Universal Periodic Review of Sudan, 3rd Cycle, 2021

Sudan Family Planning Association (SFPA)

Brief introduction to NGO

Sudan Family Planning Association

The Sudan Family Planning Association (SFPA) was established in 1965 by pioneers in obstetrics and gynecology in response to increases in maternal, neonatal and infant mortality and morbidity. As the statistics show, Sudan is a country in great need of frontline sexual and reproductive health (SRH) services. Advocacy, and undertaking information, education and communication (IEC) programs are critical. The organization has a strong team of health personnel and professional staff that operate 389 service points. These diverse outlets and outreach services are designed to secure the greatest possible access, particularly for vulnerable groups. The outlets include but not limited to 23 Static clinics (IRHCs), 8 mobile clinics, 225 associated public clinics, 100 NGOs clinics, 32 Social franchising clinics, 176 private clinics and 1242 community based service providers.

A major priority for SFPA is improving the status of women and enhancing their understanding of their rights. The organization allies SRH closely with development initiatives for women. Economic independence, or the capacity to make a significant contribution to a family's income, empowers women, and with economic empowerment comes the potential for greater control over reproductive health and family planning.

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Executive Summary

1. Sudan will be under review for the third time in 2021. Conditions and realities of women's and girls' SRHR have not been sufficiently taken into consideration in the previous cycles.

2. SFPA has exerted considerable efforts to get engaged in UPR, by joining civil society incubator for human rights, participating in series of trainings on UPR related topics, assign committee and experts in the association, national consultant to work in the preparation of the UPR, plus the engagement in the virtual and events and meetings organized by IPPF regional and central office.

3. This report is based on the national data produced by the Sudan Central Bureau of Statistics, and the UN agencies and international organizations, in addition to the data and information provided by the SFPA. The report also reflects the new changes that have been taken place after the start of the Civilian–led Transitional Government. However, older data would not reflect the real progress made between 2019 and 2020. Recommendations suggested to the state in Sudan are considering the expected transformation in the constitution, democratic transition through free elections.

General Background

Sudan's Context

4. Sudan is a country of great diversity in topography, ethnicities languages, cultural norms, and living conditions. With land area of 1.8 million square kilometers, traversed by the Nile and its tributaries, Sudan shares its borders with South Sudan, Central African Republic, Chad, Libya, Egypt, Eritrea and Ethiopia. The country is composed of 18 states and 182 localities and three or more administrative units per locality. It has a population of 43.8 million, total fertility rate of 4.3 and Life expectancy at birth is 66 years.[i] 19.78 million people live under poverty line, 2.55 million internally displaced and 1.1 million are refugees.[ii]

5. Sudan is experiencing transformative political changes with new players of different backgrounds and views. After the long-standing conflict, widespread poverty and ongoing impact of economic sanctions, all of these factors make Sudan unique when we talk about rights, especially sexual and reproductive health rights.

Overview of the Health System

6. Sudan has a three-tier health system. At primary level there are Family Health Units and Family Health Centers; at secondary level, district hospitals; and at tertiary level, specialized hospitals.

7. The provision of health care services in Sudan is shared between Ministry of Health (MoH) facilities, non-governmental organizations (NGOs) (which are not for profit) such as SFPA, and the private sector (for profit) such as private clinics. Federal Ministry of Health (FMOH) takes the lead in policy and stewardship, while direct public service delivery is largely led by states and localities administrative levels. The National Health Insurance Fund (NHIF) has a greater role in increasing access to health care where services are available. Access to other sectors such as police and army health services is limited to rural settings. Populations affected by conflict have restricted access to primary and essential health care but the presence of non-governmental organizations (NGOs) play a substantial role in improving service delivery, even in a temporary basis.

Human Rights Commitments

International and regional rights treaties to which state is a party

8. Sudan state has ratified the International Convention on Political and Civil Rights (1986), International Convention on Economic, Social, Political Rights (1986), and Convention on the Rights of Child in August 1990, among other international human rights treaties.

9. Sudan is committed to the SDGs by attending the global summit of SDG in 2015, delivering the Voluntary National Review (VNR) in 2018, and the preparation of the national plan for SDGs, plus the establishment of several structures to implement SDGs at national and state levels.

