

# Ex-combatants as entry points for HIV education in southern Sudan

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**Disarmament, demobilisation and reintegration (DDR) interventions provide potential avenues to help reach those who are most vulnerable to HIV transmission.**

Southern Sudan has been affected by conflict since the 1950s. The Comprehensive Peace Agreement (CPA), signed on 1 January 2005, brought an end to the second civil war, and the process of development and recovery is underway. Efforts to develop coherent HIV policies, however, are in their infancy. In a vast area devoid of almost all infrastructure, the challenges

urban areas or displacement camps with better service provision. Widespread gender-based violence in both rural and urban areas has both been the cause of increased HIV infection and has posed challenges for HIV interventions. Severe gender inequalities exist, and concurrent sexual relationships exist as a result of transactional sex, inheritance of multiple wives and

HIV prevalence is between 2 and 4% of the population, while a 1996 study at antenatal clinics suggested HIV prevalence was 5%. Amongst different tribes various names are given to HIV/AIDS, making data collection more difficult. Despite the lack of precise data, the high-risk post-conflict environment, combined with the lack of infrastructure, has presented both the necessity to establish and implement HIV prevention and mitigation policies – and the difficulties in doing so.

The SPLA – the army of the Government of South Sudan (GoSS), previously the armed wing of the main southern Sudanese rebel movement (the SPLM) – is in the process of transforming from a guerrilla army to a professional military force. Challenges during the transition include ambiguity surrounding command structures, and increased cultural variation among soldiers (as all other armed groups, based on mainly tribal identity, had to be absorbed into the SPLA). The SPLA plans to downsize through the DDR process, which presents an opportunity for HIV interventions as soldiers make the transition to civilians.



Returning Sudanese refugees receive information on HIV/AIDS and landmines at UNHCR's way-station on the Sudanese border.

UNHCR/P. Wiggins

are enormous. The limited data available reveal that HIV is prevalent across southern Sudan, but the exact extent is unknown.

This article presents the findings of research focusing on the Sudan People's Liberation Army (SPLA) as a high-risk group which, with its close community links, is a potentially effective entry point for responsive HIV policy development during the disarmament, demobilisation and reintegration (DDR) process.

## The post-conflict context

The post-conflict environment in southern Sudan is unstable and constantly changing. People are returning to the region after decades of forced displacement both internally and across borders, and many of them come from

the encouragement of early marriage and polygamy. Scarification with non-sterile tools and the view of circumcision as taboo also increase HIV risk. Most people lack access to basic services, and infrastructure for managing HIV policies is largely absent. Interventions for HIV prevention need to be innovative and applicable without reliance on basic health services. Many southern Sudanese have never heard of HIV, or do not know how it is transmitted or prevented. Additionally, protection through behaviour change is a choice many do not have.

Accurate data on HIV/AIDS prevalence in southern Sudan is almost non-existent, though a few studies have been conducted to try to determine the extent of the epidemic in the region. One study showed that

During the years of conflict, SPLA soldiers were constantly told they were the instruments for repopulating southern Sudan. Unsurprisingly, therefore, soldiers forgo protection with commercial sex workers. For their part, vulnerable and lacking a normal community life, women seek refuge with soldiers, and often engage in transactional survival sex. HIV interventions must address these realities if communities are to be able to move away from environments where HIV can thrive.

The DDR process provides a valuable opportunity to screen a high-risk group while still in DDR sites, creating a unique entry point where people who will soon be part of a civilian community can be addressed. DDR provides an opportunity for

those who are dependent on the army to receive clear, targeted and relevant reintegration opportunities and HIV interventions to encourage self-sufficiency and reduce vulnerability for themselves and others. Additional populations such as child soldiers and women associated with armed forces and groups should also benefit.

However, progress towards demobilisation of SPLA personnel has been slower than anticipated, with problems relating to staffing and technical assistance. While the CPA envisaged that DDR support would be given for 180,000 southern and northern combatants, it was reported by the UN in July 2010 that only 23,700 have completed DDR programmes<sup>1</sup> – and of these only 6,000 have been demobilised in southern Sudan.

The final milestone of the CPA is the forthcoming referendum scheduled for January 2011 which will determine whether Sudan is to remain one country or be split into north and south Sudan. This has become the overarching priority for all government institutions and donor communities since uncertainties regarding security and indeed risk of renewed war following the results (for unity or secession) could mean that current efforts in DDR may be undone.

