 9). fasting blood glucose, 10). bilirubin, 11).HIV
- c. Thorax röntgen
- d. ECG
- e. Psychiatric

Prior to arrival is the first HIV testing post-deployment. The second and the third will be done 3 and 6 months later as written in HIV Guidelines in TNI. For this moment, TNI conducts HIV testing once for peacekeepers returning from the mission, which is prior to arrival.

4.3. HIV prevention programme in TNI

TNI started HIV prevention programme in 2003, focused on peer leaders (PL) training with support from the Department of Defence of the United States (DoD) and the Family Health International (FHI). Since 2007 FHI did not provide financial support for TNI any longer.

In 2009 TNI has 5 HIV programmes supported by US Pacom: HIV on tuberculosis, HIV on Hepatitis C, Integrated Management in Adult and Adolescent Illness and two PL trainings in East Kalimantan and Jakarta. The current funds in running HIV prevention programme are derived from the national budget and external donors.

4.3.1. HIV/AIDS peer leaders programme

PL programme in IAF was first introduced in 2003. It was aimed to respond the result of Behavioural Behaviour Survey (BSS) 2003, where the knowledge of HIV among soldiers was found low.

PL trainings are conducted within 4 days (see the schedule in Annex). The personnel involved were officers (the minimum rank is second Lieutenant), non-officers (sergeant or lower rank), and civilians who work for military. After the evaluation, it was found that non-officers as peer leaders could not perform the mandate as expected. It might due to lack of leadership skill. Since then, PL programme is focused on the military officers and civil servants in the army, navy, air force, and Defence ministry. Recently there are 738 peer leaders in IAF (Sholihin, 2009a).

The aim of this programme is to equip peer leaders with proper knowledge about HIV and AIDS. After trained, these PL return to their workplace, expected to educate their peers on HIV/AIDS issues through daily interactions and formal activities.

To improve knowledge and skills related to HIV services in military, TNI sends its medical officer to attend training or workshop at global level. This activity is supported by government through the national budget, and from external donors, such as the United States Pacific Command (USPACOM) and Family Health International (FHI). In 2008, one officer attended the workshop about HIV prevention policy in Texas, the United States of America and two medical officers joined the Regional Training Centre (RTC) in Bangkok, Thailand (TNI Report, 2008).

4.3.2. HIV services in TNI

Personnel TNI and their families have free access and treatment in TNI health services, including for HIV/AIDS cases. Recently TNI has 42 VCT clinics, spread in Jakarta, West Java, East Java, Bali, Kalimantan, Sulawesi, Papua, etc.

These 42 VCT clinics are included VCT clinics in 11 military referral hospitals all over Indonesia to provide CST for its personnel and families (Sholihin, 2009a).

These hospitals are located in:

1. Java Island: - Army Centre Hospital Gatot Subroto Jakarta
- Navy Hospital dr. Minto Harjo Jakarta
- Navy Hospital dr. Ramelan Surabaya
2. Sumatra Island: Army Hospital Putri Hijau Medan
3. Batam Island: Navy Hospital dr. Midiato S. in Tanjung Pinang
4. Kalimantan Island: Army Hospital in Balikpapan
5. Sulawesi Island: - Army Hospital Teling Manado
- Army Hospital Pelamonia Makassar
6. Kupang Island: Army Hospital Wirasakti Kupang
7. Papua Island: - Navy Hospital dr. Sudibjo Sardadi in Jayapura
- Army Hospital Marthen Indey Jayapura

TNI has four CD4 counting machines to support HIV service. They are in Army Centre Hospital Gatot Subroto Jakarta, Navy Hospital dr. Ramelan Surabaya, Army Hospital Marthen Indey Jayapura, and Army Hospital Udayana Bali. HIV services provided by TNI are not merely for TNI personnel, but also extended to their families and civilian population (DHAPP, 2007).

HIV/AIDS team work in TNI was created in June 2008 as response to instruction letter from the Chief of TNI: Sprin/1140/VI/2008, 23 June 2008. This team now is trying to assess the capability of health personnel in dealing with personnel living with HIV/AIDS. In order to achieve the target, the team visits several military hospitals in East Java province. The findings are expected to be complete by the end of 2009 and the result will be disseminated in the military meeting.

This kind of activity should be expanded to other provinces, and Papua province, where the HIV prevalence among TNI personnel is the highest as shown in IBBS 2007, is considered as priority.

4.4. HIV prevention programme targeting Indonesian peacekeepers

Health promotion is given to peacekeepers before departure by medical officers from Puskes TNI. The information covers first aid, basic life support, stress management, malaria, avian influenza, and HIV/AIDS. One hour session is allocated for HIV/AIDS topic. One session about HIV/AIDS is given to Kontingen Garuda pre-deployment in purpose to

improve their knowledge of HIV/AIDS, to encourage them to avoid risky sexual behaviours during deployment and to keep the personnel stay negative on HIV testing post-deployment.

