

ANNEX M.

Southern Sudan

HIV/AIDS Policy
(2008)

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PRESIDENTIAL FOREWORD

PREFACE

One component of the mandate of the Southern Sudan AIDS Commission (SSAC) is to formulate and recommend policies to stem the transmission of HIV and mitigate the impact of the epidemic. It is against this backdrop that SSAC, supported by its partners and stakeholders, has undertaken the present review and update of the SPLM's 2001 *HIV/AIDS Policy and Control Strategies for the New Sudan*. As with all policies, the *Government of Southern Sudan 2007 HIV/AIDS Policy* sets the strategic direction and defines the scope of the Southern Sudan response. A crucial element of the strategic direction situates HIV/AIDS at the core of Southern Sudan's peace, reconstruction, poverty reduction, and macroeconomic planning processes, thereby requiring a multisectoral response from the outset. As for the scope, six thematic policy areas have been defined: Enabling Environment, , Prevention, Care, Treatment, Support, and Impact Mitigation, Post-Conflict Focus, Capacity Building, Monitoring, Evaluation, and Research.

The aim is to translate these policy areas into tangible programs that when implemented will stem the threat of HIV/AIDS and enhance the process of nation-building in Southern Sudan.

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Chairman
Southern Sudan AIDS Commission (SSAC)

ACKNOWLEDGMENTS

ACRONYMS

1.0 SITUATIONAL ANALYSIS AND RESPONSE TO DATE

1.1 Socioeconomic and Political Context

Population and Selected Human Development Indicators

Southern Sudan covers an estimated 640,000 square kilometers and shares borders with five countries: Central African Republic, Democratic Republic of the Congo, Kenya, Uganda, and Ethiopia.

Since Sudan's independence in 1956, Southern Sudan has endured two civil wars (1955-1972 and 1983-2005). The war between North and South Sudan that began in 1983 was the longest-running conflict in Africa and resulted in about 2 million deaths; an estimated 4 million people displaced (with over 400,000 refugees in neighboring countries); bombardment of vast areas, resulting in the destruction of social service and economic infrastructure; and significant trauma for the civilians of Southern Sudan.^{1, 2, 3}

Following the May 2002 – December 2004 peace negotiations held under the auspices of the Inter-Governmental Authority on Development (IGAD), the Comprehensive Peace Agreement (CPA) was signed on 9th January 2005. The signatories to the CPA were the Government of the Republic of the Sudan and the Sudanese People's Liberation Movement (SPLM). The CPA reached specific agreements on a permanent ceasefire and security arrangement implementation modalities,⁴ elaborated protocols on power- and wealth-sharing, and laid out plans for a referendum on the South's secession in 2011.⁵

As of mid-2007, although the two parties were adhering to the basic elements of the CPA, there were numerous obstacles, including demarcation of the border between north and south and the associated delineation of oil production and revenues.⁶ Southern Sudan's primary resources are agricultural, but since October 2000, oil production and export have increased and become the overwhelmingly dominant income source for GOSS – 95 percent of government revenues derive from oil. (The CPA stipulated that oil produced in the south be divided equally between the Government of National Unity (GoNU) and the Government of Southern Sudan (GOSS), after a 2 percent deduction is made to the oil-producing state.)⁷

Almost 20 years of civil war rendered existing government structures in Southern Sudan

¹Haslie A and Borchgrevink A. 2007 January. *International Engagement in Sudan after the CPA: Report on the piloting of OECD/DAC's 'Principles for Good International Engagement in Fragile States' for the Case of Sudan*. Paper no. 714. Oslo: Norwegian Institute of International Affairs.

²*The Comprehensive Peace Agreement between the Government of the Republic of the Sudan and the Sudan People's Liberation Movement/Sudan People's Liberation Army*. 9 January 2005.

³New Sudan National AIDS Council & UNAIDS 2006.

⁴*Agreement on Permanent Ceasefire and Security Arrangements Implementation Modalities during the Pre-Interim and the Interim Periods between the Government of the Sudan (GoS) and the Sudan People's Liberation Movement/Sudan People's Liberation Army (SPLM/SPLA)*. Naivasha, 31 December 2004.

⁵*Comprehensive Peace Agreement* 2005.

⁶World Bank. 2007. *Country Brief: Sudan*. Washington, DC.

⁷Haslie & Borchgrevink 2007.

extremely weak; indeed, many necessary governmental entities were nonexistent at the 2005 signing of the CPA. Thus, post-conflict Southern Sudan is contending not only with *reconstruction* but – more significantly – *construction* or creation of state structures, policies, governance mechanisms, and legal instruments, all against the backdrop of very weak institutional capacity.⁸

The 2003 population was estimated at 7.5 million (and therefore does not include an estimated 4 million refugees and IDPs); the population is growing rapidly (3.0 percent annual growth rate), and is very young: 53 percent of Southern Sudanese are under the age of 18.⁹

Southern Sudan's population lives in extreme poverty. In 2004, the New Sudan Centre for Statistics and Evaluation reported that gross national income per capita was US\$90, with about 90 percent of the population living on less than US\$1 a day.¹⁰