10. ICPD is another important international development framework in which Sudan state has committed itself to the implementation of ICPD, including by participating and committing to the outcomes of Nairobi's conference in 2019, Cairo Population declaration of June 2013, and Addis Ababa's Population Declaration of October 2013. Sudan state also has National Population Policy formulated in 2005, and updated in 2012.

11. All these commitments obligate States to ensure universal access to sexual and reproductive health information, education, services and rights.

Previous UPR Recommendations

12. At the previous UPR cycles, Sudan has considered (141) recommendations related to women's rights from the total number of recommendations. A high percent of these recommendations are related to ratifying the CEDAW convention and protocol, combating female gentile mutilation (FGM) child, early and forced marriage (CEFM), combatting sexual and gender-based violence, and cancellation of national discriminatory laws against women and girls and to ensure their compatibility to international standards. None, however, specifically look at women's access to sexual and reproductive health and rights.

Progress been made on these issues since 2016

13. The Civilian-led Transitional Government is obliged to commitments made in the Sudan Constitutional Declaration, 2019 and the Constitutional transitional document. Women's rights and issues are included in chapter 14, the Bill of Rights and Freedoms, paragraph 49, and paragraph 7 in the transitional document. Based on these developments, the state of Sudan repeals the public order laws, which governed among other things, women's presence in public spaces.

14. Furthermore, the state commits to the right of health, where the government expenditure for health has increased by considerable percent, plus the amendments made to ensure universal health coverage, as agreed in the Political Declaration on UHC of 2019.

Specific Issues relevant to the SRHR

Issue 1: The Right to Health

15. The change in government in 2019 has resulted in a shift of the political atmosphere and more supportive environment for improving health. The constitutional document has stated that the transitional authority should have an active role in advancement of the social care, including health, and this was translated on the ground by increasing spending on health sector. The new National Health Recovery and Reform Policy and Strategic plan 2020 – 2022 has committed to achieve better health outcomes and to leave no one behind by increasing access to essential health services, addressing gaps and promoting effective leadership. However, this plan has not yet been endorsed and implemented. Currently, the health organizations are now working with the

National Health Policy 2017 – 2030, which puts the right to health at its heart and committed to reduce the health inequalities.

16. Despite all of this, health indicators are still deteriorating. According to World Health Organization estimates in 2017, the Maternal Mortality Ratio is 295 per 100,000 live births, while the Neonatal Mortality Rate is 30 per 1000 live births, Infant Mortality Rate is 44 per 1000 live births and the Under-five Mortality Rate is 63 per 1000 live births. [iii] Sudan has the highest rate of unmet demand for family planning with modern methods in the Eastern Mediterranean region, with only 33.3 of demand satisfied.[iv] Universal Health Coverage is a key priority in the National strategies. Several policies have been developed to support it. Those policies include Health Financing policy, Family Health policy, and the Health in All Policies road map. In addition, the National Health Insurance Law and National Supply Fund law has been endorsed. However, Sudan Universal Health Coverage Index is 50 – 59 with a population coverage (estimate in thousands) of 56,950, which represents only 2.4 % of the total population. Beside that the UHC indicators are lagging behind expectations, the one year old children who have received 3 doses of diphtheria-tetanus pertussis vaccine (DTP3) is 95%, Tuberculosis effective treatment coverage is 78%, People living with HIV receiving ART is 15%, Population at risk sleeping under insecticide-treated bed nets is 34.7%, hospital accessibility (hospital beds per capita) is 8.2%.[v]

17. The WHO similarly reports 1.5 PHC facilities and 6.6 hospital bed per 10,000 people,[vi] but there is great variation in the distribution across the country. The ratio of PHC facilities to population is 1:3,000 people in the Northern State and 1:21,000 people in South Darfur. In six states over 20 percent of the population lives more than 5 km distance from a health facility, this includes the five Darfur states and Red Sea. The challenge is in the services variation, where only 24% of the PHC functioning facilities offer the PHC package (i.e. reproductive health, immunization, nutrition, prevention and treatment of common diseases and essential drugs).

18. One of the main challenges for the majority of the population is the out-of-pocket expenditure. The Sudan health system financing indicates that 65% of health funding is from private sources, almost all out of pocket expenditure, and the WHO estimates that 73.9% of health expenses is out of pocket.[vii] Reliance on out-of-pocket spending for health care exposes individuals to financial risk and is likely to reduce access for the poor.

