Universal Periodic Review of Sudan

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Joint submission by the following partners in the Sexual Rights Initiative[1]:

Action Canada for Sexual Health and Rights

www.sexualhealthandrights.ca

The Egyptian Initiative for Personal Rights
www.eipr.org

Akahatá
www.akahataorg.org

The Federation for Women and Family Planning
www.federa.org.pl

Coalition of African Lesbians
www.cal.org.za

[1] The SRI partners developed this submission in collaboration with an activist in Sudan who chooses to remain anonymous.

Key Words: [Child and forced marriage, FGM, sexuality education, reproductive health, HIV/ AIDS]

Executive Summary

1. This submission addresses three issues related to women and girls sexual and human rights, namely (Female Genital Mutilation, Early and Forced marriage, sexuality education and the prevention of HIV/AIDS). This report provides background of the situation in Sudan in regards to the legal, policy and social aspect for each issue.
2. The submission then looks at the interventions required to address these issues, outlines the existing human right violations on these issues and analyses Sudan's previous UPR report: the recommendations made and how they have been implemented by Sudan. Suggested recommendations on FGM, early and forced marriage and sexual and reproductive education to prevent HIV/AIDS are also included.

Background

1. The projected total population of Sudan for 2013 is 34,109,472, of which 33.2% live in urban areas, 57.9% live in rural areas while 8.9% are nomadic. There is an almost equal gender distribution and youths (10 – 35 years) comprise almost half of the population.[2]
2. Since its separation from the South four years ago, Sudan has been in the process of renewing its constitution and reforming the system of government. This has resulted in increased restrictions in freedom of speech, access to information and the right to form alliances.
3. Sudan is a generally conservative and highly religious society where sexuality is not openly discussed, and an illness such as HIV/AIDS is surrounded by myths and taboos and ignored in official circles. It is difficult to persuade people to talk openly about HIV/AIDS and requires a sensitive approach. The government's denial and lack of investment in public awareness raising campaigns to prevent HIV places these communities in great danger.
4. A household health survey conducted in 2010 shows that 88% of adult Sudanese women, 83.7 % of girls between 15 and 19, and 72.2 % of girls between 10 and 14 years have been circumcised. In most parts of Sudan, girls are usually circumcised before they reach their 12th birthday. However, there are also cases where uncircumcised women are pressured into having the procedure prior to entering marriage. Infibulated Sudanese women usually undergo re-infibulation after giving birth.[3]
5. The primary goal of sexuality education is to equip children and young people with the knowledge, skills and values needed to make informed choices about their sexual and social relationships and reproductive lives.
6. In Sudan, sexuality education is not taught as a separate subject in the formal education system, even though schools are the main places for delivering sexuality education programs. In secondary school many components of adolescent health and sexuality education are integrated with existing subjects, such as biology, religious studies and primary health care.
7. In the absence of a formal system of sexuality education, adolescents seek information from peers outside of their families. Sudan has a growing number of peer education programs, which the country is greatly in need of.

[2] 2008 Sudan Population Census
[3] Ending FGM in Sudan, UNFPA.

8. In the last UPR review, Sudan received recommendations on amending its laws, including those on marriage, custody, divorce, property rights, and indecency, to ensure compliance with international human rights law. Other than the drafting of a national strategy to stop early marriage by the National Council for Child Welfare, none of the other recommendations have been implemented.
9. A recommendation was accepted on enhancing school programmes and community education to raise public awareness about the harmful effects of FGM. The government supports the *Saleema*[4] *initiative* which promotes FGM prevention through work with communities that have decided not to practice FGM and to fight the stigma faced by circumcised girls.
10. However, a recommendation was also made to pass legislation at the federal level to prohibit female genital mutilation and early forced marriages, and to ensure that such legislation would be enforced. This has not happened and only four states out of fifteen have passed local laws to criminalize FGM. This is a barrier towards passing a National level law.

FGM

1. The practice of FGM is a serious health issue affecting women and girls. In Sudan, the practice is deeply rooted in, culture and society and in some areas of the country has been given a religious basis.
2. FGM has serious implications for the health of women and increases the risk of childbirth difficulties. It is a clear violation of human rights and is a form of violence against women and girls that also denies women the right to a healthy, safe and satisfying sex life.

Legal context

1. The CRC's Concluding Observations and recommendation from Sudan's latest reviews in 2002 and 2007, highlight that the prevalence of FGM remains a concern. The committee recommended that Sudan continues to strengthen its efforts to eradicate the practice and to seek cooperation with other countries in the region to that end.[5]
2. Sudan has still not developed or implemented national legislation that explicitly prohibits female genital mutilation.