The health status of the Southern Sudanese population is among the world's lowest. Infant and child mortality are very high (150 and 250 deaths per 1,000 live births, respectively). The total fertility rate (the average number of children a woman will have over her lifetime) is 6.7. A woman's lifetime risk of dying from a pregnancy- or delivery-related cause is one in nine, and the maternal mortality ratio is among the highest in sub-Saharan Africa (1,700 deaths per 100,000 live births). Only five percent of births are attended by skilled health staff. Among children under-five, the prevalences of general malnutrition and severe malnutrition are 48 and 21 percent, respectively.¹¹ In 2006, WHO reported that, concurrent with cholera epidemics, there was a resurgence in diseases such as leprosy, elephantiasis, river blindness, sleeping sickness, guinea worm, and Buruli ulcers.¹²

In 2003, Southern Sudanese children had the world's lowest primary school enrolment ratio (20 percent), lowest primary school completion rate (2 percent), and lowest ratio of female-to-male enrolment (35 percent). The adult literacy rate was 24 percent (for adult females: 12 percent), and the youth literacy rate was 31 percent.¹³

1.2 HIV/AIDS Situation

The findings (published in mid-2007) of a UNHCR study that included Southern Sudan (as well as six other conflict-afflicted countries) suggest that HIV prevalence was likely low when the 1983 war began and remained fairly low throughout the conflict, compared with peaceful neighboring countries. Explanations for this scenario include the war's protective effects against HIV transmission including (1) living in (or fleeing to) difficult-to-access regions and the subsequent reduced accessibility of populations, and (2) the high numbers of war-related deaths,

⁸Haslie & Borchgrevink 2007.

⁹ New Sudan Centre for Statistics and Evaluation in association with UNICEF. 2004 May. *Towards a Baseline: Best Estimates of Social Indicators for Southern Sudan*. NSCSE Series Paper 1/2004.

¹⁰ New Sudan Centre for Statistics and Evaluation & UNICEF 2004.

¹¹ New Sudan Centre for Statistics and Evaluation & UNICEF 2004.

¹² Wakabi W. "Peace has come to southern Sudan, but challenges remain." *Lancet* 2006 Sept 2;368(9538):829-30.

¹³ New Sudan Centre for Statistics and Evaluation & UNICEF 2004.

both of which decrease consensual sexual exposures and infection incidence.¹⁴ Southern Sudan's current post-conflict period, however, does entail high population mobility, frequent mixing of sexual networks, and subsequent heightening of exposure to HIV.^{15, 16} Since the signing of the CPA in 2005, there has been massive population movement as roads are built, IDPs are relocated, returnees are repatriated, ex-combatants transition to civilian life, commercial transporters travel to and from the country, and workers from other countries arrive (e.g., aid/relief workers, private enterprise).

A 2007 analysis of HIV/AIDS in Southern Sudan undertaken by the U.S. Centers for Disease Control and Prevention (CDC) indicated that the epidemic is extremely heterogeneous – with high prevalence found in some areas and much lower prevalence likely in other areas (the report underscored the paucity of robust epidemiological and behavioural surveillance data). The report highlighted that the prevalences recently obtained in some areas from antenatal surveillance are “alarming,” as they indicate that the epidemic is further advanced than previously thought. Although ANC data suggest the existence of a generalized epidemic in Southern Sudan, the existing ANC sites do not adequately represent the entire autonomous region. Noting the many limitations of the unlinked anonymous ANC surveillance data collected since late 2005, the CDC utilized them to underscore wide variations among locales, with prevalences ranging from 1 percent in Leer to 12 percent in Tambura.¹⁷

CDC also cited population-based surveys conducted in Yei and Rumbek¹⁸ (again noting their limitations) to highlight these critical findings:

- HIV prevalence varies widely within Southern Sudan (as it does in many other countries).
- Prevalence appears to be higher in towns than in rural areas, a trend found in many other countries.
- Prevalences among women are markedly higher than those among men (again, a scenario in numerous other countries).
- Prevalence may be higher in areas that have experienced greater population mobility and possibly contact with other countries.
- Although participants in Yei were much more likely than those in Rumbek to have been displaced either internally or as refugees, history of displacement was *not* found to be significantly associated with HIV status.¹⁹

Against the backdrop of major gaps in data and limitations in interpreting available evidence, there does appear to be general consensus that HIV prevalence among the adult population in

¹⁴ Spiegel PB, Rygaard Bennedsen A, Claass A, Bruns L, Patterson N, Yiweza D, Schilperoord M. “Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan African countries: A systematic review.” *Lancet* 2007 Jun 30;9580(369):2187-95.

¹⁵ New Sudan National AIDS Council & UNAIDS 2006.

¹⁶ Kaiser R, Kedamo T, Lane J, Kessia G, Downing R, Handzel T, Marum E, Salama P, Mermin J, Brady W, Spiegel P. “HIV, syphilis, herpes simplex virus 2, and behavioral surveillance among conflict-affected populations in Yei and Rumbek, southern Sudan.” *AIDS* 2006 Apr 4;20(6):942-44.

¹⁷ Boo T. 2007 June. *The HIV Situation in Southern Sudan: An Overview of Available Data with Comments Upon Program Implications*. Draft. Juba: Global AIDS Program-Sudan, U.S. Centers for Disease Control and Prevention.

¹⁸ Kaiser R et al. 2006.

¹⁹ Boo 2007.