19. Human resources for health are essential component of service delivery. Uneven distribution of medical doctors relative to nurses, midwives and paramedics, and the tendency of doctors to emigrate for better work and living conditions in the urban cities or abroad, leaving PHC and rural hospitals understaffed.

20. Basic equipment and services, such as clean water and sanitation are not available in a significant proportion of health facilities, especially in poorer rural states. Medicines are a major share of the health expenditure by individuals reaching more than 40% in most cases. Officially, the public system approves single supply agency for the public sector, but in practice, there are multiple procurement and supply arrangements.

21. Health information in Sudan is primarily based on health facility reporting, community-based surveillance and event/incidence base surveillances that are underutilized and all are supplemented by periodic surveys. Hospitals and health facilities within reach of administration supervision are regular reports. There is a big gap in PHC facilities reporting in many states and low coverage of other sectors, including private providers. The main weaknesses are in documentation, data quality assurance and limited use of systems for data management at the state and locality levels. Annual statistical reports are produced at national level, with limited use of data in decision making at sub-national levels.

22. Economic sanctions, poverty, the longstanding conflicts, and the already exhausted health system make Sudan a unique case when we talk about the COVID-19 pandemic. To date, there are 30,989 confirmed cases and 1,959 deaths. The health system could not respond effectively to the pandemic, which shifted the treatment options to the private sector, which in turn increased the out of pocket expenditure. Sudan received the COVID-19 vaccine with support from UNICEF, but it will be only to limited populations, the medical staff and small number of elderly people.

Issue 2: Maternal Mortality/ Reproductive Health

23. In Sudan, girls are confronted by harmful traditional practices that affect their reproductive health; one of the most traumatic is early marriage and childbearing. Almost 12% are married before age 15, and by 18 years, 38% of people are married.[viii] The total adolescent birth rate for ages 15-19 is 87 (per 1000 women), but 5.2% of girls had a child before the age of 15, and 23% of women had at least one live birth before age 18.[ix] The rates vary widely by geographical location. For example, the adolescent birth rate per 1000 women is 53 in urban settings, but 103 in rural areas, and birth before age 15 in rural areas is almost double the rate in urban areas.[x] Early child-bearing is one of the main factors for increased maternal mortality and development of serious pregnancy related complications, such as obstetric fistula.[xi]

24. In terms of maternal health, there are significant differences among the states for women who received antenatal care (ANC) from any provider; ranging from

61.8 percent of women in South Darfur state to 97.1 percent of the women in Khartoum state.[xii] Differences also exist among women in the wealth index households who received ANC ranging from 61.7 in the poorest households to 97.2 percent in the richest households.[xiii] National records reflect that total antenatal care coverage is 79.1% (at least one visit by skilled health personnel),[xiv] an increase from 74%,[xv] whereas deliveries attended by skilled personal (percentage of women age 15-49 years with a live birth in the last 2 years who were attended by skilled health personnel during their most recent live birth) is 77.5% showing no major increase.[xvi] National figures reflect low institutional deliveries at 27.7%.[xvii]

25. According to the Sudan Multiple Indicator Cluster Survey, the percentage of women who received ANC was found to be influenced by the women's educational level and the level of household wealth: only 65.7% of women with no formal education received ANC at least once by skilled personnel, while 83.8% of women with primary education and 92.5 % and 98.6% of women with secondary and higher level of education, respectively, received ANC at least once by skilled personnel.[xviii] There were significant differentials among women who received ANC from households in the richest quintile (97.2%) and those in the poorest quintile (61.7%) respectively.[xix] The current provision of specific care provided as part of the antenatal care of facilities remains quite inadequate, with 62.8% of women age 15-49 years with a live birth in the last 2 years who had their blood pressure measured and gave urine and blood samples during the last pregnancy that led to a live birth.[xx]

26. These variations reflect that poorer women with lower education living in remote areas with least access to health care are more likely to develop complications with pregnancies, labor or during postpartum period, this includes but not limited to fistulae formation or maternal death. Despite some improvements in certain areas of the country over the past years, there is no signal to indicate the same improvement for populations with limited access to PHC.