Policy context

1. Sudan has adopted a national initiative to stop FGM - The National Strategy to End FGM/C 2008-2018. This aims to end FGM within a generation[6]. However, there remains the need for a national law to criminalize FGM, or for the National criminal law to be amended to ensure that FGM is criminalized.
2. The Ministry of Health has a strategy and work plan to minimize FGM for 2001, signed by the minister of Health.
3. The ministry is implementing a workshop with doctors and midwives on advocacy to stop FGM. This approach forbids medical personnel from practicing FGM as a violation of the right of health.
4. The government of Sudan has, through the National Council on 20-6-2007 issued Declaration No 29 which states the need "To establish legislations that forbid FGM and the importance of fighting this practice using all the possible efforts and with coordination with relative institutions".
5. The punishment for a midwife that performs FGM is either the removal of their work permit or a suspension of between 4 to 6 months.
6. Although Sudan was the first country in Africa to have a record of legislating against FGM, today there remains no national law against FGM.

[4] Saleema is a national campaign promoting positive social change of letting girls healthy and not circumstanced, supported by key persons and community leaders, started 2010, http://www.saleema.net

[5] Sudan Country Case Study: Child Rights Commissioned by NORAD and SIDA, by Samia al-Nagar and Liv Tønnessen, UTV Working Paper 2011:3

6 The National Strategy to end FGM, 2008-2018, Arabic version http://nccw.gov.sd/files/91.pdf

Social Context

1. In Sudan, FGM has long been an integral part of the social system. It is a cultural belief of many Sudanese that the practice safeguards the family's honour and the prospect of their daughters' future marriage, linking it with premarital virginity and marital fidelity. Consequently, there is a great deal of stigma against women and girls who are not circumcised.

Problem identification

1. FGM can have a devastating short and/or long-term impact on a woman and girl's sexual and reproductive health.
2. FGM can be a direct cause of death, infibulation, and may cause obstructed childbirth and is one of the main causes of Obstetric Fistula and maternal morbidity.

Child and forced marriage

Legal context

1. Sudan regulates marriage as a civil contract but not on an equal basis between men and women. Women are required to have a guardian to conduct the contract on her behalf. In the instances where a woman does not have a guardian, a judge will act in that role.
2. The legal minimum age of marriage is regulated by the 1991 Muslim Personal Status Law and the 1926 Marriage of Non-Muslims Act. The Muslim Personal Status Law, which is based on Islamic law, stipulates that boys and girls can get married when they reach puberty. Puberty is generally recognized in girls between the age of 9 and 15 and boys between the age of 14 and 18 in Muslims law and 13 for girls and 15 for boys in Non-Muslims law.
3. For a girl to marry she needs the permission of a wali (a male guardian). This gendered-biased legislation is a clear violation of the principle of gender equality. The (informal and formal) legislation is gendered.
4. There are different marriage laws for Muslims and non-Muslims. This is a clear contradiction. Marriage should be treated as a civil right, governed by civil laws that do not discriminate on gender or religious grounds.
5. Another area where legal reform is required is in the instance of forced marriage. When instances of forced marriage are taken to court the decision is often that the marriage is not valid, but the courts do not provide a clear settlement for the affected girl or her family, especially in regard to her housing and financial resources so that she is able to restore her life to how it was prior to the marriage or for covering her medical or sociological treatment if required. This results in further suffering to the girl or woman.

Policy context

1. Since 2014 Sudan through the National Council for Child Welfare (NCCW) has been working on developing a National Strategy to prevent Child marriage.

Social Context

1. Decisions on child and forced marriage are in most cases made by the man and most of these marriages are arranged by families without giving voice or consideration to the wishes of the girl.
2. Child and forced marriage causes several human rights violations including gender-based violence, the denial of the right to access education and domestic violence.

Problem identification

1. Child and forced marriage affects 15 million girls worldwide each year. It is defined as a harmful practice that negatively affects girls' sexual and reproductive health.[7] It results in childbirth at an early age, which can lead to both physical and psychological ill health.[8]
2. In the first cycle of the UPR Sudan received recommendations on amending its laws, including those on marriage and divorce, to ensure compliance with international human rights law. Sudan has signed international covenants such as the Convention on Rights of Child. The Committee on the Rights of the Child has required Sudan to reform its national laws in accordance with the Convention to guarantee these rights. Ever since the signing of the Comprehensive Peace Agreement (CPA) in 2005 and the creation of a new constitution, Sudan developed a very strong bill of rights. There were many calls and campaigns to reform Sudanese laws, especially those laws that affected women's rights.
3. Unfortunately those laws have not been reformed even though the government has announced that a process to do so is under development.
4. Sudan's commitment (Beijing platform, 1995) to protect women's and girls' rights, requires amending the 1991 Muslim Personal Law Act of Sudan, so as to help end early and forced marriage.