Southern Sudan ranged from 2.6 to 3.1 percent in mid-2007.^{20, 21} Assuming a mid-2007 adult population of 6.9 million,²² roughly 214,000 Southern Sudanese adults are living with HIV. Of them, 38,520 are in urgent need of antiretroviral therapy (ART).²³ The GOSS Ministry of Health estimated that as of May 2007, the number of people receiving ART was 293, spanning five sites in Juba, Wau, Kajo keji, Bentiu, and Malakal.²⁴ Thus, only 0.76 percent of those in need of ART are receiving it, thereby highlighting the enormity of the challenges this policy seeks to address.

Among the myriad factors that render Southern Sudanese highly vulnerable to HIV acquisition are:

- Extremely low knowledge of and misconceptions about HIV/AIDS.
- High levels of stigma, discrimination, and denial regarding HIV/AIDS.
- The low status of women and girls, polygamy, widespread sexual and gender-based violence, and concomitant constraints to accessing health services and legal recourse.
- Inadequate attention to child rights.
- Poverty, poor/nonexistence health infrastructure and services.
- Traditional practices performed in an unsafe manner (e.g., scarification).^{25, 26, 27, 28}

Although UNAIDS reports that a general trend of stabilizing HIV prevalence appears to be continuing in East Africa, it projects that serious AIDS epidemics will likely continue for some time in the subregion (this projection also applies to parts of Central Africa). In Uganda, for example, UNAIDS classifies the epidemic as stable, but notes that although there have been reported declines in prevalence among women attending ANCs in urban areas, in some rural areas there is now evidence of an increase in HIV prevalence. UNAIDS also deems Tanzania's epidemic stable, but highlights that prevalence has increased markedly among older age groups; an increase in injecting drug use is also a concern. In Ethiopia's urban areas, HIV prevalence among women seeking ANC has remained stable at high levels since the late 1990s;

²⁰ Wakabi 2006.

²¹ Dr. Riek Lul, Deputy Director, Southern Sudan AIDS Commission, "The HIV/AIDS Epidemic in Southern Sudan," presentation at GOSS HIV/AIDS NSF and Policy Development Stakeholders' Workshop, 9 July 2007, Rumbek.

²² Derived from the 2003 population estimate of 7.5 million previously cited plus the approximately 4 million IDPs and refugees. From the general population figure of 11.5 million, it was assumed that approximately 40 percent of the population is under age 15; thus, subtracting 4.6 million from 11.5 million yields a *very rough* estimate of the adult population at 6.9 million. *Source*: Personal communication with Mr. Laila B. Lokosang, Director, Monitoring & Evaluation, Southern Sudan Commission for Census, Statistics, and Evaluation (SSCCSE), 18 July 2007, Juba.

²³ Based on WHO and UNAIDS global estimates that between roughly 15 and 18 percent of those living with HIV are urgently in need of ART. *Sources*: UNAIDS and WHO. 2006 Dec. *AIDS Epidemic Update 2006*. Geneva; WHO. 2003. *Treating 3 million by 2005: Making It Happen: The WHO Strategy*. Geneva.

²⁴ This figure does not include those living in Southern Sudan who travel to other countries to obtain ART. *Source*: Personal communication with Dr. Emmanuel Lino, Manager, Department of HIV/AIDS, GOSS Ministry of Health, 18 July 2007, Juba.

²⁵ Boo 2007.

²⁶ White S V-R. 2006 December. *Mainstreaming HIV/AIDS into the Laws of Southern Sudan: A Legal Analysis*. Southern Sudan AIDS Commission: Juba.

²⁷ Akechak Jok A, Leitch RA, Vandewint C, Hum B. 2004 March. *A Study of Customary Law in Contemporary Southern Sudan*. Juba: World Vision International and South Sudan Secretariat of Legal and Constitutional Affairs.

²⁸ Key informant interviews with Ms. Sheila Mangan, UNICEF (3 July 2007), Dr. Omari Mohamed, JSI (4 July 2007), and Ms. Shashu Zegeye, UNDP (5 July 2007) (see Annex 1 for more detail).

concurrently, the epidemic appears to have intensified in some rural areas in recent years. (UNAIDS notes that surveillance data from CAR and DRC are very limited.)²⁹

Analyzing HIV/AIDS in neighboring countries can provide useful lessons to GOSS for managing Southern Sudan's epidemic; however, such analysis in no way seeks to "blame" other countries or put the onus on their citizens (nor Sudanese returnees) for having "brought" HIV into Southern Sudan. Given the massive population mobility within the subregion – which will likely increase as more roads are built and business opportunities expand – the *GOSS 2007 HIV/AIDS Policy* underscores the importance of continuing to learn from and cooperate with neighboring countries to reduce exposure to HIV.

1.3 Response to date

In 1995, Dr. John Garang de Mabior, the Chairman and Commander-in-Chief of the SPLM/SPLA, identified HIV/AIDS as the second-most critical issue facing New Sudan.³⁰ In April 2001, Dr. Garang launched the nation's first HIV/AIDS National Conference in Natinga, charging it with developing a national HIV/AIDS policy and program. The mission of the *HIV/AIDS Policy and Control Strategies for the New Sudan*, which came into force on 1 September 2001, was to "Prevent the spread of HIV/AIDS and mitigate its effects on the people of New Sudan to ensure economic development and progress. Consequently, the main aims of the intervention strategies were to (1) prevent the spread of HIV to those that are not infected, (2) reduce HIV/AIDS-related morbidity and mortality, and (3) protect the rights of those who are infected with and affected by HIV/AIDS."³¹

