Order Code RL30761

HIV-1/AIDS and Military Manpower Policy

Updated November 28, 2000

(name redacted)
Specialist in National Defense
(name redacted)
Research Associate
Foreign Affairs, Defense, and Trade Division

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Summary

In October 1985, the Department of Defense (DOD) began screening all applicants for military service for Human Immunodeficiency Virus-1 or HIV-1. Such screening was controversial. Since then, DOD has taken other actions and issued guidlelines on various aspects of its AIDS policy which have been carefully watched and scrutinized by Congress, and other Federal and State agencies because of their ground-breaking nature.

This report examines aspects of DOD policy on HIV-1/AIDS and legislation introduced to modify this policy. Under current DOD policy, applicants who test positive for HIV-1 infection are not eligible for enlistment or appointment to the military. This policy also sets guidelines on the assignment of military personnel with HIV-1 infection, disease surveillance and health education, retention, separation, safety of the blood supply, and limitations on the use of information.

In recent years, legislation has been introduced calling for the military separation of HIV-1-positive personnel. However, these efforts have not been successful. The most recent development is that legislation in the FY2001 Defense Appropriations Act earmarks $10 million in defense funding to help address the problem of HIV-1/AIDS in Africa.

The ongoing debate on HIV-1/AIDS and military manpower policy includes the following issues. First, although HIV-1 testing procedures have remained largely the same, opponents have suggested that the President should terminate testing. Second, concerns exist over the career implications for personnel who test positive for HIV-1. These include providing information concerning the source of the infection, assignment limitations, and the separation or retention of service members who test positive for HIV-1. Third, AIDS could be expected to strain the military health care system only if the rate of infection significantly increases. AIDS is an expensive illness to treat; however, so far, the services have not incurred major economic impacts from the disease. Fourth, although DOD took an early lead in medical research on AIDS, this role has been questioned. Proponents of a continued DOD role cite DOD's ability to conduct extensive and controlled tests. But, opponents argue that DOD clinical studies are redundant and wasteful. Fifth, DOD works to protect military personnel and dependents from HIV-1 infection through testing, screening blood supplies, and developing educational initiatives. If, in the future, DOD approaches this issue from simply a readiness perspective, protection of personnel might include the separation of infected service members. Such separations may have an effect on the member's access to health care and future income. Sixth, current policy states that HIV-1-positive service members are not deployable overseas. Were proposed legislation enacted to separate HIV-1-positive personnel, it would only marginally affect the number available for deployment.

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Most Recent Developments

The FY2001 Defense Appropriations Act, P.L. 106-259, contained language providing $10,000,000 from the Defense Medical and Health Core Programs "for HIV prevention educational activities undertaken in connection with U.S. military training, exercises, and humanitarian assistance activities in African nations."[1]

This report considers the current DOD policy on HIV-1/AIDS and the nature of the situation that precipitated its creation. This report then looks at the issues raised concerning this policy. Finally, this report considers the legislative efforts to modify this policy. Included in this consideration is the recent decision to utilize DOD funds to address the issue of HIV-1/AIDS in countries in Africa.

Background

In October 1985, DOD began testing all recruits entering the armed services for evidence of infection with HIV-1 (human immunodeficiency virus-1; although the term HIV is also used, HIV-1 will be used for purposes of clarity). In addition to testing all recruits, the services began testing those personnel already serving. DOD has established other policies regarding HIV-1 and military personnel. These include restricting the deployment of infected personnel overseas, cushioning the effects of such an infection may have on the careers of military personnel, and providing adequate care for personnel suffering from the Acquired Immune Deficiency Syndrome (more commonly known as AIDS). In these efforts, DOD has created one of the most extensive and comprehensive policies dealing with AIDS infection. Early congressional interest on the subject of HIV-1/AIDS in the military concentrated on the need for effective preventative measures, and was characterized by an approach seeking to balance the needs of the individual and the needs of the service when individuals became HIV-1-positive while on active duty. This included allowing them to remain on active duty, with restrictions on their deployability that some have characterized as detrimental to readiness.

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[1] U.S. Congress, Making Appropriations for the Department of Defense for the Fiscal Year Ending September 30, 2001, and for other Purposes, Conference Report, H.R. 4576, 106th Congress, 2nd Session, July 17, 2000: 17 (H.Rept. 106-754).

Scope of the Problem

Acquired Immune Deficiency Syndrome is a contagious and deadly disease primarily transmitted sexually or through the exposure to blood or blood products (e.g., transfusions or sharing syringes), and is generally fatal. AIDS in the United States has been found to be concentrated in certain groups, particularly male homosexuals and intravenous drug users (approximately 86% of all AIDS cases reported through 1999). Male homosexuals and/or IV drug users account for 78% of the cumulative total of all AIDS cases, as of 1999.[2] Concern exists, however, that the incidence of AIDS spreading through heterosexual contact may rise dramatically. Although AIDS is increasing among women, the greatest increase in the incidence of AIDS is among the minority population in general.

HIV-1/AIDS and the Military

In 1995, the Department of Defense reported:

To counter the threat of HIV to our military forces, in fiscal year (FY) 1986, DOD initiated a research program to prevent infection (e.g., vaccine development) and monitor the spread of HIV infection in military forces. The impact of mandatory testing has resulted in a progressive reduction in the rate of HIV infection in applicants to military service as can be seen in **Tables 1 and 2**.

> This rate reduction is most likely due to the growing knowledge among the applicant pool about the testing policy and the exclusion criteria for illicit drug use as well as HIV positive status.
>
> Since 1986, there have been 9,473 positive HIV infected persons across all DOD categories of personnel (active duty, reserve, etc.) Of those, 804 are deceased. Over 3.5 million civilian applicants for military service have been screened and over 3,860 infected applicants have been excluded from military service.
>
> As of June 15, 1995, 1128 active duty members were infected with HIV. The rate per 1,000 has steadily decreased from 2.83 (1985-1987) to 0.7 (1995).
>
> This drastic reduction in HIV seroconversion [the number of HIV-1-positive personnel per 1,000 in the military] can be attributed to the aggressive ongoing educational program across the military services for all levels of personnel.[3]

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[2] Centers for Disease Control & Prevention, National Center for HIV, STD and TB prevention. *Surveillance Report*, Vol. 11, No. 2, [http:// www.cdc.gov/hiv/stats/hasr1102/tables5.htm].

[3] U.S. Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), " HIV Seroconversion and Military Manpower Policy," updated September 22, 1995.

Table 1. Incidence of HIV-1-Positive Applicants to Military Service
(Rate per 1,000 by Year)

Period	Rate per 1000
Oct. 1985 - Dec. 1985	1.62
CY 1986	1.49
CY 1987	1.35
CY 1988	1.05
CY 1989	1.04
CY 1990	0.85
CY 1991	0.73
CY 1992	0.51
CY 1993	0.45
CY 1994	0.48
CY 1995	0.41
FY1996*	0.40
FY1997	0.38
FY1998	0.35
FY1999	0.35
FY2000**	0.33

*Data reported after 1995 is in Fiscal Year.
**Data though August 2000.