The HIV/AIDS messages for Kontingen Garuda will be delivered by the officer in charge, followed by discussion. Basic information on HIV/AIDS prepared for peacekeepers covers these following points:

- HIV/AIDS at global level
- HIV/AIDS in Indonesia
- HIV/AIDS in TNI
- HIV-test result post-deployment UNPKO
- Basic facts about HIV/AIDS: HIV transmission route and HIV prevention
- HIV treatment

(Sholihin, 2009b)

Unsafe sex, injecting drug use, and mother to child transmission are mentioned as HIV transmission route. HIV is not transmitted through social contact, such as shaking hand or having meal with PLHIV, nor via mosquito bite. Furthermore the presenter explains that HIV can be prevented by practising safe sex behaviour. ABCDE is used to remind soldiers how to protect themselves from getting HIV infection (Sholihin, 2009b). ABCDE stands for:

A: Abstinence, abstinence for sex for not-yet married soldiers and for married soldiers who separated from their spouses due to duty

B: Be faithful, stick to one HIV-negative sexual partner

C: Condom, condom use in each risky sexual contact

D: Drug, don't use drug; moreover injecting drug.

E: Equipment sterilisation, practice universal precaution in health service

A session about HIV/AIDS provided by Puskes TNI is aimed to remind the soldiers to stay away from any risky sexual contact while on duty in PKO. A few personnel in Kontingen Garuda returned with HIV shows that during the mission every soldier is at risk in contracting with HIV. In Kontingen Garuda, an existing HIV prevention programme during deployment is ad-hoc. There is no compulsory HIV prevention programme to be run by medical personnel during deployment.

Survey result in peacekeeping setting showed that peer educator has not shown predominate role in providing HIV information to the peers (Bazergan, 2006). It may due to the lack of number of soldiers trained as peer educators in their home country. The result will be small number of peacekeepers who have proper knowledge on HIV/AIDS.

In TNI PL training are designed for officers (with rank: second lieutenant, first lieutenant, and captain). In the mission, there are only a few number of officers, name it battalion commander or medical officer. The majority

are non-officers (sergeants and privates). Officially the battalion commander will have a short briefing to deliver instruction to follow, which from public health approach the commander can also deliver the message of HIV/AIDS awareness at the same time.

But the official briefing takes only short period, and the chance of seeing the commander, talking about HIV/AIDS is uncommon thing in TNI. It means that the contact hour between the commander and the subordinates is limited. In the other hand, contact hour between non-officers are quite long, both in the field and during their leisure time. This situation gives a chance for TNI to design PL training for non-officers because non-officers have more contact hour with their peers. Thus, PL training for non-officer should be taken into consideration.

4.5. Ethical issues on HIV/AIDS in TNI

Having HIV/AIDS Guidelines in TNI (2004) is the fundamental element that need further effort so this guidelines can be implemented in all level in TNI organisation, including the attitude towards PLHIV. In military service, response to HIV/AIDS should not be given by health corps only. Other corps should also pay attention to HIV/AIDS because stigma and discrimination is still surrounding this problem.

In one of ceremonial event in November 2008, one of high-rank commander declared his concern on TNI personnel living HIV/AIDS. The commander mentioned that TNI personnel serving under his military territory will be separated and quarantined in military hospital once they were found to have HIV-positive result in regular health examination (TNI, 2008). The reason behind this policy is to avoid HIV infection to their families and other personnel in their workplace. Separation and quarantine affect PLHIV psychologically and may decrease the immune system of PLHIV, later on will reduce his/her quality of life. It seems that stigma and discrimination are directly labelled to HIV-positive personnel.

Breaching the confidentiality seems to be anecdotal reality that may be a burden to personnel to cope with HIV. As TNI has strong hierarchy system, where commander's word is a command for soldiers, it is important to ensure that the commanders have comprehensive understanding of HIV/AIDS. Strong message on HIV/AIDS awareness and sympathetic approach from the commander will encourage personnel to know HIV/AIDS better. A process that takes time.

Chapter 5: Risky sexual behaviour among Indonesian peacekeepers

5.1. Knowledge of HIV among TNI personnel

KAP survey among Indonesian peacekeepers has never been done before. The information about knowledge level of HIV/AIDS then, derived from two national surveys carried out by Indonesian government: Behavioural Surveillance Survey (BSS) in 2003 and Integrated Biological-Behavioural Survey (IBSS). Knowledge level about HIV prevention, right perception about HIV/AIDS, and comprehensive knowledge level about HIV prevention and right perception about HIV/AIDS are some indicators measured in both surveys. They are measured in percentage, from 0% to 100%. Zero percent represents zero correct answer, 100% represents all correct answer towards the questionnaire.

A. Behavioural Surveillance Survey 2003

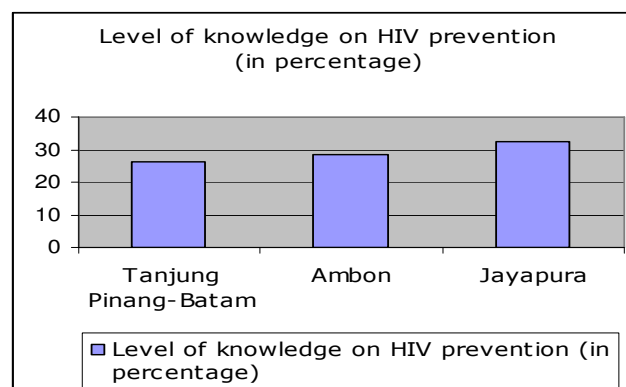
In 2003, a BSS was done among TNI and police personnel in 3 cities: Tanjung Pinang-Batam, Ambon, and Jayapura. To be able to get proper description of behaviours, around 500 samples from each city was taken. The criteria for sample from TNI are male, active-duty military personnel. When the data collection was done in April 2003, 1,512 respondents from TNI were participated in BSS.