Also in 2001, the New Sudan National AIDS Council was created, with its chair reporting directly to the chair of the SPLM (and, post-CPA, the President of Southern Sudan).³² In 2006, the Southern Sudan AIDS Commission was created by a presidential decree 55/2006, also reporting directly to the President of Southern Sudan. SSAC is mandated to, inter alia:

- "Provide national leadership in national planning, supervision and support of HIV/AIDS programs.
- Initiate and recommend policies, regulations and strategies for curbing and combating the spread of HIV/AIDS and to expand and coordinate the national response to HIV/AIDS.
- Foster national and international linkages among all stakeholders through proper coordination of all HIV/AIDS prevention and control programs and activities within the overall national multi sectoral strategy.
- Reduce the vulnerability of individuals and communities to HIV/AIDS and to contribute in alleviating the socio-economic and human impact.
- Promote and protect the rights of both infected and affected persons."³³

Other examples of high-level GOSS leadership in HIV/AIDS include:

²⁹ UNAIDS & WHO 2006.

³⁰ Dr. Mary Kiden, Minister of Gender, Social Welfare and Religious Affairs, speaking at the Launch of the GOSS Policy and Strategic Framework Planning Processes, 26 June 2007, Juba.

³¹ Sudan People's Liberation Movement (SPLM), Social and Services Commission, Secretariat of Health. 2001 April. *HIV/AIDS Policy and Control Strategies for the New Sudan*. Juba.

³² New Sudan National AIDS Council & UNAIDS 2006.

³³ Republic of Sudan, Government of Southern Sudan (GOSS). 2006. *The Establishment of the HIV/AIDS Commission Act*. Juba.

- The SPLA held an HIV/AIDS Policy and Program Development Workshop in January 2006 in Rumbek at which senior military commanders called for greater attention to HIV/AIDS. The policy statement elaborated by the workshop endorsed, inter alia, the establishment of an SPLA Advisory Council on HIV/AIDS.³⁴ The Council's current foci include mainstreaming HIV/AIDS into the Military Justice System, the creation of policies in conjunction with the SPLA Medical Corps, capacity building at all levels, and addressing severe funding gaps.³⁵
- Dr. Riek Machar Teny Dhurgon, the First Vice President of Southern Sudan, took a public HIV test in conjunction with World AIDS Day in late 2006.³⁶
- In June 2007, the First Vice President endorsed the launch of the GOSS Policy & National Strategic Framework Planning Processes.³⁷

1.4 Policy Environment

The development of the *GOSS 2007 HIV/AIDS Policy* was influenced by and occurred within the context of numerous existing treaties, conventions, declarations, policies, and other instruments,³⁸ including:

Global

1. The eight Millennium Development Goals, with particular reference to no. 6:

“Halt and begin to reverse the spread of HIV/AIDS”³⁹
2. Declaration of Commitment on HIV/AIDS, UN General Assembly Special Session on HIV/AIDS, 25-27 June 2001, New York, e.g.:

“People destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, IDPs, and women and children, are at increased risk of exposure to HIV.”⁴⁰
3. Inter-Agency Standing Committee Taskforce on HIV/AIDS in Emergency Settings, *Guidelines for HIV/AIDS Interventions in Emergency Settings*
4. OECD Development Assistance Committee, *Principles for Good International Engagement in Fragile States and Situations*, 2005
5. OHCHR and UNAIDS, *HIV/AIDS and Human Rights International Guidelines*, 2003

³⁴ Sudan People's Liberation Army (SPLA). 2006. *Report of SPLA HIV/AIDS Policy and Program Development Workshop*. Rumbek.

³⁵ Interview with Major John Woja Elliana, Deputy Director, SPLA HIV/AIDS Secretariat, 29 June 2007, Juba.

³⁶ UNAIDS. 2007. *HIV Update: Sudan: October – December 2006*. Khartoum.

³⁷ Dr. Riek Machar Teny Dhurgon, First Vice President of Southern Sudan, speaking at the Launch of the GOSS Policy and Strategic Framework Planning Processes, 26 June 2007, Juba.

³⁸ After the 2011 referendum, it is anticipated that GOSS will become a signatory to many of the regional and international conventions cited throughout this section.

³⁹ UN Millennium Development Goals. Accessed 8 July 2007 <<http://www.un.org/millenniumgoals>>.

⁴⁰ UNAIDS 2002.

6. Universal Declaration of Human Rights, 1948
7. International Covenant on Economic, Social and Cultural Rights, 1976
8. Convention on the Elimination of All Forms of Discrimination Against Women, 1979
9. African Charter on Human People's Rights, 1986
10. Convention on the Rights of the Child, 1989
11. International Conference on Population and Development, Cairo, 1994
12. Fourth World Conference on Women, Beijing, 1995

Regional

1. *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, African Development Forum/UNECA, 27 April 2001, with particular reference to:

“11. ...[W]e note that special attention should be given to migrants, mobile populations, refugees and internally displaced persons in national and regional policies. We also note that special attention should be given to the problem trafficking in human beings and its impact on HIV/AIDS.

12. We are aware that stigma, silence, denial and discrimination against people living with HIV/AIDS increase the impact of the epidemic and constitute a major barrier to an effective response to it. We recognize the importance of greater involvement of People Living with HIV/AIDS.

13. We recognise that the epidemic of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases constitute not only a major health crisis, but also an exceptional threat to Africa's development, social cohesion, political stability, food security as well as the greatest global threat to the survival and life expectancy of African peoples.