“...I don’t want protection. All these years we have been suffering, we have not produced and some of our children even got lost. We need to produce children... and if we were to die, we would have died in the bush. AIDS doesn’t kill...” SPLA soldier, April 2008

### HIV policy development

The SPLA has made HIV prevention a priority but it is unclear if these messages have been absorbed throughout the ranks. It has a voluntary testing and counselling policy, and an HIV/AIDS Secretariat, established in 2006, which is responsible for the oversight and implementation of an army-wide HIV response. The lack of sufficient command, however, remains a challenge for the SPLA’s war against HIV.

Additional attempts to create HIV policy have been met with varied success. The New Sudan National AIDS Council (NSNAC), formed

to coordinate HIV policy efforts, was developed in 2001 but was unsustainable due to insufficient funding and institutional support. As a result, scattered HIV policies were generally put in place by independent NGOs, which were both short-term in focus and limited in scope. In June 2006, the Southern Sudan AIDS Commission (SSAC) was established in partnership with the GoSS at state and county levels. Both the SSAC and the SPLA have created long-term plans intended to implement HIV/AIDS prevention policies. Specifically, the SSAC has partnered with key stakeholders to develop the Southern Sudan HIV/AIDS Strategic Framework (SSHASF) for 2008-2012.

Both the SPLA and the SSHASF agree on key policy areas:

- creating an enabling environment for a sustained financial, legal and institutional framework for HIV interventions
- emphasis on prevention to reduce new infections
- care, treatment and impact mitigation to improve the quality of life for people living with HIV
- mitigating exposure to and impact of HIV among emergency-affected populations during the post-conflict and reconstruction phase
- capacity building to strengthen, decentralise and sustain a national HIV response
- monitoring and evaluation to strengthen evidence-based management of national multi-sectoral HIV response at all levels.

This response appears to be comprehensive but many challenges still exist in creating relevant frameworks and fine-tuning policies across each of these thematic areas. These difficulties include policy coordination between the SPLA and SSHASF and maintaining consistent budget allocations for the management of HIV response. In addition, it needs to be better understood that the determinants that place people at risk of HIV relate more to the socio-economic and cultural factors in people’s lives than to the desire of individuals

to be promiscuous or engage in concurrent relationships. For policies to be effective, the SPLA and SSAC should identify all groups that need access to HIV prevention materials, including often overlooked groups such as widows. Policies must also address the instability of the post-conflict region, with special consideration for formerly displaced people returning to the region.

### Recommendations and next steps

Despite the volatile environment, there are many opportunities for HIV interventions, particularly within the SPLA, which must match their rhetoric with action. Military leadership must be at the forefront of efforts to tackle the epidemic within the institution, implementing and enforcing a code of conduct – and also protecting others associated with barracks. Funding should be consistent to implement programmes, and mandatory testing – accompanied by confidential counselling and treatment – should be encouraged for the SPLA to understand the scale of the epidemic within its forces. The SPLA can use its command structure to reach a very high-risk group, encouraging responsible behaviour and reducing new infections through discipline and a holistic approach. DDR is also an opportunity to teach new skills – in agriculture, for example – for future self-sufficiency. Only known family members should be allowed near military barracks, in order to eliminate dependency and survival sex.

Post-conflict conditions pose a real challenge and threaten to compromise progress made to date. Interventions must reach the majority and must affect behaviour amongst people with little or no access to resources. That said, the simple ‘ABC’ approach – Abstain, Be faithful, Condomise – will not work in the region, and HIV policies must take into account cultural practices.

The SSAC should take the lead in maintaining a political commitment to improve conditions for HIV interventions, and lobby for line ministries that affect the socio-economic drivers of the epidemic. The SSAC should identify areas where traditional behaviours are high risk, and should target groups such as

midwives, healers and chiefs as entry points to discuss unhealthy practices.

Although post-conflict analysis offered in the fuller study is non-exhaustive, it reveals a range of challenges that can weaken intended HIV policy direction if it is not evidence-driven, practical and realistic. Vulnerability to HIV/AIDS in the region is high, and many typical

prevention strategies involving education, sensitisation and advocacy will have limited impacts because of gender inequalities, absence of rule of law and weak governance structures. The potential for effective HIV intervention is high; there is a large and captive audience within DDR programmes, and these individuals present important entry points for reaching many at the individual level.

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1. <http://tinyurl.com/UN-ddr-southsudan>