Table 2. HIV-1 Test Results of Civilian Applicants to Military Service
(Number Positive by Fiscal Year)

FY Period (Oct. - Sept.)	Number Positive
FY1987	843
FY1988	614
FY1989	564
FY1990	417
FY1991	306
FY1992	189
FY1993	161
FY1994	159
FY1995	142
FY1996	137
FY1997	140
FY1998	120
FY1999	121
FY2000**	114

**Data through August 2000.

Description of Department of Defense Policies on HIV-1/AIDS

Taking a lead in dealing with contagious diseases is not new to the Department of Defense. The ability to apply larger-scale medical surveillance and treatment has made the military an institution within which larger health and social policies are often developed and tested. The most recent Department of Defense policy on HIV-1/AIDS is embodied in a directive of March 19, 1991 as modified.[4] The following represents a summary of its provisions. (The language in italics is quoted from the 1991 DOD Directive).

1. Deny eligibility for appointment or enlistment for Military Service to individuals with serologic evidence of HIV-1 infection.

Under this policy, all personnel entering the military are screened for evidence of the presence of the AIDS virus – that is, for serological evidence of HIV-1 infection using the commercial enzyme-linked immunosorbent assay (ELISA) serological test. If the ELISA outcome is positive, the ELISA is repeated and a second, more precise immunoelectrophoresis test (known as "Western blot") is conducted. If found to have tested positive on **two** ELISA tests **and** the Western blot test, the individual is not eligible for appointment or enlistment for military service. (Under testing conditions, an individual is tested using the ELISA. If the first ELISA is positive and the second is negative, a third ELISA is conducted. The outcome of the third ELISA will be used to determine if the Western blot test is indicated.)

Personnel may enter the military through a variety of channels including enlistment and various officer training programs: Reserve Officer Training Corps (ROTC), the Armed Forces Health Professions Scholarship Program, the service academies, and direct appointment of various specialists such as Judge Advocate General (legal officer) programs. In each of these, individuals undergo a screening process. If a positive HIV-1 serologic test is in evidence, the individual is simply released or separated from the program.

2. Screen active duty (AD) and Reserve component military personnel periodically for serologic evidence of HIV-1 infection.

With approximately 1.37 million personnel on active duty deployed worldwide and 1.35 million Selected Reservists and Standby Reservists in the United States,[5] it is virtually impossible to test all military personnel at a particular time or in a particular location. After initial testing, the services retest each active duty member at least once every 2 years. Certain individuals (those subject to overseas deployment or working in certain medical specialties) may be tested more frequently. (On July 8, 1996, Army officials reported that Army Reserve and Army National Guard members,

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[4] U.S. Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), Directive, Human Immunodeficiency Virus-1 (HIV-1), No. 6485.1, March 19, 1991 (Administrative Reissuance Incorporating Change 1, August 10, 1992).

[5] [http://www.defenselink.mil/pubs/almanac/almanac/at_a_glance.html], as of March, 1999.

not serving on extended active duty, will be retested every 5 years.[6] This change in policy was implemented on July 1, 1996.) Individuals who are eligible to receive military health care (spouses and dependents of active-duty personnel, for example) and who are at risk (through sexual contact with infected persons, HIV-1-exposed women with newborn children, users of contaminated intravenous drug paraphernalia, and so on) are to be notified of their potential exposure. In addition to notifying the potentially exposed beneficiaries of the military health care system, the spouses of infected reserve component personnel are notified either through military health care providers or through local public health authorities. The names of those not eligible for military health care services will be provided to the appropriate civilian health authorities unless such notification is prohibited by civilian ordinance.

3. Refer AD personnel with serologic evidence of HIV-1 infection for a medical evaluation of fitness for continued service in the same manner as personnel with other progressive illnesses, ... Medical evaluation shall be conducted in accordance with the standard clinical protocol, ... Individuals with serologic evidence of HIV-1 infection who are fit for duty shall not be retired or separated solely on the basis of serologic evidence of HIV-1 infection. AD personnel with serologic evidence of HIV-1 infection or who are ELISA repeatedly reactive, but WB [Western Blot] negative or indeterminate, shall be advised to refrain from donating blood.

Under this policy, active-duty personnel with evidence of HIV-1 infection who are found otherwise fit for duty in accordance with military medical standards are eligible for continued service in the armed forces. In this respect, such individuals are treated the same as others with evidence of other progressive illnesses (such as cancer that is in remission and does not inhibit or restrict the service member from performing his or her normal military duties). Under this policy, personnel with evidence of HIV-1 infection without evidence of physical or neurological impairment will not be separated from the service solely on the basis of such evidence of HIV-1 infection.

4. Deny eligibility for extended AD (duty for a period of more than 30 days) to those Reserve component members with serologic evidence of HIV-1 infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). Reserve component members who are not on extended AD or who are not on extended full-time National Guard duty, and who show serologic evidence of HIV-1 infection, shall be transferred involuntarily to the Standby Reserve only if they cannot be utilized in the Selected Reserve.

Reserve component personnel (including members of the National Guard) who evidence HIV-1 infection are not eligible for extended active duty (i.e., periods greater than 30 days), with limited exceptions. Reserve component personnel not serving on extended duty will be involuntarily transferred to the Standby Reserve[7]

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[6] Patterson, Kristin, Soldiers now to be screened for HIV once every five years, *Army Times*, July 8, 1996: 24.

[7] According to 10 United States Code 10151 "The Standby Reserve consists of those units or members, or both, of the reserve components, other than those in the Ready Reserve or Retired (continued...)

only if they cannot be assigned to the Selected Reserve in accordance with current regulations.

5. Retire or separate AD or Reserve Service members infected with HIV-1 who are determined to be unfit for further duty, ...

The 1991 DOD directive covers several situations. First, those HIV-1-infected active-duty personnel who are determined to be unfit for duty will be separated or retired. Second, certain infected personnel who are found not to have complied with a lawfully ordered preventive medicine procedure (such as refraining from certain high-risk behavior) may be subjected to disciplinary action (including separation, if appropriate). Third, the Secretary of the military department concerned, under plenary authority, may separate an infected member at the member's request. Fourth, "reserve members with serologic evidence of HIV-1 infection may be transferred to the Standby Reserve or separated when they fail to provide from their civilian physician an evaluation" conforming to standard clinical protocol as directed by DOD.[8]

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[7] (...continued)
Reserve, who are liable for active duty only as provided for in sections 12301 and 12306 of this title." In practice, the Standby Reserve contains those reservists who have a temporary disability or hardship and those who hold key defense related positions in their civilian jobs which limit their mobilization potential. In the Standby Reserves, reservists are not required to participate in training and are subjection to involuntary activation (mobilization) only in case of a "full mobilization." Under current conditions, a full mobilization can only occur when Congress declares war or national emergency due to restrictions on the mobilization of reserve manpower in the absence of such a declaration.