26. WE COMMIT OURSELVES to take all necessary measures to ensure that the needed resources are made available from all sources and that they are efficiently and effectively utilized. In addition, WE PLEDGE to set a target of allocating at least 15% of our annual budget to the improvement of the health sector.”⁴¹

Southern Sudan

1. Government of Southern Sudan Presidential decree No. 55/2006 of 27th June 2006
2. *The Establishment of the HIV/AIDS Commission Act*, 2006, including creation of 10 State AIDS Commissions
3. State HIV/AIDS action plans
4. SPLA Policy Statement on HIV/AIDS, January 2006
5. *Southern Sudan Interim Health Policy 2006-2011*, December 2005, including “Policy Statement on Cost-Effective Control of Communicable Diseases and Evidence-Based Public Health Interventions”

⁴¹ UN Economic Commission for Africa (UNECA). *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, 27 April 2001. Accessed 8 July 2007
<<http://www.uneca.org/ADF2000/Abuja%20Declaration.htm>>.

6. *Interim Constitution of Southern Sudan*, 5 December 2005, with particular reference to the following sections of the Bill of Rights:

- a. Sec. 15: Life and Human Dignity
- b. Sec. 21: Rights of the Child
- c. Sec. 19: Rights to Found a Family (relevance for women who are living with HIV)
- d. Sec. 20: Rights of Women, including:

“20(5) Women shall have the right to own property and share in the estate of their deceased husbands together with any surviving legal heirs of the deceased.”

- e. Sec. 33: Right to Education, including:

“33(1) Education is a right for every citizen and all levels of government in Southern Sudan shall provide access to education without discrimination as to religion, race, ethnicity, HIV status, gender or disability.”

- f. Sec. 26: Privacy
- g. Sec. 32: Right to Own Property
- h. Sec. 34: Rights of Persons with Special Needs and the Elderly
- i. Sec. 35: Public Health Care
- j. Sec. 37: Rights of Ethnic and Cultural Communities

7. State Constitutions

8. Customary Law, crucial as in Southern Sudan, over 90 percent of criminal and civil cases are tried under customary law.⁴²

9. Comprehensive Peace Agreement, 9 January 2005, e.g.:

“...the commitment of the parties to a negotiated settlement on the basis of a democratic system of governance which is...founded on the values of justice, democracy, good governance, respect for fundamental rights and freedoms of the individual, mutual understanding and tolerance of diversity within the realities of the Sudan.”⁴³

10. Policies related to peace, sustainable development, and poverty eradication, which have been identified as Southern Sudan’s key development goals⁴⁴

11. Laws governing decentralization

12. Child Act of 2006

13. Draft Land Law, which is anticipated to address women and property rights

⁴² Akechak Jok A, Leitch RA, Vandewint C, Hum B. 2004 March. *A Study of Customary Law in Contemporary Southern Sudan*. Juba: World Vision International and South Sudan Secretariat of Legal and Constitutional Affairs.

⁴³ *Comprehensive Peace Agreement* 2005.

⁴⁴ Sudan Government of National Unity Central Bureau of Statistics and Government of Southern Sudan Centre for Census, Statistics and Evaluation. 2006 16 February. *Project Proposal Document for the Fifth Population Census of Sudan*. Khartoum and Juba: Sudan Multi-Donor Trust Fund.

14. Anticipated revisions to labor laws to address HIV/AIDS, utilizing, inter alia, the ILO Code of Practice on HIV/AIDS and the World of Work
15. The Penal Code Act of 2003

2.0 POLICY REVIEW PROCESS

In August 2006, SSAC and its partners recognized the need to develop an HIV/AIDS policy and strategic framework to guide the national response and coordinate and harmonize the work of all stakeholders. In June 2007, the First Vice President of Southern Sudan endorsed the launch of the GOSS HIV/AIDS Policy & Strategic Framework Planning Processes. An international consultant was contracted to facilitate the process of review of the 2001 HIV Policy and to come up with a draft policy.

3.0 POLICY RATIONALE

The SPLM's creation of a national HIV/AIDS policy in 2001 in the midst of civil war stands as an extraordinary achievement. Moreover, the policy's unequivocal support of the rights of PLHIV provides a solid foundation upon which to create a comprehensive GOSS policy. Numerous factors – both global and Southern Sudan-specific – require a revision of the 2001 policy. They include:

- SSAC's mandated task to "review, update and streamline the New Sudan National AIDS policy and control strategies developed by the SPLM Secretariat of Health in 2001 to capture in new developments and to go in line with new political realities provided by the CPA."⁴⁵
- The changed (and evolving) sociopolitical landscape following the signing of the Comprehensive Peace Agreement in January 2005.
- The need for guidance to service delivery areas and interventions, which was largely absent from the 2001 policy.⁴⁶
- Although human rights aspects were incorporated in the 2001 policy, there is a need to provide guidance to operationalize the linkages between HIV/AIDS and human rights (e.g., legal instruments, enforcement mechanisms).⁴⁷
- Availability of financing for HIV/AIDS, both from GOSS and from external donors, and the opportunities and challenges that it poses.
- New scientific knowledge in the field of HIV/AIDS prevention, treatment, care, support, and impact mitigation.