A.1. Knowledge level about HIV prevention

The BSS result shows that these personnel have the characteristics as follow: average age 30.2 years old (standard deviation: 6 years), more than 50.5% are married, and above 70% living in dormitory.

Nearly all of the respondents said that they have heard about HIV/AIDS. But their level of knowledge on HIV prevention is lower than 35%. The highest is in personnel serving Jayapura (32.41%), followed by Ambon (28.29%), and Tanjung Pinang-Batam (26.4%). Level of knowledge on HIV prevention is represented by: abstinent, being faithful, condom use, and no drugs (injecting drugs).

Figure 3. Knowledge level about HIV prevention

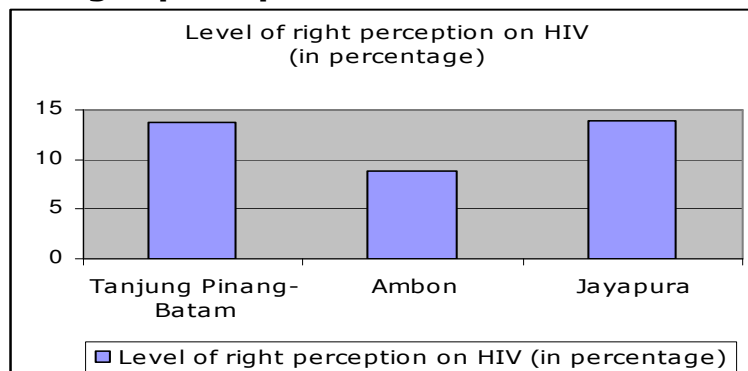


(Source: BSS, 2003)

A.2. Right perception about HIV/AIDS

A right perception about the transmission route of HIV infection is very essential. Proper knowledge about how people can get infected with HIV will reduce the stigma and discrimination toward PLHIV (BSS, 2003). Perception that expected to be owned by TNI personnel are: PLHIV may have healthy appearance, HIV cannot be transmitted by mosquito bite or social activity with PLHIV. BSS result shows that the level of right perception on the transmission route of HIV infection is still low, less than 15%.

Figure 4. Right perception about HIV/AIDS



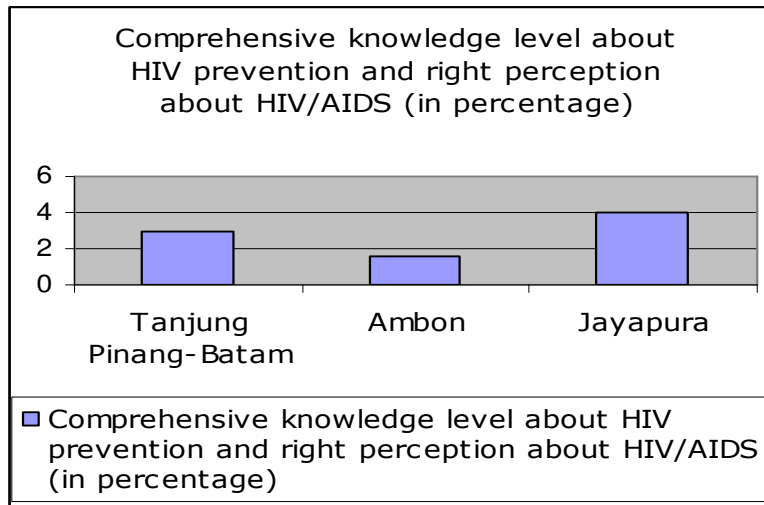
(Source: BSS, 2003)

A.3. Comprehensive knowledge level about HIV prevention and right perception about HIV/AIDS

TNI personnel are supposed to have comprehensive knowledge about HIV/AIDS. In Indonesia, SWs' clients come from various sub populations and level of society, namely students, private employees, civil servants, TNI and police personnel (IBBS, 2007).

Comprehensive knowledge can reduce stigma and discrimination, as well to prevent TNI personnel from getting infected with STIs and/or HIV. The BSS result on comprehensive knowledge among TNI personnel is less than 5% (BSS, 2003).

Figure 5. Comprehensive knowledge level about HIV prevention and right perception about HIV/AIDS



(Source: BSS, 2003)

B. Integrated Biological-Behavioural Survey 2007

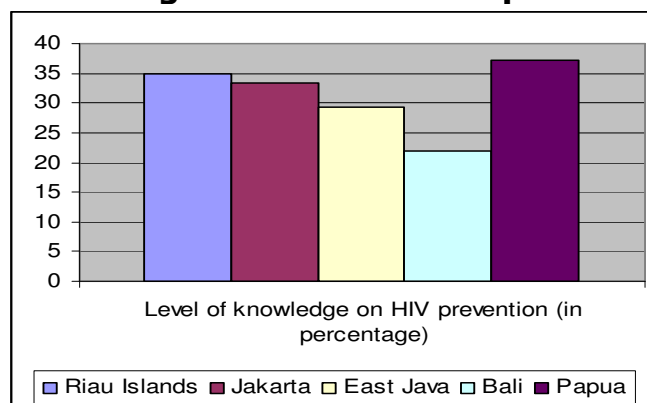
IBBS 2007 involved TNI personnel in 5 provinces, Riau islands, Jakarta, East Java, Bali, and Papua. All 3,410 respondents from TNI are men, age 19-56 years old with average age 28.6 years old (standard deviation: 6 years). Over 40% are married, and more than 68% living in dormitory.