[8] A medical evaluation, under standard protocol, needs to be conducted annually with T-cell evaluations every six months for those infected. The medical assessment must include: an epidemiological assessment; history of physical, neurological and neuropsychological exams; relevant blood and lymphocyte counts (including T-lymphocyte cell count and absolute CD4 an CD8 levels); intradermal skin tests, HIV-1 ELISA confirmation, and a chest x-ray. In addition, the medical workup shall include evaluations for other sexually transmitted diseases. Blood samples shall be maintained for at least 3 years at minus seventy (-70) degrees Celsius. Finally, a mental health assessment must be conducted as specified for illness or behavioral indications associated with HIV-1 infection. The infected individual must be classified according to the stage of the infection as defined in the armed forces HIV-1 disease classification, and the information must be recorded according to codes used in the International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM). The infected member is evaluated for duty fitness and referred to a Medical Evaluation Board if progressive signs of the illness are indicated. "AD Service members determined to have been infected with HIV-1 at the time of enlistment are subject to discharge for erroneous enlistment."

6. Ensure the safety of the blood supply through policies of the Armed Services Blood Program Office, the FDA guidelines, and the accreditation requirements of the American Association of Blood Banks.

Protecting the blood supply or health of potential donors and recipients, (i.e., service members) is of critical importance to DOD and therefore a central issue. Combat or combat-related injuries, especially during major battles, require large supplies of blood for transfusions. The need for screening the blood supply is therefore critical. In certain cases, "battlefield transfusions" may be required. Protecting this blood supply is an important rationale behind DOD policy. One result of this policy is that HIV-1 infected service personnel will not be assigned to units subject to deployments outside the United States.

7. Comply with applicable statutory limitations on the use of information obtained from a Service member during, or as a result of, an epidemiologic assessment interview and the results obtained from laboratory tests for HIV-1, ...

Information gained as a result of testing may not be used as the sole basis for an adverse administrative action. However, these results may be used for other purposes consistent with DOD regulations or directives that pertain to separation (for disability reasons, for example), control of the blood supply, or under Federal or military rules of evidence or the rules of evidence of a State under specific circumstances. These circumstances include the failure to follow preventive medical procedures or orders, as part of a criminal prosecution in which evidence of HIV-1 infection is an element of proof of an offense charged, or a proper ancillary matter in a relevant legal proceeding (e.g., a member convicted of rape after being informed of an HIV-1 infection).

8. Control transmission of HIV-1 through an aggressive disease surveillance and health education program.

Aggressive disease surveillance includes the periodic retesting of all military personnel. Active duty personnel who show evidence of serologic infection receive a medical evaluation under established protocol to determine the status of the infection and duty fitness. Reserve component personnel who are ineligible for military medical care are counseled on the significance of a positive test result and referred to their private physician for further care and counseling.

In terms of health education, reduction of the rates of occurrence of HIV-1 in military personnel and other health care beneficiaries is the goal. To this end, DOD provides testing, information, education, and behavior modification programs to limit or prevent the spread of HIV-1. These programs are explicitly targeted to those who are infected or who are at high risk for infection.

9. Provide education and voluntary HIV-1 serologic screening for DOD health care beneficiaries (other than Service members).

Education and voluntary testing are carried out in those instances where information is received by an appropriate authority that a military health care beneficiary (such as a spouse) may be at risk. Individuals with serologic evidence of

HIV-1 infection receive appropriate testing, counseling, and education (particularly with regard to minimizing the potential for spreading the infection).

An epidemiological investigation is conducted to determine the source of the infection as well as the potential for exposure to others via blood banks, sexual relations, and drug paraphernalia, for example. As appropriate, information obtained as a result of an epidemiologic assessment will be provided to local health care authorities in compliance with the provisions of the Privacy Act of 1974, which regulates government record-keeping and disclosure practices. Finally, disease reporting is conducted consistent with the provision of the directive, "through liaison between the military public health authorities and the appropriate local, State, territorial, Federal, or host-nation health jurisdiction."

10. Comply with host-nation requirements for HIV-1 screening of DOD civilian employees, ...

Under this directive, requests for HIV-1 screening of DOD civilians employed overseas based on, and only on, host-nation screening requirements are made to the Assistant Secretary of Defense. Such requests concerning prospective employees are considered to be imposed by the host nation with no official commitment on the part of DOD for those who refuse or are diagnosed as HIV-1 seropositive.

Those employees who test positive (with a confirmatory Western blot following two positive ELISA tests, at DOD expense) will not be assigned to host nations that require seronegativity. Such employees will be retained in their positions without prejudice, provided appropriate counseling and education, as well as retain all rights and benefits that accrue from such employment. Efforts will be made to protect employee confidentiality consistent with other DOD directives.

> Some host nations may not bar entry to HIV-1 seropositive DOD civilian employees, but may require reporting of such individuals to host-nation authorities. In such cases, DOD civilian employees who are evaluated as HIV-1 seropositive shall be informed of reporting requirements . . . . counseled and given the option of declining the assignment without prejudice or reporting to the host-nation. If assignment is accepted, the requesting authority shall release the HIV-1 seropositive result, as required.[9]

Those employees currently assigned overseas, in such cases, may request and receive early return at government expense, or other appropriate action (such as transfer to another host nation) without prejudice.

As a result of this policy, DOD had instituted several procedures which limit the deployment of HIV-1 infected military personnel:

> Service members with serologic evidence of HIV-1 infection shall be assigned within the United States, including Alaska, Hawaii, and Puerto Rico, due to the high priority assigned to the continued medical evaluation of military personnel. The Secretaries of the Military Departments may restrict such individuals to

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[9] U.S. Department of Defense, Directive, March, 19, 1991: 35.

> nondeployable units or positions for purposes of force readiness. To protect the health and safety of service members with serologic evidence of HIV-1 infection and of other service members (and for no other reason), the Secretaries of the Military Departments may, on a case-by-case basis, limit assignment of HIV-1-infected individuals on the nature and location of the duties performed in accordance with operational requirements.

Thus, HIV-1 infected personnel are not assigned to duty outside the United States. This policy is designed to protect the health and safety of infected personnel, non-infected personnel, and citizens of the host country.

Issues

DOD policy has raised questions about the appropriate balance between the health needs of affected people here and abroad, on the one hand, and the requisite level of military readiness, on the other hand. Those who stress the importance of disease management view medical and patient considerations as paramount. Those who stress the importance of military readiness view deployability and mission accomplishment as paramount. Defenders contend the 1991 DOD policy pursued a workable balance between the two approaches. Opponents contend that the policy needs to give additional emphasis to readiness.