The *GOSS 2007 HIV/AIDS Policy* builds on the following opportunities:

- GOSS (and its predecessor, the Government of New Sudan) has demonstrated strong political commitment to HIV/AIDS. Moreover, the emphasis of SPLM's 2001 HIV/AIDS policy on (1) the rights of PLHIV and (2) the importance of women's equality provides some of the basic but nevertheless key elements required for an effective national response.
- As discussed above, although there is a paucity of robust evidence regarding HIV prevalence and incidence in Southern Sudan, available data do indicate that the vast majority of Southern Sudan's

⁴⁵ Republic of Sudan, GOSS 2006.

⁴⁶ New Sudan National AIDS Council & UNAIDS 2006.

⁴⁷ New Sudan National AIDS Council & UNAIDS 2006.

population is HIV-negative. There is a tremendous opportunity to work to ensure that most Southern Sudanese remain negative, and indeed, to decrease HIV prevalence across the nation.

- Several GOSS institutions have been highly proactive in addressing HIV/AIDS; in the absence of policies and technical guidance, they have sought out models from neighboring countries and have invited subregional and regional experts to Southern Sudan to learn from them. This proactive approach provides a promising foundation for ongoing and strengthened knowledge sharing (including GOSS's sharing of its experiences with other countries, particularly those that are post-conflict).
- GOSS is a young government that can learn from the experiences of its neighbors with advanced epidemics and jump ahead or "leapfrog" to utilize strategies that have been proved efficacious while bypassing those strategies that have been demonstrated to be less or ineffective. (An example is the use of line ministry HIV/AIDS focal points to address "multisectorality"; many countries that have adopted this approach have found it ineffective.⁴⁸ Therefore, as the *GOSS HIV/AIDS Strategic Framework 2007-11* discusses, GOSS will utilize strategies based on "good practice" and "what works" while concurrently piloting cutting-edge mainstreaming strategies.
- GOSS's policy and legislative environment is evolving. There is thus the opportunity to influence these spheres, ensuring that HIV/AIDS is central to their processes, rather than a component added at a later date. There is also the chance to contribute to the formulation of legislation not specific to the epidemic but that will have an enormous impact on whether HIV/AIDS interventions succeed or fail.

The 2007 HIV/AIDS policy is also designed to address current and emerging challenges, including:

- Weak epidemiological and behavioral surveillance systems, i.e., a weak evidence base for HIV/AIDS programming.
- The myriad challenges posed by post-conflict reconstruction and rehabilitation (including the psychosocial trauma that the war inflicted on the population of Southern Sudan).
- Although GOSS has made HIV/AIDS its top priority,⁴⁹ the epidemic still must compete with other priorities for resources.
- Massive population movement due to repatriation of returnees, IDPs, building of roads, influx of international aid workers, burgeoning private enterprise and concomitant arrival of investors and workers, and population mobility spurred by environmental degradation.
- Enormous and diverse capacity building needs at all levels.
- Low absorptive capacity within GOSS and among service providers.
- Limited coordination of the response as increasing numbers of players, especially at the state level, emerge.

⁴⁸ Garbus L. 2003. *Multidisciplinary Analysis of HIV/AIDS in Zambia*. Study prepared for the Country AIDS Policy Analysis Project under USAID Cooperative Agreement PHN-A-00-01-00001-00. San Francisco, CA, USA: University of California San Francisco <http://ari.ucsf.edu/programs/policy/countries/Zambia.pdf>; Garbus L. 2003. *Multidisciplinary Analysis of HIV/AIDS in Malawi*. Study prepared for the Country AIDS Policy Analysis Project under USAID Cooperative Agreement PHN-A-00-01-00001-00. San Francisco, CA, USA: University of California San Francisco <http://ari.ucsf.edu/programs/policy/countries/Malawi.pdf>.

⁴⁹ Dr. Riek Machar Teny Dhurgon, First Vice President of Southern Sudan, speaking at the Launch of GOSS HIV/AIDS Policy and Strategic Framework Planning Processes, 26 June 2007, Juba.

- Although there have been concerted efforts to contribute to building the *administrative* capacity of GOSS, there has been relatively little attention to building *accountability*.⁵⁰
- Critical funding shortfalls.⁵¹
- There is a vital need for comprehensive policies on the thematic areas found in Section 7.0 below that are tailored to the political, economic, societal, and cultural context of Southern Sudan. With the 2006 establishment of SSAC and the 2007 creation of the Department of HIV/AIDS within the Directorate General of Preventive Medicine in the GOSS Ministry of Health,⁵² the process of developing *Southern Sudan-specific* comprehensive policies to guide interventions is of paramount importance.^{53 54 55}

4.0 GUIDING PRINCIPLES

The *Southern Sudan 2007 HIV/AIDS Policy* is based on the following principles

1. The “Three Ones,” i.e:
 - i. One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
 - ii. One National AIDS Coordinating Authority, with a broad based multisector mandate.
 - iii. One agreed country level Monitoring and Evaluation System.”
2. Strong government commitment, leadership, and accountability at all levels are necessary for a sustained and effective national response to HIV/AIDS.
3. With GOSS’s provision of policy and intervention guidelines, every sector, institution, community, and person has a role to play in combating HIV/AIDS.
4. Social justice and equity will guide all components of the national response.
5. All policies and interventions will be grounded in a human rights approach, including the rights of PLHIV.
6. The reduction of stigma, discrimination, and denial will guide all components of the national response.
7. Meaningful involvement of PLHIV, members of marginalized groups, and civil society is paramount.
8. Effective mainstreaming of HIV/AIDS into all sectors is crucial, including within Southern Sudan’s peace, reconstruction, poverty reduction, and macroeconomic development processes.
9. Gender equality and equity will be mainstreamed into all HIV/AIDS policies and interventions

⁵⁰ Haslie & Borchgrevink 2007.