HIV/AIDS prevention, sexuality education and reproductive health

1. In the last two decades and a half, many aspects of reproductive health have become politically or culturally sensitive in Sudan.
2. Although health centers offer varying levels of reproductive health services, a comprehensive package has not yet been integrated into primary health care. Basic levels of antenatal care and limited family planning services such as Prevention of Mother to Child Transmission (PMCT) are available at most health clinics.
3. Health facilities that offer maternal and child health (MCH) and family planning services are often small and address these areas separately. These facilities are often understaffed, clients have to make frequent trips to receive services, which often results in lost time and additional expenses, especially if centers charge for consultations.[9]
4. According to a 2002 behavioral and epidemiological survey conducted by the Sudan National AIDS Program (SNAP), the overall HIV/AIDS prevalence rate in Sudan was 1.6%. The prevalence rate among women attending antenatal clinics was 1.0%, among refugees 4.0%, while prevalence in other high risk groups such as sex workers was 4.4%, 1.6% among TB patients, 2.5% among tea sellers [10] (categorized among the most at risk population, comprising some 25% of the suspected AIDS patient, and who some believe engage in transactional sex).

5. Most adolescents usually lack knowledge on sexual and reproductive health because they do not receive education about sexuality from their families or school, mainly due to the fact that these issues are culturally sensitive. Therefore, adolescents seek information from peers outside of their families.
6. Peer educators convey information about sexuality and reproductive health in order to stimulate behavior change, create a more supportive and understanding attitude towards people who are infected with HIV/AIDS, through changing their knowledge, attitudes and beliefs. Such programs are supported by UN agencies and implemented by NGOs, CBOS and governmental bodies.

7 Committee on the rights of the child General comment No4. 2003

8 Sudan Country Case Study: Child Rights Commissioned by Norad and SIDA, Samia al-Nagar and Liv Tønnessen, UTV Working Paper 2011:3: page 19

9 UNFPA, Today's Challenges m Tomorrow Potential Findings from a Rapid Population and Reproductive Health Analysis for Sudan May 2006.

10 Tea sellers a group of women selling tea and food items outside public buildings, government departments and private companies.

7. Public education can reduce vulnerability to HIV/AIDS by increasing literacy and general awareness levels so that people acquire the knowledge, attitude and skills necessary to resist negative pressure, avoid harmful behavior and make healthy choices.[11] Despite these risks, only 5% of young girls and 11% of young boys aged 15-24 years have comprehensive knowledge on HIV/STIs and their modes of transmission[12].

Legal context

1. The National AIDS Council is the governmental body that administers the HIV/AIDS control program. Eleven line ministries (Ministry of Defense, Higher Education, Education, Labor, Social Affairs, Finance, Youth and Sports, Justice, Interior, and Guidance) have developed their own sectoral strategic plans but most do not have earmarked budgets to implement them.
2. The HIV response remains multi-sectoral but mostly though a health sector response coordinated by The Sudan National AIDS and STI Control Program (SNAP) under the National Ministry of Health. SNAP is the technical body with the responsibility for national level policy, planning and coordination[13].
3. The Ministry of Health advisory and supervisory body on AIDS is the National AIDS Executive Committee; which in the implementation level includes focal points from different sectors to facilitate the implementation of the plan[14].

Policy context

1. The current response to AIDS in Sudan is based on the National Strategic Plan II (2010-2014) which was developed with the new understanding of the epidemic's profile in Sudan[15].
2. The Sudan House Hold Survey (SHHS) conducted in 2010 estimated that the HIV/AIDS test coverage was only 1% for Sudanese population.
3. A lot of work in awareness raising and encouraging informed decisions regarding sexual and reproductive health, especially among adolescents, is needed, which NGOs and CBOs seek to do. The Humanitarian Aid Commission (HAC) is responsible for the registration and performance of the non-governmental organizations but has failed to build trust and cooperative relations between these organizations and the government.
4. Other aspects to note are that Political verbal commitments are not translated into action or financial support. Organizations working in the field are faced with several administrative obstacles, security permits and procedures that often change and are unclear.
5. Even though no laws or regulations are in place to prohibit condom use, condoms remain a "taboo" issue among policy makers and decision makers, probably due to the influence that Islamic leaders' have and the anti-condom position they have taken.
6. Based on the National Strategic Plan of HIV 2010-2014 (NSP), condom use remains a key measure for HIV prevention but it also acknowledges the cultural sensitivity around condom use. Men hold the

11 The Price of Silence: HIV/AIDS control in Sudan El-Sadig El-Mardi, The Sudan Tribune, 2008, http://www.sudantribune.com/spip.php?article29496.