Testing

The original controversy that arose when DOD implemented testing in 1985 has subsided somewhat. Early reporting on the results of testing were confusing.[10] Nevertheless, following the election of the Clinton Administration in 1992, homosexual rights activists requested that testing by the military and other governmental organizations be brought to an end.[11] Many of the arguments for and against testing continue to be debated.

Those *who oppose testing* have cited the following arguments:

- Testing may label, identify, persecute and stigmatize homosexuals in the military.
- Testing is not without errors, and such errors may cause irreparable damage to a person.
- Testing positive for exposure to the AIDS virus arguably does not provide definitive evidence that a person will ultimately contract AIDS during a military career: there exists a great disparity in estimates on the rate of those who test positive for AIDS antibodies who ultimately develop the disease. According to the Centers for

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[10] See Robinson, John, AIDS exposure high in recruits, military finds, *Boston Globe*, November 20, 1985: 3. See also 'Tests find AIDS exposure low: Screening by Pentagon detects relatively few', *Chicago Tribune*, November 26, 1985: 14.

[11] Nelson, Soraya S., Some activists want end to required testing for virus, *Air Force Times*, December, 14, 1992: 17.

Disease Control, earlier studies showed that on average, within 5 years of infection with HIV-1, 12% of homosexual/bisexual men and 15% of transfusion recipients developed AIDS. On average, within 3 ½ to 4 years, 18% of intravenous drug users developed AIDS. However, with recent advances in treatment, these estimates are much more problematic. This time may vary greatly from person to person depending on many factors, including a person's health status, their access and adherence to treatment, and their other health-related behaviors. Scientists estimate that without treatment half of HIV-infected people would develop an AIDS-related illness within 10-12 years.[12]

- Testing negative does not guarantee infected applicants will be prevented from entering the service. An individual may become infected and test negative due to the fact that the HIV-1 infection has not been present for a sufficient period of time to be detected by the testing procedure. According to the Centers for Disease Control & Prevention, the tests commonly used to detect HIV infection actually look for antibodies produced by the body to fight HIV. Most people will develop detectable antibodies within 3 months after infection, the average being 22 days. In rare cases, it can take up to 6 months. For this reason, the Centers for Disease Control & Prevention currently recommends testing 6 months after the last possible exposure (unprotected vaginal, anal, or oral sex or sharing needles). It would be extremely rare to take longer than 6 months to develop detectable antibodies.
- Given the inaccuracies of testing, lack of assurance that a positive result will lead to AIDS, the absence of a medical cure, and the relative infrequency of the illness, it can be argued that costs of service-wide testing are unjustified.
- Positive test results may be used unfairly against the service members.
- Allowing the military to test could be used to justify large-scale testing in the public and private sectors that may not be subject to controls that will protect the rights and civil liberties of the individual.

Those *who favor* testing have cited the following points:

- The issue of homosexuality in the military is not significant in this context because, when testing began in 1985, homosexuals were barred from the service. Under the statutory policy implemented in FY1994, homosexual behavior continues to be prohibited. An individual's sexuality under this policy is irrelevant.
- The two tests used by the services – the ELISA and the Western blot – together are a statistically accurate indicator of the presence of

[12] According to discussions with staff at the Centers for Disease Control & Prevention, October, 5, 2000.

HIV-1 infection. The false positive rate is statistically estimated to be 1 in 100,000.

- Although testing for DOD is expensive, the cost of treating infected personnel admitted into the service would be overwhelming. Annual costs for testing recruits are estimated to range from $4 million to $5 million. The lifetime costs of caring for each HIV-1/AIDS patient are estimated to be between $75,000 and $260,000. The Journal of the American Medical Association estimated in 1993 that the average is approximately $119,000.[13] Based on this average, the cost of providing lifetime care for the 1,128 active duty personnel who were HIV-1 infected as of 1995 would be $134,232,000. In addition, recent advances in treating AIDS have led to increases in the cost of treating AIDS patients. These new treatments have allowed AIDS patients to live longer, thus requiring an increase in costs purely on the bases of the amount of care that may be provided/required. According to an analysis by Holtgrave and Pinkerton, more recent cost estimates indicate the lifetime cost of HIV medical care is about $155,000-$195,000, depending on the rate of discounting used. (Discounting, a process to convert future costs to their present values, is a commonly accepted practice in economic evaluations).[14]
- If the services do not test for HIV-1 infection, those who believe that they are infected or at risk for infection, and lack insurance or other medical protection, may enter the service as the only viable alternative to acquire medical care.
- The services and Congress have taken steps to insure that positive test results do not lead to unwarranted adverse personnel actions and to educate personnel concerning HIV-1/AIDS to deal both realistically and compassionately with the illness, and eliminate unwarranted prejudice.
- Although precedents regarding HIV-1 testing may be lacking, the services do screen for other communicable and, arguably, less dangerous illnesses and conditions, including drug abuse.
- Maintaining the health of military personnel is essential for force readiness. This is the primary objective of military health care – provision of a healthy force to accommodate the defense needs of the country. Decisions on testing for HIV-1 or any other contagious disease must be justified in terms of readiness of the force.
- Screening military personnel for HIV-1 infection acts as a safeguard against infection via blood transfusions, and therefore, protects the blood supply. Failing to test could lead to the situation in which soldiers survive wounds inflicted by the enemy only to die from tainted transfusions from fellow soldiers.
- Today, the system for reporting HIV-1/AIDS is quite robust. The services provide a reliable source for statistics on infection rates.

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[13] Hellinger, Fred. J, The Lifetime Cost of Treating a Person with HIV, *The Journal of the American Medical Association*, July 28, 1993, Vol. 270, No. 4: 474.

[14] Holtgrave, D.R. and Pinkerton, S.D, *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, Vol. 16, No. 1, September 1, 1997: 54.

> The ability of health care professionals to measure, track, and thereby understand the illness and its mode and rate of transmission is crucial in preventing further spread of the illness and to finding a cure. DOD provides one central source of data on the infection rate in the United States through the screening of applicants. In addition, those in the service as well as those who leave and receive care from DOD and the Department of Veterans' Affairs, provide valuable information from which to monitor the progress of the illness while continuing to ensure that those who are infected continue to receive appropriate and available health care.