⁵¹ From key informant interviews (see Annex 1).

⁵² Interviews with Dr. John Rumunu (3 July 2007) and Dr. Emmanuel Lino (5 July 2007), GOSS Ministry of Health, Juba (see Annex 1 for detail).

⁵³ UNAIDS. *Country Brief: Sudan*. Accessed 7 July 2007
<http://www.unaids.org/en/Regions_Countries/Countries/sudan.asp>

⁵⁴ From key informant interviews (see Annex 1).

⁵⁵ Collier & Hoeffler 2002.

10. The national response will be built on fostering and nurturing the substantive, early involvement of all sectors and key stakeholders (government, NGOs, religious groups, civil society, traditional authorities, PLHIV, trade unions, private enterprise).
11. Ensuring that the vast majority of Southern Sudanese who are HIV-negative remain negative is imperative.
12. The national response will be continuously informed by robust evidence and concomitant rigorous analysis of that evidence.
13. Universal access to comprehensive HIV prevention, treatment, care and support programs.

5.0 AIMS AND OBJECTIVES OF THE POLICY

5.1 *Aim*

A policy and legislative environment that supports and strengthens the HIV response in Southern Sudan

5.2 *Objectives of the Policy*

The *Southern Sudan 2007 HIV/AIDS Policy* provides a framework within which HIV/AIDS prevention, treatment, care, support, and impact mitigation efforts will be undertaken over the next five years. More specifically, it is designed to:

1. Ensure GOSS commitment to addressing HIV/AIDS and underscore its preeminent role in leading Southern Sudan's response to the epidemic.
2. Provide broad policy guidance on HIV/AIDS to all sectors and at all levels (GOSS, states, NGOs, civil society, traditional authorities, religious groups, private enterprise/business community, trade unions, external partners).
3. To ensure HIV/AIDS is mainstreamed into Southern Sudan's peace, reconstruction, poverty reduction, and macroeconomic development processes.
4. Provide a framework for future legislation in the HIV/AIDS sector as well as other laws that have an impact on AIDS.
5. Provide a framework for mobilization of resources to support an expanded HIV multi-sectoral response

6.0 POLICY STATEMENTS

Mindful of the drivers of HIV/AIDS epidemic in Southern Sudan and considering the available resources; human, financial and material, the GOSS HIV/AIDS policy statements are designed around six priority thematic areas namely enabling environment; prevention; care, treatment, support and impact mitigation; post conflict; capacity building; and Research, Monitoring and evaluation as follows.

6.1 *Enabling Environment*

1. Ensure strong, committed, sustained, and consistent leadership related to HIV/AIDS, in words and in deeds, at all levels and in all sections of society.
2. Ensure that all laws and policies relevant to the fight against HIV/AIDS are in place and that the laws promote the rights of marginalized groups including women, children, youth, disabled, OVCs, PLHIV, and older persons. Any existing laws and regulations that impede the fight against HIV/AIDS shall be reformed.
3. Ensure that advocacy and awareness campaigns address misconceptions that contribute to stigma, denial, and discrimination.
4. Be committed to the “Three Ones”, and ensure that these principles are adhered to at all levels of government and by all stakeholders.
5. Increase the share of the national budget allocated to health from the present 5.5 percent to 15 percent as set forth in the Abuja
6. Establish and enforce effective mechanisms that embrace principles of good governance, including transparency and accountability. Such mechanisms shall include developing and sustaining mechanisms for financial resource mobilization, utilization, and tracking in the public, private, and civil society sectors.
7. Ensure that all implementers/stakeholders shall be guided by and comply with the GOSS Aid Coordination Strategy.
8. Ensure that all government and non governmental institutions mainstream HIV/AIDS into their plans, policies, strategies, procurement mechanisms, and budgets.
9. Promote and nurture mechanisms for subregional, regional, and global cooperation, collaboration, and knowledge-sharing on HIV/AIDS.

6.2 *Prevention*

1. Ensure (1) availability of adequate supplies of blood and blood products and their accessibility to all patients requiring transfusion, (2) safety of blood and blood products, and (3) safe and appropriate clinical use of blood and blood products.
2. Create and enforce a policy on universal precautions for health care facilities, public and private industry, and at community levels.
3. Develop and implement culturally appropriate behavior change communication strategies based on evidence from behavioral surveillance.
4. Undertake culturally appropriate intensive HIV awareness raising and STI prevention, management, and promotion of care-seeking behavior.
5. Involve the media in HIV prevention, grounded in ethical reporting and provision of accurate and culturally appropriate information that protects the rights of PLHIV and ensures minimization of stigma and discrimination.
6. Promote counseling and testing as a prevention strategy and ensure that its provision adheres to laws, policies, and guidelines on informed consent, privacy, confidentiality, and facilitation of an environment for safe disclosure for those who voluntarily choose to share their serostatus.
7. Promote prevention of mother-to-child transmission of HIV and ensure that its provision adheres to laws, policies, and guidelines on informed consent, privacy, confidentiality, and voluntary safe disclosure.

8. Ensure universal access to, and promotion of condoms is a priority preventive measure, including adequate quality control in procurement and supply chain management.
9. Develop and implement policy guidelines on post-exposure prophylaxis (PEP).