B.1. Knowledge level about HIV prevention

IBBS result shows that 98.6% TNI personnel have heard about HIV/AIDS. Their level of knowledge on HIV prevention is lower than 40%. The highest is in personnel serving Papua (37.3%), followed by Riau Islands (34.9%), Jakarta (33.3%), East Java (29.3%), then Bali (21.8%).

Abstinent, being faithful, condom use at every risky sexual intercourse, and avoid using unsterile syringe needle become the indicators of knowledge level on HIV prevention.

Figure 6. Knowledge level about HIV prevention

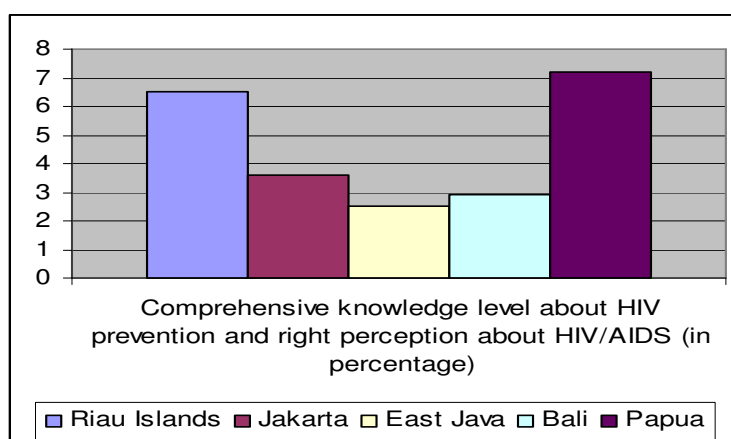


(Source: IBSS, 2007)

BSS in 2003 has shown that level of knowledge on HIV prevention among TNI personnel is less than 35%. Afterward, in IBBS 2007, the level of knowledge referred to below 40%.

BSS is involved 1,512 TNI personnel in 3 cities: Tanjung Pinang-Batam, Ambon, and Jayapura. In IBBS, the number is more than double, included 3,410 TNI personnel serving in 5 provinces: Riau Islands, Jakarta, East Java, Bali, and Papua.

Figure 7. Comprehensive knowledge level about HIV prevention and right perception about HIV/AIDS



(Source: IBSS, 2007)

Both in BSS 2003 and IBBS 2007, the results of “Comprehensive knowledge about HIV prevention and right perception about HIV/AIDS” are lower than 10%.

Indonesian peacekeepers are a part of TNI population. Candidates of Indonesian peacekeepers are male, active-duty military personnel, and healthy. Male, active-duty personnel are exactly the characteristics of personnel participated in BSS and IBBS. We can assume that their comprehensive knowledge is around this number.

5.2. Sexually Transmitted Infections issues among Indonesian peacekeepers

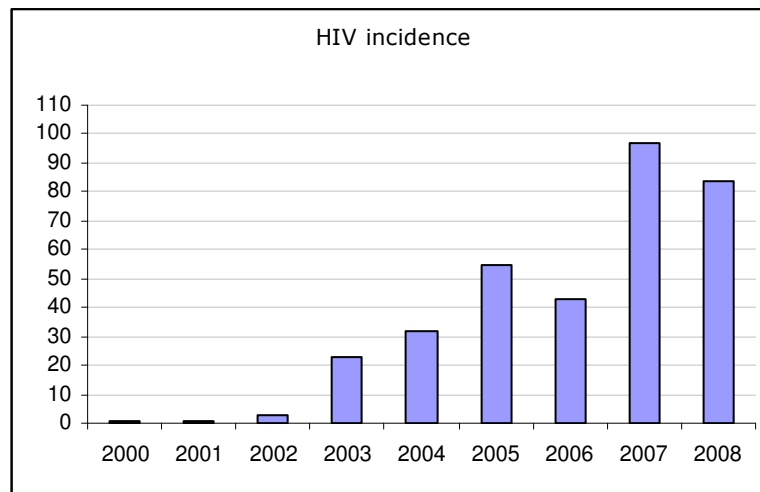
In each UNPKO, TNI also sends medical personnel to provide health information and treat Indonesian soldiers who suffer from any health problems, including STIs. Regrettably, as Bazergan wrote in 2004, reported STIs cases during deployment are believed to be under-reported. Uniformed peacekeepers may search for treatment from outside their own health services because of fear getting disciplinary measures from commanding officer due to getting a STI.