Career Implications

Under the 1991 DOD policy, procedures for military personnel infected with HIV-1 sought to balance the needs of the individual with the mission requirements of the military by allowing HIV-1-infected personnel to remain in uniform until unable to perform their duties. Nonetheless, some argue that testing HIV-1-positive does expose a person to prejudicial attitudes and actions. A positive test may well result in a restricted assignment, limiting a service member's opportunities for advancement. The careers of certain personnel may also be adversely affected if, and when, they reveal information regarding the source of exposure to the virus and are subsequently removed from their position as a result of such disclosures. Such a policy, it is argued, tends to discourage personnel from being frank regarding exposure to the illness. They may cite exposure via means that will not be threatening to career advancement. HIV-1 infection (without the presence of an opportunistic secondary illness) can result in impaired coordination, cognitive difficulties, or other neurologic dysfunctions.[15] This may lead to reassignment (from hazardous duty, for example), limiting the career opportunities of infected personnel who do not otherwise exhibit a secondary illness indicative of AIDS. If sufficiently severe, such impairment may lead to discharge. (The Legislation section of this report discusses efforts to mandate the removal of HIV positive personnel.)

Health Care Concerns

Specific structures within DOD have been created to deal with AIDS. DOD has designated particular medical facilities as treatment centers for certain AIDS patients. This concentration of AIDS-related care in a few facilities allows the services to maximize the amount of care available and minimize costs. Nevertheless, the costs of caring for AIDS patients, including military personnel as well as their dependents can be extremely high. If, in spite of testing and educational efforts, the spread of AIDS in the military were to rise substantially, medical costs could, in effect, compete

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[15] Willis, Grant, AIDS news won't affect 'fit for duty' policy, *Army Times*, January 11, 1988: 12; "Some people who are infected with the AIDS virus may have damaged mental functions, even though they show no outward symptoms of the disease.... 'If a person's brain is not functioning correctly, you don't want him flying high-performance aircraft, decoding sensitive messages for the President, or driving tanks [said Col. (Dr.) Edmund C. Tramont a physician at Walter Reed Army Medical Center].'"

for limited resources with the primary mission (force readiness) of the military health service system.

Conversely, as noted above, some have advocated a more aggressive separation policy for those with HIV-1 infection. They view this type of policy as central to the preservation of the force readiness essential for an effective military. Although such a policy could increase levels of protection for uninfected service members, it could prove injurious to those separated. Although separated individuals would have access to DOD (if retired) and/or Veterans' Administration (VA) health care, they could find it extremely difficult to obtain civilian employment.

Research on HIV-1/AIDS

In recent years, DOD has taken a leading role in the fight against AIDS.[16] In part, this role has arguably been mandated less by defense interests than by political concern. In FY1999 DOD obligations for AIDS amounted to $24 million for research, $10 million for prevention and $52 million for treatment. FY2000 estimates are, respectively, $34 million, $10 million and $54 million, while the President's FY2001 budget is estimated at $24 million, $21 million and $56 million.[17]

Proponents of military AIDS research note that should DOD terminate these programs, a major source of clinical research would be lost. Such research, they argue, is nearly impossible to conduct in the civilian community.[18] Also, they argue that DOD would be turning its back on infected personnel and thereby denying them the hope of a possible cure. Proponents note that DOD personnel may have more limited health care options outside of the military establishment if they do not live near a DOD or VA facility.

Opponents to this use of funds, including then Assistant Secretary of Defense (Health Affairs), Dr. Stephen Joseph, argue that clinical studies conducted by DOD are redundant given studies conducted in the civilian sector and such research is more appropriately handled by the Department of Health and Human Services. Critics argue

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[16] Such spending has been contentious. For example, in FY1995, DOD obligations for AIDS research were $41 million, representing approximately one-third of defense obligations for AIDS (the remaining two-thirds, or approximately $86 million, going to preventative measures; these amounts do not include funds spent for health care of infected personnel). Some activists have been lobbying Congress to write legislation that would require the Department of Defense to spend one-third of any AIDS research money on experimental treatment. It should be noted that in FY1995, the President requested $3.2 million for military-related AIDS research. House and Senate Appropriations Committees voted for $23.2 million and $33.4 million, respectively. P.L. 103-335 ultimately appropriated $33.5 million.

[17] Johnson, Judith A, *AIDS Funding for Federal Government Programs: FY1981-FY2001,* CRS Report 96-293 SPR, February 23, 2000: 5.

[18] Donnelly, Anne, "The DoD AIDS research program was originally structured to take advantage of the military's unique capabilities and study population and to provide HIV-infected military personnel with access to cutting edge treatment." San Francisco Project Inform, updated June 24, 1994.

that Congress is being forced by political pressure to use scarce and declining DOD resources for HIV-1 research that has no direct beneficial effect on defense needs. Indeed, it has been argued that DOD resources could be better spent preventing the spread of the illness among military personnel via testing and education, thereby protecting the uninfected and maintaining the readiness of the force.

It was reported in 1995 that DOD officials were proposing that funds used for research on combating HIV-1/AIDS be shifted to preventing the spread of the illness. In a memo released by the Army Surgeon General, Assistant Surgeon General for Research and Development, Brig. Gen. Russ Zajtchuk, stated "If a soldier is already infected, that soldier is a casualty and is of limited use to the force."[19] Such a proposed shift would, some argue, leave those infected in uniform feeling abandoned. Conversely, some have argued that such a shift is more cost effective, humane, and prudent given the military mission.

Protecting Military Personnel and Dependents

The major strategy for protecting military personnel from AIDS has involved testing applicants and current personnel, screening blood supplies, and developing educational and medical surveillance initiatives. Although testing procedures are a means of protecting personnel from HIV-1 infection, educational initiatives represent an indirect means of protection. By educating personnel about the illness and its means of transmission, it is expected that military personnel will modify their behavior to minimize the possibility of exposure. Beyond educating service members, military officials notify the respective spouses of service members who test positive (on the grounds that the spouse is a military dependent and eligible for care provided by the military). More aggressive programs that might help prevent the spread of the illness, are viewed as unduly intrusive and threatening to individual civil liberties. Coupled with other programs, such as anti-drug abuse and anti-prostitution programs, it is argued that educational programs can be an effective means of deterring the spread of AIDS and respecting individual rights.

In a number of instances, military personnel who have tested positive have been convicted by courts-martial of continuing to engage in sexual relations without informing their partner(s) of the their infection. In one particular instance, an infected airman was charged and ultimately convicted of aggravated assault "with the means likely to cause death or bodily harm" for engaging in sexual relations.[20] Although information acquired as a result of an epidemiological assessment may not be used against a service member who tests positive for an HIV-1 infection, the individual

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[19] Derochi, Kerry, Military could quit AIDS research, *Norfolk The Virginian Pilot*, June 19, 1995:A30.

[20] 'Lawyers for the soldier had sought to bar the test results as evidence on the ground that they were protected by confidentiality provisions of Army and Defense Department regulations. The judge in the soldier's court-martial agreed with that argument. But the government appealed to a three-officer panel of the Army Court of Military Review, in Falls Church, VA., which ruled Thursday that the regulations had been misinterpreted by the judge'. *New York Times*, 'Army Appeals Court Allows AIDS Test Result in Prosecution', October 19, 1987: 35.

remains responsible for his or her subsequent behavior.[21] Therefore, an individual service member who engages in behavior that is considered threatening to others (such as knowingly attempting to donate inflected blood) may be subjected to criminal prosecution in the military.