6.3 *Care, Treatment, Support, and Impact Mitigation*

1. Promote and facilitate access to Basic Care Packages for PLHIV and affected. The package should be composed of the following sub packages (1)home based care (2) Health facilities (3) Care givers
2. Support, facilitate and strengthen TB-HIV collaboration at all levels of the health care system.
3. Develop and implement policies on OIs and ART based on international best practice and tailored to the Southern Sudan context.
4. Promote and facilitate universal access to (1) prevention and treatment of OIs and (2) ART.

Support and Impact Mitigation

1. Develop a policy on nutritional interventions for PLHIV and those affected by the epidemic.
2. Work with its multisectoral partners to promote access to education and basic social services for OVCs.
3. Ensure development of workplace policies to address HIV/AIDS related issues including stigma and discrimination.
4. Promote and support income-generating projects (including the provision of micro-credit) for sustained livelihoods of PLHIV and those affected.
5. Develop policies to ensure the full, substantive participation of PLHIV in all aspects of care, treatment, support, and impact mitigation at all levels.

6.4 *Post-Conflict Focus*

1. Develop policies and programmes directed towards addressing post conflict situations such as (IDPs camps, returnees, demobilized camps, and other economically disadvantaged groups)
2. Ensure that policies and interventions are of participatory and inclusive approach with particular attention to gender dimensions.
3. Ensure sustainability of programmes is paramount during the transition from (1) emergency to stabilisation phase (2) International to national response
4. Concurrently, within existing structures, promote a referral system for persons with special needs to support services.

6.5 Capacity Building

1. Facilitate the development of comprehensive recruitment, training, and retention policies to strengthen human resource capacity. Such a policy shall promote meaningful participation of PLHIV and be gender sensitive.
2. Work with key coordinating agencies and implementing partners to facilitate the assessment of capacity gaps and subsequent creation of strategic plans to address these gaps.

6.6 Monitoring, Evaluation, and Research

1. Promote “One” Southern Sudan HIV/AIDS M&E framework that guides HIV/AIDS data collection, analysis, storage, retrieval, reporting, and dissemination; all data collection tools, procedures, and reporting formats shall be standardized and harmonized.
2. Data collection and reporting shall be driven by a set of priority/core indicators.
3. Ensure that the Southern Sudan HIV/AIDS response is informed by high-quality strategic information obtained from, inter alia, epidemiological and behavioral surveillance; basic, operational, formative, and evaluative research; and routine program monitoring.
4. Ensure that all research complies with the highest ethical and technical standards, utilizing international best practice adapted to the Southern Sudan context.
5. Enhance a system for resource allocation, utilization and resource tracking for HIV/AIDS response in Southern Sudan

7.0 IMPLEMENTATION STRATEGY, AND MONITORING & EVALUATION

7.1 Implementation

Dissemination

The Southern Sudan Government *HIV/AIDS Policy* is meant to be a living document, one that is owned and utilized by the people of Southern Sudan. While the policy will be disseminated to key stakeholders in the public and private sectors, a more proactive approach will be utilized, one that is based on dissemination and branding techniques. To raise awareness of and generate interest in the GOSS HIV/AIDS policy, dissemination campaigns will be undertaken using a range of media, including:

- Radio and television (talk/call-in shows; another avenue to explore is having the tenets of the HIV/AIDS policy written into the plots of soap operas and other dramas)
- Posters and billboards
- Awareness-raising workshops
- Local artists (e.g., drama/dance/drumming troupes)

- Summaries of the policy's key points available in various formats (e.g. pamphlets and other media translated into Arabic and local dialects, calendars/office supplies, CDs)

Audiences will span:

- Government, including:
 - i. GOSS and state parliamentarians/assembly members
 - ii. Officials from GOSS ministries, commissions, and agencies
 - iii. State-, county, and payam-level officials
- Civil society, including traditional leaders and community opinion leaders
- The nonprofit sector, including international, national, local NGOs, CBOs and FBOs
- The for-profit sector, including the subregional and national business communities

Intervention

The *Southern Sudan HIV/AIDS Policy* set the tone for and guided the development of the Southern Sudan HIV/AIDS Strategic Framework (2008-2012), which in turn is the instrument deployed to implement the policy. Based on the Southern Sudan HIV/AIDS Strategic Framework, SSAC and MoH shall work with their partners and stakeholders to create and cost annual action plans.

7.2 *Monitoring and Evaluation*

GOSS shall develop a system to monitor the HIV/AIDS policy. Such a system will entail:

1. That the policy recommendations are captured by Southern Sudan HIV/AIDS Strategic Framework (2008-2012).
2. That the actions plans undertaken by our partners are in conformity with both Southern Sudan Strategic Plan and the policy.
3. That the policy evaluation review will be undertaken in mid 2012. That review will be influenced by: Sociopolitical developments within Southern Sudan; Lessons learned from implementation of the NSF and from other countries; Emerging scientific knowledge (e.g., results of clinical trials of new prevention technologies); Policy and programmatic guidance issued by global, regional, subregional, and national bodies.

SSAC shall coordinate and facilitate an independent evaluation of the policy's success in realizing its outcome at the 5-year mark (2012). It is anticipated that the tools used by the independent evaluator will include those developed by the World Bank/AIDS Strategy & Action Plan, and the AIDS Program Effort Index.