The medical officer in charge in Puskes TNI for collecting medical data from PKO mentioned that there were no STIs cases reported during the mission, from 2004 up to now (Fuad, 2009). However, HIV cases are

5.3. HIV incidence among TNI personnel

After the first finding of HIV cases in Indonesian peacekeepers returning from Cambodia in 1993, next HIV case was reported in 2000. It was one case. The HIV incidence keeps going up, which in 2008 the cumulative HIV cases in TNI is as high as 339 (Sholihin, 2009b). The trend of HIV incidence among TNI soldiers is shown in the figure below:

Figure 8: HIV incidence in TNI



5.4. HIV incidence among Indonesian peacekeepers

When TNI implemented HIV testing policy for its peacekeepers for the first time in 2003, there was no HIV case found pre-deployment. A year later, when they returned, there was no HIV-positive finding.

The result of HIV testing in pre- and post-deployment United Nations Peacekeeping Operation

After mandatory HIV testing policy of Indonesian peacekeepers started in 2003, TNI participates in two UNPKO, UNIFIL and MONUC. TNI sends its contingent to Lebanon and Democratic Republic of Congo (DRC) annually. TNI only dispatches HIV-negative personnel to join UNPKO.

Kontingen Garuda which is deployed for MONUC in 2003 is the first contingent that followed HIV testing pre- and post deployment for UNPKO. Among 250 personnel in pre-deployment test, none of them was found with HIV-positive result. From 250 personnel, 175 qualified personnel were dispatched for the mission. A year later, when they returned and followed the mandatory HIV testing, they were HIV-negative.

Two personnel, from 322 candidates in pre-deployment test for UNPKO in 2004 were HIV-positive. In that year TNI sent 175 soldiers to DRC, and one personnel had HIV-positive result when returned from MONUC in 2005.

TNI ensures its peacekeepers to have HIV-negative status and provides HIV prevention programme before departure. The data indicated that there have been personnel returning with HIV-positive serostatus after one year participating UNPKO. HIV-positive result are found in HIV-test prior to arrival. HIV incidence among Indonesian peacekeepers is shown in the table 4 below.

Table 4: The result of HIV testing among Indonesian peacekeepers

HIV TESTING AMONG INDONESIAN PEACEKEEPERS

No	PKO (year)	Candidates for peacekeepers	Pre-deployment HIV (+)	Peacekeepers on deployment	Post-deployment HIV (+)
1.	MONUC (2003-2004)	250	0	175	0
2.	MONUC (2004-2005)	322	2	175	1
3.	MONUC (2005-2006)	323	1	175	1
4.	MONUC UNIFIL (2006-2007)	325 1.140	0 1	175 850	0 2
5.	MONUC UNIFIL (2007-2008)	319 1.172	1 2	175 850	2 2
6.	MONUC UNIFIL (2008-2009)	352 2.121	0 0	on duty on duty	on duty on duty

(Source: Fuad, 2009)

TNI has sent 175 personnel to participate UNPKO at the first three years after HIV testing policy was implemented. New HIV cases were found, both in pre- and post deployment. Since 2006 TNI not only sent the troops to DRC, but also to Lebanon. The number of peacekeepers being sent are more than 1,000 personnel. This high number of personnel in Kontingen Garuda unfortunately brings impact to a higher number of personnel returning home with HIV. Both single HIV case in post-deployment from MONUC in 2005 and 2006 doubled in 2008.

Chapter 6: Discussion

The first HIV cases among Indonesian peacekeepers were found in 1993, after returning from PKO mission in Cambodia. After that, the next HIV case reported to Puskes TNI was in 2000. One HIV case among TNI personnel all over the country. Since then, the HIV incidence in TNI continues to rise. And when TNI practiced pre- and post-deployment test for its soldiers joining UNPKO started in 2003, HIV cases among peacekeepers appeared every year. In fact while the HIV incidence in TNI keeps rising, the HIV incidence post-deployment shows the same pattern. Zero HIV cases in 2004, became two cases in 2007, then double in 2008. The number may seem small but the trend shows a constant increase. Will HIV case finding be increasing once more in peacekeepers who accomplish their mission in 2009? According to trend the number is likely to increase in the future.

Surprisingly, although the data shows that HIV incidence in peacekeepers keeps rising, there is no STIs reported-case during the mission (Fuad, 2009). This leads to some assumptions. Firstly, Indonesian peacekeepers may treat the STIs themselves with medications that they bring from their home country. Secondly, they may visit a medical service outside of that which provided by TNI. Having STI record for TNI personnel is an experience that may lead to punishment from their commander. It can be a reason why STIs cases are so little to none among TNI personnel in Kontingen Garuda. The pressure from their working environment may encourage soldiers to seek for treatment from non-TNI health service in order to keep their record on STI clean.

STI increases the susceptibility of a peacekeeper getting HIV infection (MMWR 1998). If there is HIV case found in post-deployment test, then why would STI be unlikely to appear in the medical record? This could be related to the policy that is being implemented. HIV policy is pointed out by UNDPKO. Indonesia also has a HIV policy in the military. But so far, there is no policy on STIs other than HIV in TNI. Before exploring factors that may influence the risky sexual behaviour among military personnel, we will first discuss about HIV policy in UNDPKO and TNI.

UNDPKO has a HIV policy to address HIV among UN peacekeepers and states that HIV-positive personnel may join UNPKO. Despite this policy, UNDPKO recommends the TCCs not to send their personnel who are HIV-positive. It seems that UNDPKO consider that the human rights issue and the risk of HIV infection from peacekeeper to host population and vice versa to be one of the reason. In practice, UNDPKO which is expected to settle on the policy for PLHIV attainment in UNPKO has no conclusive decision.