12 Sudan Household Health Survey, 2010.

13 Global AIDS Response Progress Reporting 2012 – 2013, Sudan National AIDS and STI Control program, 2014.

14 Sudan National Strategy Plan and sectoral Plans on HIV/ AIDS, 2004-2009, http://www.nationalplanningcycles.org/sites/default/files/country_docs/Sudan/hiv_plan_sudan.pdf

15 Sudan AIDS Response Progress Reporting 2012-20103, http://www.unaids.org/sites/default/files/country/documents//SDN_narrative_report_2014.pdf , P 5.

perception that condom use reduces sexual pleasure. The NSP does not have a specific plan to address these perceptions.[16]

Social Context

1. Sexual and reproductive health issues are dealt with in secret and as a taboo subject. This forces youth to seek out information on their own. There is a lot of misinformation available, for example, on family planning there are a lot of misinterpreted Islamic quotes
2. The means in which HIV/AIDS is addressed in the media and in government polices is to state that it is a problem that affects only certain people, and it is not therefore a community or public health issue. This increases the burden of stigma on HIV positive people and their families.

Problem identification

1. Sudan is in the early stages of an HIV and AIDS epidemic, which has an almost exclusively heterosexual transmission pattern but with indications of higher infection rates in the South than in the North. Years of civil war and limited epidemiological data make it difficult to generalize about HIV and AIDS in Sudan.
2. The estimated HIV prevalence rate is 1.6 % among the adult population in northern Sudan and 3.1 % in southern Sudan (UNAIDS Reports 2008). In southern Sudan children below five years constitute 21 per cent of the population while 53% are under the age of 18 .The epidemic is more marked in the 20–34 age group, which is similar to data from other countries.[17]
3. One of Sudan's challenges is that the school's curriculum teaches nothing about social issues. Teaching on HIV/AIDS programs for example are highly censored by the security authority under the guise of guarding public morality. This only adds to the difficulties faced by non-governmental organizations that work with communities to tackle HIV/AIDS, gender based violence and child and forced marriage.

Recommendations for action:

1. The Government should develop national laws to criminalize FGM and these need to be implemented as soon as possible.
2. The Government should enhance school programmes and community education to raise public awareness about the harmful effects of FGM, which constitutes a serious form of violence against women and a serious attack on health and sexual rights.
3. The Government should increase awareness raising among health sector staff to prevent the practice of FGM. The punishment for doctors and midwives practicing FGM should be increased.
4. The Government should support programs that address the social stigma faced by uncircumcised girls, and encourage communities to abandon FGM.
5. The Government should ensure holistic and coordinated approaches to addressing FGM as a social practice though related sectors such as health, education, social services and law enforcement mechanisms.
6. The Government should establish laws that prohibit child and forced marriage, setting the age of marriage to 18 for both girls and boys.

[16] National Strategic Plans on HIV and AIDS in five global region, team lead by Hayley Thomson, 2010, Page 57, http://esaro.unfpa.org/sites/esaro/files/pub-pdf/Sonke_Analysis_of_Men_and_Gender_Transformation_in_NSPs_on_HIV_and_AIDS_Dec_20101.pdf

[17] Sudan Country Case Study: Child Rights Commissioned by Norad and Sida, by Samia al-Nagar and Liv Tønnessen, UTV Working Paper 2011:3: page 16, http://www.sida.se/contentassets/e3a7b0cb84274558afc2720451885d62/20113-sudan-country-case-study-child-rights_3127.pdf

7. The Government should develop women's and girls' empowerment programs to ensure that decisions to marry are taken freely without coercion or undue influence. The Government of Sudan should also support the development of facilities for women victims of such violence.
8. There is an urgent need for full legal reform of the 1991 personal law that governs marriage and divorce so as to eliminate gender-based discrimination in marriage for girls that require a guardian.
9. The Government should take into consideration social and cultural aspects in prohibiting child and forced marriage, and enforce marriage registration.
10. Laws dealing with marriage and divorce need to address social aspects and protect girls and women from exploitation. This includes fast and easy access to the courts and ensuring the best interest of the child that is born from an invalid or forced marriage.
11. The Government should adopt a national HIV/AIDS awareness campaign and ensure access to appropriate HIV/AIDS education and information, and undertake sensitization activities to stop the stigmatization of HIV positive people.
12. The government should develop a clear policy with regard to sexuality education for adolescents and youth, including its provision through the educational system.
13. The Government should ensure the location and staffing of health facilities are better coordinated so as to ensure coverage of key target groups.
14. The Government should provide increased funding and logistical support for peer education programs.