Dependents who have AIDS present a special concern to DOD officials. Compulsory testing of dependents is not authorized. Nevertheless, dependents could be a source of infection for service members. Likewise, a dependent who is known by DOD health care officials to have an HIV-1 infection is beyond the immediate control of the services.

What authority or responsibility the services have to protect civilians from sexually transmitted HIV-1 infection via an infected military member is not clear, nor is the associated legal responsibility for failure to do so.[22] In 1994, it was reported that an infected and married Navy petty officer had sexual relations with an off-duty Navy reservist without informing her that he was HIV-positive. The reservist became infected with HIV. The reservist sued the Navy, on the grounds that Navy officials failed to order the petty officer to refrain from behavior that could lead to the transmission of the illness, or at least to disclose that he had the infection. The reservist claimed that military officials were warned of the petty officer's illicit sexual activities by his wife but failed to act.[23] Military attorneys argued that the reservist had no standing to sue based on the Feres doctrine – a doctrine which prohibits military personnel from suing the government for injuries sustained incident to military service. The Ninth Circuit Court of Appeals ruled against the reservist stating that the case would represent "an impermissible intrusion into military affairs."[24] The petty officer was convicted in a court-martial of assault with a dangerous weapon and sentenced to a dishonorable discharge, 30 months confinement in the brig and reduction to E-1 (the lowest enlisted grade). The reservist received care at a VA hospital, although the VA does not consider her case service-related since she was in a civilian status and not on duty when she became infected.

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[21] U.S. Congress, Conference Committee, National Defense Authorization Act for Fiscal Year 1987, Conference Report, 5.2638. 99th Congress, 2nd Session, October, 14, 1986: 92

[22] See Associated Press, U.S. Liable for AIDS's Destruction of Marine's Family, *Washington Post*, April 27, 1990: 13. See also Willis, Grant, Member's Wife Said to Be Spreading AIDS, *Air Force Times*, July 27, 1987: 23.

[23] 'HIV-infected sailor facing court-martial for lying about results of AIDS test', *European Stars & Stripes*, November 16, 1991: 7; HIV soldier sentenced for unprotected sex, *Washington Times*, March 11, 1998: 6; Adde, Nick, For HIV carriers, sex can be a military crime, *Navy Times*, October 20, 1997: 22; Harrison, Don, AIDS-infected Soldier Faces Assault Charges, *Army Times*, April 20, 1987: 6. See also Murray, Frank J, 'Justices hear case of HIV-infected soldier: Clinton wants to fire him for misconduct', *The Washington Times*, March, 23, 1999: A6. See also, HIV-infected charged with assaults, *The Times* (a supplement to *Army Times*), June 26, 2000: 3.

[24] Adde, Nick, Courts uphold Feres doctrine in HIV lawsuit, *Army Times*, September 19, 1994:22.

Foreign Policy Questions

Current DOD policy views questions of foreign policy in relationship to AIDS as a medical issue. It states that military personnel with serologic evidence of HIV-1 will not be posted abroad, and that service members stationed overseas who test positive are returned to the United States. However, some foreign critics have charged that personnel stationed abroad are responsible for spreading the AIDS virus among foreign nationals, and argue the removal of U.S. forces from a host country. The U.S. has attempted to safeguard the host countries through periodic testing of both service personnel and civilian employees.

Once the virus is contracted, military personnel who are unaware they have the disease, or who are infected and fail to refrain from disease transmitting activities, can be responsible for the continued spread of the disease overseas. Likewise, personnel who contract the disease while overseas, are rotated to the United States, bringing the disease home with them. (Military personnel and dependents returning home under normal rotation policy are not routinely tested for HIV-1.) Current policy seeks to restrict the spread of AIDS overseas through routine testing and to care for those individuals infected by returning them to the U.S. where they may be monitored and provided with care and needed counseling. More aggressive policies, such as limiting off-base or liberty activities in areas that have high endemic rates for HIV-1 infection may be considered as has been the case for areas harboring prostitution near bases in the U.S. Such efforts may prove difficult to enforce, and are for the present no longer as vital due to a shift in areas of deployment. In part, as a result of the drawdown, the United States has reduced the number of troops deployed to AIDS high-risk areas, such as the Philippines, and to a lesser extent in parts of Africa, and Thailand. In 1990, the U.S. had 13,863 military personnel in the Philippines, 213 in Thailand and 338 in sub-Saharan Africa. By 1999, these numbers had fallen to 84, 120 and 301, respectively.[25]

By limiting the number of personnel who may be stationed overseas or aboard ship, the services would arguably limit the defense capabilities of the United States. Because the number of AIDS cases or those with HIV-1 infection is small, this represents a rather insignificant effect on military manpower policies. However, in the unlikely event that the number of cases expands, the options concerning overseas deployments could become increasingly limited.

Legislation

During the mid-1990s a number of legislative initiatives were proposed to require the discharge of HIV-positive service members. Ultimately, these initiatives failed. In addition, as part of the FY2001 Defense Appropriations Act, provisions were included that would use Defense funds to address the issue of HIV/AIDS in countries in Africa. The legislative histories of these initiatives are examined below.

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[25] U.S. Department of Defense, Directorate for Information Operations and Reports, Duty Military Personnel Strengths by Regional Area and by Country, September 30, 1990 and 1999.

DOD Discharge Policy

As already noted, the FY1996 House National Defense Authorization Act modified the discharge policy. According to the conference report on the bill:

> The House bill contained a provision (sec. 561) that would require the Secretary of Defense to separate or retire service members who are identified as HIV-positive.
>
> The Senate amendment contained no similar provision.
>
> The Senate recedes with an amendment that would provide the discharged member with an entitlement to medical and dental care within the Military Health Care System, to the same extent and under the same conditions as a military retiree.[26]

This provision would change parts of the existing policy--any member of the armed forces, except those within 2 years of retirement, would be discharged. Specifically, items 3 and 5 in the section "Description of Department of Defense Policies on HIV-1/AIDS" (above) would be stricken or modified to conform to the new law. Item 3 states that individuals "with serologic evidence of HIV-1 shall not be retired or separated solely on the basis of serologic evidence of HIV-1 infection." Likewise, item 5 directs the Secretary of Defense to "(r)etire or separate AD or Reserve Service members infected with HIV-1 who are determined to be unfit for further duty, ..." DOD had until August, 1996 to separate HIV-infected personnel currently serving.