In Indonesia the policy on HIV status for the peacekeeper is quite different. TNI ensures that its peacekeepers have an HIV-negative status before joining UNPKO by applying mandatory HIV testing. If found to be positive, the personnel are referred to VCT clinic to receive counselling services. It happened in 2004 when two personnel were found positive in pre-deployment test for UNPKO. This practice also applied to HIV-positive personnel found in post-deployment.

From the discussion above, we find that there is a difference between UNDPKO and TNI policy in which TNI applies the mandatory HIV testing. In my opinion, the mandatory HIV testing in TNI is an appropriate policy to implement. The reason is by being tested, the personnel will have access to HIV services and care and treatment. This package of services is fully supported by TNI health finance. TNI health service is not exclusive for TNI personnel only. Their spouse and children have access to TNI health services as well. The mandatory HIV testing which is applied by TNI will be able to find HIV cases among its personnel, which then enable the personnel to access CST in TNI health service. The family members of the personnel living with HIV have access to these services as well. Thus, the mandatory HIV testing enables a provision of a comprehensive support, care, and treatment for TNI personnel and their families.

Once there is a policy, the programme will follow. UNDPKO in collaboration with UNAIDS designed two kinds of programme, namely HIV/AIDS awareness card and SAP. The awareness card that should be carried by peacekeepers in missions is aimed to provide the basic information on HIV. SAP, designed for targeting the military service in general, seems to work more effectively. It is because SAP has a longer term goal, to improve the knowledge of HIV/AIDS among the military. This programme is expected to lead to safer sexual behaviour among soldiers, and in the end may reduce HIV cases in the military service. Although Indonesia is not one of the countries chosen by UNAIDS for SAP, military service in Indonesia has a HIV prevention programme. This programme started in 2003 focusing on PL training. At first, the programme was funded by DoD and FHI. Later in year 2007 FHI was no longer supporting financially the PL training. With minimum budget, it seems that it is hard for TNI to continue PL training. As one of the NAC members, the Chief of TNI is responsible to mobilize resources either from domestic or international fund for implementing the HIV prevention programme.

The issue about the budget in implementing the HIV prevention programme is one. Another important thing to be considered is the exclusive target of PL training in TNI. Only officers have the chance to attend this training, while the higher rank, the smaller the number of people. Officers cover a small number of TNI personnel compared to non-officers. Thus, PL training for non-officers has the potential to increase the

knowledge about HIV. If the non-officers are included in the PL programme the number of beneficiaries will significantly increase. However that strategy still needs further improvement to reach the effectiveness of the programme.

PL training is a programme run in home country. While Kontingen Garuda personnel are on mission, whether in Lebanon or in DRC, they will need a different programme implemented in the host countries. Continuous information programme about HIV/AIDS given to the personnel during the mission is very essential. Peacekeepers may have sexual contact with refugees in camps or even with SW. HIV prevention programme during PKO is important, but Indonesia does not have this kind of programme. Providing the HIV information to the troops is not compulsory for the TNI medical officer in charge. Knowing the importance of peacekeepers knowledge on HIV prevention, TNI should ensure the provision of the programme in mission.

A survey in Indonesia showed that comprehensive knowledge of HIV among TNI personnel in general is low. It is much lower compared to those of other countries. This finding may confirm the fact that the PL training are focused only for officers instead of the non-officers. The ones who get the benefit of the programme are mostly officers. If the programme can be expanded to non-officers, the discussion on AIDS among the TNI personnel may become more open. But, this is not the case yet because the barrier due to hierarchy is still there. The non-officers are unlikely to talk comfortably about HIV with the officers.

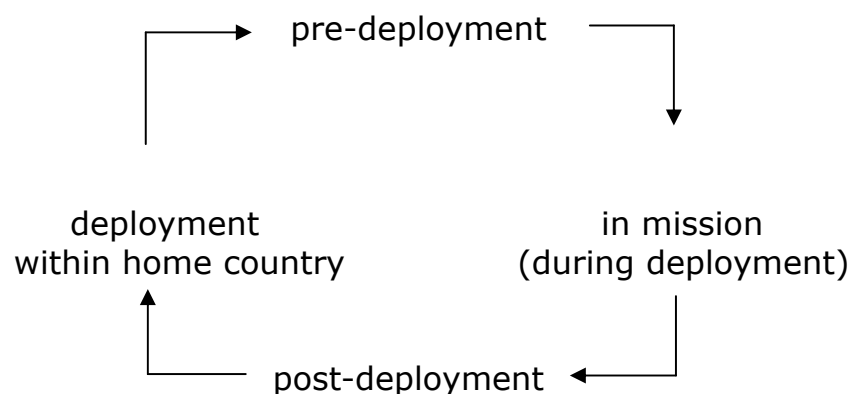
Now when we return to issues around STIs and HIV in military service as mentioned at the beginning of this chapter, we can see the link between HIV incidence in TNI and the KAP among TNI personnel. Low comprehensive knowledge of HIV combined with low condom use as shown in surveys among TNI personnel is likely to fuel the spread of HIV among TNI soldiers. Moreover buying sex from SW is often practiced by the soldiers, whether he is single, married, or divorced (IBBS, 2007). This situation supports the finding that HIV incidence among TNI personnel is soaring.

High risk sexual behaviour seems to be a part of soldiers' characteristics. Being fearless and aggressive, built during the military training are often practiced in personal life. These characteristics become the driving factor of HIV epidemic among TNI soldiers. On the other hand, HIV is highly stigmatized in TNI. The attitude towards PLHIV in military setting does not support TNI personnel to deal with his or her life as PLHIV. A status of a TNI personnel living with HIV is easily spread and people start gossiping the person. That is the example from my personal experience working in military hospital. Breaching confidentiality is a serious issue to be addressed in TNI. Another example comes from a statement of high rank

officer in TNI who mentioned the action he will take to handle HIV. The action he will take is separating HIV-positive personnel from his or her family and quarantine them in order to avoid HIV spreading. If the commander or high rank officers in TNI stick to this action, it will discourage the soldiers to discuss openly about HIV/AIDS. When stigma and discrimination is high, the initiative from the soldiers to gain more information about HIV/AIDS or knowing their HIV status is not likely to come up.

Some countries show that when their leaders support HIV programme, ask the participation from other sectors in addressing HIV issue, and encourage people to discuss HIV openly, these all reduce stigma and discrimination. In this context, TNI needs to provide information about HIV on various aspects from the high rank levels. This information should cover the health aspect, as well as security and ethical issues.

From the study questions that were raised in the previous chapters and using the framework as a guiding tool to assess HIV prevention programme in Indonesian contingent joining UNPKO, the writer created a cycle of Indonesian soldiers on duty as figured out below:



The cycle shows the existing system of soldiers joining PKO and when returning home they will be posted in any military-base in Indonesia. HIV prevention programme should be designed based on particular needs of the soldiers in the different phases of the cycle.

Chapter 7: Conclusions and Recommendations

Conclusion

The HIV incidence among the soldiers keeps rising. This epidemic should be addressed seriously by TNI leaders. Any HIV prevention programme that is being implemented should be continuous. The ethical issue also needs to be taken into consideration. A emphatic approach from the commander in addressing HIV will encourage the soldiers to gain more knowledge on HIV/AIDS. If this assumption works, the risky sexual behaviour among the soldiers may be reduced. It is expected that such a process will bring the current trend in HIV incidence down in the following years.

Recommendations

The recommendations are purposed to design a comprehensive programme for TNI and engage in lobby with NAC to ensure the sustainability of HIV prevention programme in TNI. Next to that, collaboration with the military services from other countries and seeking for the international donors are possibly to create.

The recommendations are based on the cycle of Indonesian soldiers on duty as mentioned in the discussion.

1) Pre-deployment:

- to add STIs/HIV knowledge in the basic curriculum, both in military academy and military training (for 'non-military academy' alumni)
- to include non-officers as target group of PL trainings

2) In mission (during deployment):

- to design a structured programme schedule on STIs and HIV/AIDS which will be run by experienced medical personnel in charge during UNPKO
- to strengthen the report system of STIs cases among peacekeepers

3) Post-deployment:

to promote the utilization of VCT services in TNI

4) Deployment within home country:

- to provide HIV-information in the "soldier's pocket book" which already exists but lacks a link to HIV/AIDS
- to put confidentiality of soldiers living with HIV/AIDS into serious consideration by commanders
- to provide information for commander's level (the importance of not 'breaching confidentiality')

5) For research purposes

to design and administer questionnaires for soldiers in assessing their KAP. The results will then be used to determine the interventions for the comprehensive HIV programme in TNI