The legislation, arguably, shifted the balance of the existing medical/readiness compromise to a more deployment oriented policy but would leave in place many of the privacy and civil rights protections. In proposing this language, Representative Dornan argued that since HIV-1-infected personnel cannot be deployed, they represented a drain on readiness and adversely affected the morale of those who have to take their place. Critics contended that the language would do little to affect readiness since so few individuals in uniform are infected and that it raises legal questions of equal protection since other "medically nondeployable" personnel would not be involuntarily discharged. DOD opposed the bill, calling it inhumane, and thus adversely affecting morale. In addition, DOD said it was contrary to the notion that the services "take care of their own." Proponents of mandatory discharge noted that HIV-1 was the only illness that results in permanent assignment of members within the Continental United States (CONUS). (Each Service, based upon specific requirements, may limit the assignment of members with certain other illness.) Thus, they argued, HIV-1 infected personnel receive "special treatment" not available to other individuals (as a group) with illnesses.

On December 19, 1995, President Clinton vetoed the first version of the FY1996 National Defense Authorization Act citing, among other things, his concern that this language would "unfairly affect certain service members." The President stated that

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[26] U.S. Congress, Conference Committee, National Defense Authorization Act for Fiscal Year 1996, Conference Report, H.R. 1530, 104th Congress, 1st Session, December 13, 1995: 810.

the language would require the "medically unwarranted discharge procedures for HIV-positive service members."[27]

On January 5, 1996, the House substituted the FY1996 Defense Authorization Act language (including that pertaining to the discharge of HIV-positive personnel), via a substitute amendment, into S. 1124, and sent the language to conference anew. This act was passed by both houses, and signed by the President on Feb. 10, 1996.[28] The Administration stated that it would try to repeal the provision, possibly via a legal challenge. H.R. 2959 was introduced to specifically repeal this provision. This bill had been referred to the same committee that drafted the mandatory separation language.

On March 19, 1996, the Senate amended the Balanced Budget Downpayment Act, II, (H.R. 3019) with language that overturned the authorization provision requiring the discharge of HIV-1 infected personnel.[29] Thus, no one was discharged for being infected with HIV under the FY1996 language.

As part of its markup for the FY1997 Defense Authorization bill, the House Military Personnel Subcommittee included language that once again called for the mandatory discharge of certain HIV-1 infected personnel.[30] Under this new language, the services were required to discharge HIV-1 infected personnel within two months of confirmation of HIV-1 infection. "Unlike the provisions signed into law by the President, this new provision would have provided a medical retirement of HIV-positive service members, as well as an income. This legislation would also have provided the service Secretaries the discretion to retain service personnel with 15 or more years of service if the service Secretary deemed their retention as necessary for service".[31] This bill was passed by the House on May 15, 1996. The Senate language required the Secretary of Defense to establish regulations setting forth uniform policies and procedures regarding the retention of members of the armed services who are nonworldwide deployable for medical reasons. Ultimately, the Conferees dropped both of these provisions.[32]

The language adopted by both the House and the Senate in 1996, attempted to reorient policy to give greater weight to the needs of the military rather the needs of the individual. Under the House provision, personnel who have tested positive for HIV-1 would be separated from the military because they are no longer fully capable

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[27] Congressional Record, January 3, 1996: H12.

[28] U.S. Congress, National Defense Authorization Act for Fiscal Year 1996, P.L. 104-106, February 10, 1996.

[29] P.L. 104-134. See also Congressional Record S2293-2295, March 19, 1996.

[30] U.S. Congress, House, Armed Services Committee, National Defense Authorization Act for Fiscal Year 1997, H.R. 3230, 104th Congress, 2nd Session, H.Rept. 104-563, May 7, 1996.

[31] Opening remarks of Subcommittee chairman Robert Dornan, Military Personnel Subcommittee Mark-up, FY1997 Defense Authorization Act, April 25, 1996.

[32] U.S. Congress, National Defense Authorization Act for Fiscal Year 1997, Conference Report, H.R. 3230, 104th Congress, 2nd Session, H.Rept. 104-724, July 30, 1996.

of performing military service (i.e., they are not deployable). Such an outcome based solely on HIV-1 infection would end the careers of infected personnel who did not otherwise exhibit a secondary illness indicative of AIDS. Thus, concerns bearing on further military career implications (as described above) would have become moot for personnel who had been discharged. The only situation in which these issues would continue to be relevant would have been in the case of personnel who are within 5 years of retirement. Because they are within a "sanctuary period" and consequently would be protected from separation except for cause (such as violations of the Uniform Code of Military Justice), these issues would continue to face HIV-1-positive personnel until they retire from military service. Under the Senate language, HIV-1 infected personnel would be treated as are others, and vice-versa. Since both of these provisions were dropped from the Conference report, only HIV-1-infected personnel, as a group, are protected from worldwide deployment.[33] Other diseases are treated on a case-by-case basis.

Evolution of Defense Department Involvement in U.S. HIV Initiatives in Africa

As the dimensions of the AIDS epidemic, especially in the developing world, are being understood, new global efforts, including those by the United States, to combat the HIV/AIDS epidemic have become more prominent and multifaceted. Estimates from the UNAIDS (joint United Nations Program on HIV/AIDS) indicate that globally 16,000 new HIV-infections take place every day and that 34.3 million people are currently living with HIV/AIDS worldwide. A projected 24.5 million of these live in sub-Saharan Africa.[34] So far, an estimated 18.8 million people have died of the epidemic worldwide of which 11.5 million of these deaths have occurred in sub-Saharan Africa.[35] The overall rate of infection among adults in Sub-Saharan Africa is approximately 8.6% compared to 1.1% worldwide and the number of HIV/AIDS cases in Southern Africa continues to grow at an alarming rate. Further, the infection rate of several southern African countries is believed to have reached 20% or higher. Botswana, for example, has reported an infection rate of 35.8%.[36]

A series of events began in 1999 which would result in greater involvement of the U.S. and DOD in combating the HIV/AIDS epidemic in Africa. In March, 1999, the United States hosted a U.S. - Africa ministerial conference in Washington. Later that year, December, 1999, Richard Holbrooke, the U.S. ambassador to the United Nations, made a visit to several African countries. On Holbrooke's initiative, January 2000 was then designated by the U.S. as the 'month of Africa', shedding light on topics such as wars, epidemics and economic needs of the continent. Furthermore,

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[33] According to Patricia Collins, Office of the Assistant Secretary of Defense (Health Affairs), March 7, 1996: "HIV is the only illness that results in permanent assignment within the Continental United States (CONUS)."

[34] Report on the global HIV/AIDS epidemic, [http://www.usaid.org], June 2000: 6.

[35] AIDS in Numbers, [http://www.washingtonpost/world/daily/july00].