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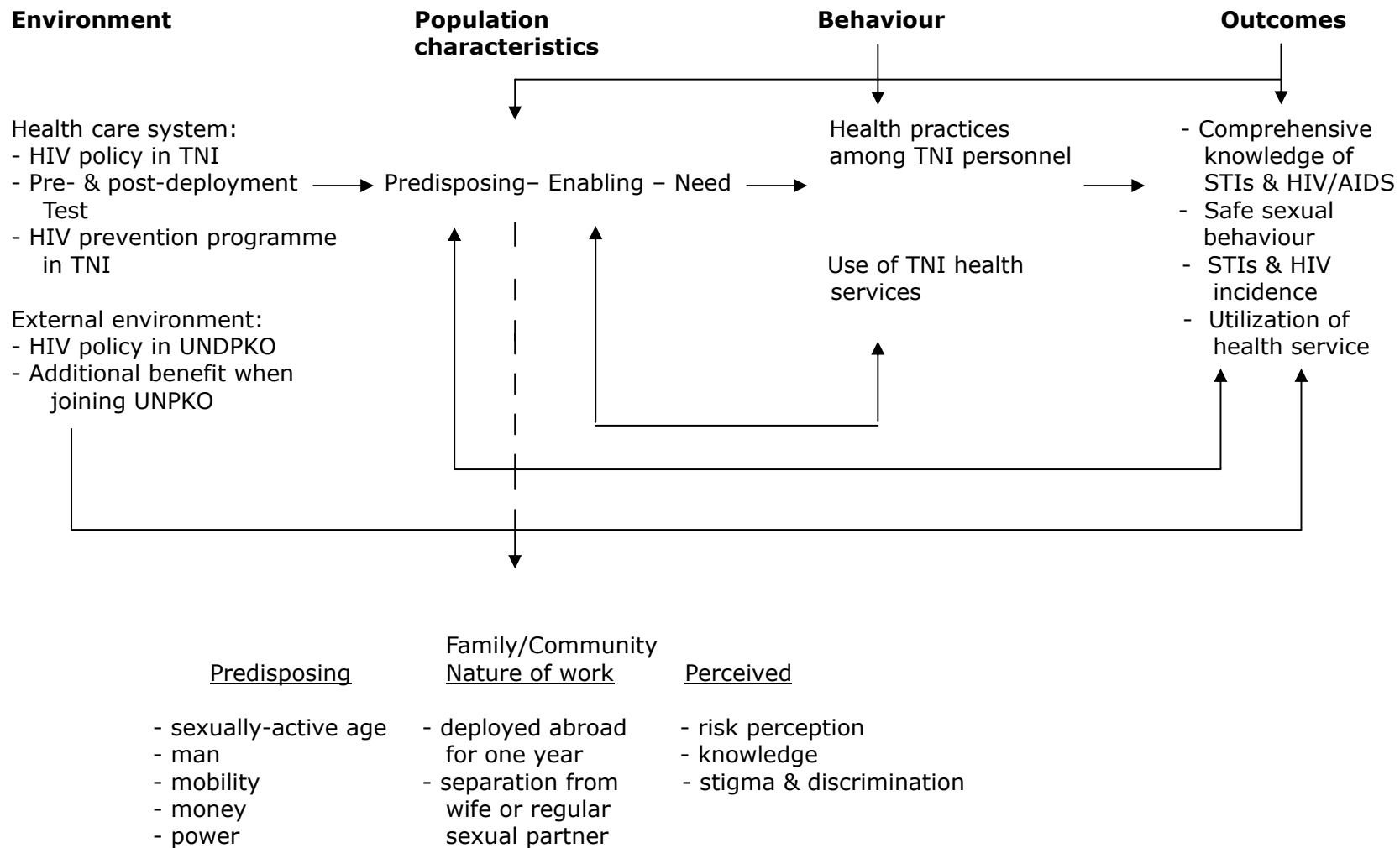
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Annexes

Annex 1: Framework (Andersen's behavioural model)



[Adopted from: Andersen's Behavioural Model (Andersen, 1995)]

Annex 2: Referral military hospitals for HIV/AIDS cases in Indonesia



Military referral hospitals for HIV/AIDS cases:

1. Java Island:
 - Army Centre Hospital Gatot Subroto Jakarta
 - Navy Hospital dr. Minto Harjo Jakarta
 - Navy Hospital dr. Ramelan" Surabaya
2. Sumatra Island: Army Hospital Putri Hijau Medan
3. Batam Island: Navy Hospital dr. Midiato Tanjung Pinang
4. Kalimantan Island: Army Hospital Balikpapan
5. Sulawesi Island:
 - Army Hospital Teling Manado
 - Army Hospital Pelamonia Makassar
6. Kupang Island: Army Hospital Wirasakti Kupang
7. Papua Island:
 - Navy Hospital dr. Sudibjo Sardadi Jayapura
 - Army Hospital Marthen Indey Jayapura

(source: Sholihin, 2009a)

Annex 3: Peer leader training schedule in TNI

JADWAL PELATIHAN PEER LEADER DEPHAN TNI

Waktu	Materi Pelatihan	Fasilitator
HARI PERTAMA		
08.00 – 08.30	Pre Test	
08.30 – 09.30	Pengantar Pelatihan - Perkenalan - Tujuan Pelatihan - Kontrak Belajar	
09.30 – 10.30	Nilai Kelompok dan Nilai Individu	
10.30 – 12.00	Infeksi Menular Seksual dan Disetisiasi	
12.00 – 13.00	ISHOMA	
13.00 – 14.30	Wild Fire	
14.30 – 14 .45	Break	
14.45 – 16.00	HIV/AIDS	
HARI KEDUA		
08.00 – 09.00	Mitos dan Fakta	
09.00 – 09.15	Break	
09.15 – 10.30	Kondom dan Permasalahan	
10.30 – 12.00	Napza	
12.00 – 13.00	ISHOMA	
13.00 – 15.00	Orientasi Seksual dan Perilaku Seksual	
15.00 – 15.15	Break	
15.15 – 16.00	Pengenalan Peer Leader	
HARI KETIGA		
08.00 – 09.00	Komunikasi	
09.00 – 09.15	Break	
09.15 – 11.00	Komunikasi Perubahan Perilaku	
11.00 – 12.00	Strategi Pendekatan dan Intervensi	
12.00 – 13.00	ISHOMA	
13.00 – 14.30	Strategi Pendekatan dan Intervensi	
14.30 – 14.45	Break	
14.45 – 15.45	Media dan Alat Bantu	
15.45 – 16.00	Post Test	
HARI KEEMPAT		
08.00 – 09.30	Studi Kasus (Respon terhadap isu HIV/AIDS)	
09.30 – 11.00	Penyusunan Rencana Kerja PL	
11.00 – 12.00	Penutupan	

(Source: Sholihin, 2009c)