[36] See Copson, Ray, *AIDS in Africa*, CRS Issue Brief IB10050, August 11, 2000: 1-2.

on February 28, 2000, the U.N. Economic and Social Council (ECOSOC) gathered to discuss HIV/AIDS issues. These initiatives suggest a greater vigilance towards African affairs and an increased interaction with African leaders.[37] On January 10th, later followed-up on July 17th, 2000, the United Nations Security Council made AIDS the subject of U.N.'s first session ever dedicated to a single health issue.[38]

The Clinton Administration re-emphasized the interdependence between domestic and international consequences of the epidemic by linking AIDS to U.S. national security interests. In April 2000, the Clinton Administration officially designated HIV/AIDS as a threat to U.S. national security. This conclusion appeared to be based on the anticipation that the AIDS epidemic can lead to regional instability and a slowing of democratic development and economic growth. This new push is, among other things, reflected in the doubling of FY2001 budget requests – in which the Clinton Administration is asking Congress for an increase of $100 million to $342 million – for international AIDS prevention and care. These funds will primarily be targeted in the worst hit HIV/AIDS areas, predominantly in Southern Africa.[39] Critics contend that although the Southern Africa pandemic has been common knowledge for years, recent U.S. efforts serve a more political rather than practical purpose.

On May 10, 2000, President Clinton signed an executive order to help make HIV/AIDS-related drugs and medical technologies more affordable and accessible to beneficiaries sub-Saharan African countries.[40] In addition, the U.S. Export-Import Bank announced on July 19th, 2000, that it would lend $1 billion per year to finance the purchase in sub-Saharan African countries of anti-retroviral drugs manufactured by U.S. firms.[41]

Recent international efforts to draw attention to the HIV/AIDS crisis were conducted at the XIII-International Conference on HIV/AIDS, July 9-14, 2000, in Durban, South Africa. This conference emphasized the urgency of dealing with this growing health/poverty crisis. Furthermore, on July 23, 2000, pledges were made at the G-8 summit meeting in Okinawa, Japan, to reduce the number of young people with HIV infection by 25%.[42]

On August 8, 2000, H.R. 4576, P.L. 106-259, was signed into law, earmarking $10 million in Department of Defense appropriations for HIV prevention educational activities undertaken in connection with U.S. military training, exercises and humanitarian assistance activities conducted in African nations. On the same day,

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[37] U.S. Department of State, Bureau of African Affairs, Congressional Budget Justification for Foreign Operations, Office of the Secretary of State, Susan E. Rice, FY2001: 258.

[38] [http://www.usembassy.state.gov/tokyo/wwwh2622.html].

[39] Fact Sheet from the White House, Office of the Press Secretary, 'U.S. Efforts on HIV/AIDS and Infectious Diseases', September, 7, 2000.

[40] Fact Sheet from the White House, Office of the Press Secretary, U.S. Efforts on HIV/AIDS and Infectious Diseases, September, 7, 2000.

[41] See Copson, Ray, *AIDS in Africa*, CRS Issue Brief IB10050, August 11, 2000: 1

[42] See Copson, Ray, *AIDS in Africa*, CRS Issue Brief IB10050, August 11, 2000: 1

President Clinton signed into law H.R. 3519, PL 106-264, the 'Global AIDS and Tuberculosis Relief Act of 2000' which authorizes funds for several HIV/AIDS programs. These efforts are to be done in cooperation with other governments and the United Nations.[43] Notably, Mr. Holbrooke has played a vital part in the passage of H.R. 3519. At the Security Council on HIV/AIDS and International Peacekeeping Operations on July 17, 2000, Mr. Holbrooke explained the importance of taking the AIDS epidemic seriously stating that '...of all the problems what we face in the world today and there are many -- the conflicts we are here to try to prevent or contain; nuclear proliferation, population issues, environmental issues, and social and economic issues - I think that this [the AIDS epidemic] is the most serious problem we face because of the damage that it can do to everything else.'[44]

Those who favor earmarking DOD funds to AIDS activities in Africa appear to believe that:

- in a world defined by interdependence, domestic and foreign issues are not easily separated. Since AIDS knows no national boundaries, helping to contain AIDS in Africa is in the interest of the U.S.
- AIDS may destabilize regions, causing social, economic and political unrest, which may have a direct effect on U.S. national security.
- Africa is strategically important to the U.S. in terms of transport lanes and oil supplies and the AIDS epidemic may threaten the establishment of a stable consumer market which could benefit America's trade.
- for DOD $10 million dollars is a small allocation of its total budget. Furthermore, the department should invest in conflict prevention and share the responsibility towards the containment of the AIDS epidemic.
- According to Holbrooke, it is natural that DOD plays its part in preventing the spread of the AIDS epidemic arguing that the spread of the disease by peacekeepers has become a major problem.[45]

Those who oppose the use of DOD funds for such purposes appear to believe that:

- the AIDS problems faced by the African military is of no, or limited, strategic interest to the U.S. and the cost and responsibility should

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[43] Fact Sheet from the White House, Office of the Press Secretary, U.S. Efforts on HIV/AIDS and Infectious Diseases, September, 7, 2000. Also see Copson, Ray, *AIDS in Africa*, CRS Issue Brief IB10050, August 11, 2000.

[44] Ambassador Richard C. Holbrooke, United States Permanent Representative to the United Nations, Statement in the Security Council on the HIV/AIDS and International Peacekeeping Operations, July 17, 2000. [http://www.un.int/usa/00_092.htm].

[45] Ambassador Richard C. Holbrooke, 'U.N. Security Council Now Focused on HIV/AIDS, Holbrooke says', U.S. Department of State, International Information Programs, Washington File, July 13, 2000.
[http://www.usinfo.state.gov/cgi-bin/wa...=products/washfile/newsitem.shtml].

therefore be handled by the respective countries themselves or other appropriate international organizations supported by the U.S.

- an already strained defense budget should not be used as a tool to provide social welfare in other countries. Other agencies or departments, such as USAID or the World Health Organization would be more appropriate to handle this issue.
- $10 million in funding for AIDS activities in the African military is far from sufficient to have any realistic effect on the disease. Furthermore, containing AIDS in Africa should not be a responsibility disproportionately tackled by the U.S. alone. It is a worldwide problem that calls for international solutions and burden sharing.[46]
- the labeling of AIDS as a 'national security threat' is done to assign more significance to the AIDS pandemic, in hope that a skeptical Congress and public could be induced to approve more spending. Such proposals, it is argued, are more a political gesture that aims at appealing to certain interest groups rather than a serious effort at addressing the problem of AIDS.

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[46] According to the *Washington Post*, in 1997, "the United States spent $7 billion in development aid overseas, with $121 million of it going toward fighting AIDS. Only last year [1999] were appreciably more funds allocated. U.S. funds to fight the epidemic now make up about half of all donor nations' contribution."
[http://www.washingtonpost.c...-srv/world/daily/july00/aidsgraphic2.htm].