27. Although family planning is a known intervention to reduce the maternal mortality, not all the primary health facilities offer the service, and women in rural areas don't have the access to long acting contraceptive methods due to a lack of medical staff who is authorized by the Ministry of Health. Currently only 12.2% of women who are married or in union are using a family planning method (only 11.7% are using modern methods), with 87.8% using no form of contraception. Of married girls and women aged 15-49, 26.6 % have unmet need (but the met need for contraception is only 33.4%), with clear variations between urban and rural areas, and among different educational level of women and household wealth.[xxi] This unmet need is due to multiple reasons: husband refusal, quality of service, accessibility problems; lack of information, fear of

experience side effects, limited choice of methods, and cultural or religious oppositions, all of these factors violate women's reproductive health rights.

28. Maternal mortality ratio is among the highest in the Arab region, with an estimated average of 295 per 100,000 live births, with a range of 207-408 depending on the state.[xxii] However, the data represents a major problem because the maternal mortality surveillance in Sudan does not include the deaths from the community level, depends on resident doctors who don't have fixed jobs, and as a result there is no accurate data.

29. A shortage of emergency equipment, ambulance availability, lack of quality services in the public sector, leakage of essential reproductive health medications to the black markets for a high price, employment problems for community midwives who are the backbone of women health, and low governmental efforts in community engagement all result in about three quarters of all maternal deaths occurring due to directly preventable obstetric causes.

Issue 3- Gender Based Violence (GBV) – Female Genital Mutilation (FGM)

30. Women and girls in Sudan are still suffering from the inherited traditional norms and customs and harmful traditional practices affecting their reproductive rights and health. One of the most devastating old traditional practices is FGM. The Multiple Indicator Cluster Survey revealed that overall, 86.65% of women aged 15-49 years were subjected to any form of FGM, and 31.5% of daughters age 0-14 years have undergone one of any form of FGM, as reported by mothers.[xxiii]

31. It is worth mentioning that the government of Sudan represented in the National Council for Children Welfare (NCCW) produced an assessment report on the implementation of the national strategy for abandonment of FGM 2008-2018 which noted reduction in the prevalence of FGM is observed in most of states, although at different levels. Unfortunately, the reduction is slow and lagging behind what the situation demands. A recent UNCIEF report based on the Simple Spatial Survey Method (S3M II) reported that FGM prevalence for girls under 8 years of age was 16.5 per cent; for girls under 14 years of age it was 27.2 per cent, and by age 14 prevalence is 68.8 per cent.[xxiv] UNFPA reports a rate of 82% for girls 15-19 from 2004-2018.[xxv]

32. SFPA has built on its experience in the area of reproductive and sexual health, and expanded its role to cover other areas relevant to SRH as FGM. SFPA has a joint project with the Norway Government to eliminate FGM in Sudan, starting in 2018 and covering 10 states in Sudan. The project main focus of is advocacy,

awareness raising and capacity building for concerned government officials, national NOGs, CBOs and services providers in the 11 branches existing in the 10 targeted states. The SFPA also partnered with counterpart NGOs, established the network for NGOs working in health, and became the chair of the network. Furthermore, the SFPA has succeeded to build new funding partnerships with Plan Sudan to expand the project activities in North Kordofan, and with UNICEF to join SALEEMA Initiative for eliminating FGM in Sudan.

33. In April 2020, Sudan's Cabinet of Ministers approved the amendments to the criminal code that would punish those who perform FGM, by assigning Article 141 in the criminal code for criminalizing FGM. Progress made to respond to the recommendation about elimination of FGM, the NCCW completed the first draft for the new national strategy for abandonments of FGM, with time span from 2021-2030, the strategy is aligned with SDGs and it has also included the road map for implementing the amended code '141' in the criminal law for the abandonment of any type of FGM issued in 2020.

Recommendations:

34. In the context of the new transitional political period in Sudan, a new permanent constitution will be written to lead peaceful transition of power in Sudan. The state needs to consider the protection of people's rights to sexual and reproductive health and rights, in particular women and girls. We suggest the following recommendation to be made by the state in Sudan in the third cycle of the UPR:
    I. **Accelerate universal health coverage including SRHR services, especially for marginalized and vulnerable groups, as agreed in the 2019 Political Declaration on UHC.**
    II. **Reduce direct, preventable maternal mortality by adopting quality maternal/ reproductive health services and improve maternal mortality data by strengthening, and institutionalization of Maternal Death Surveillance and Response system.**
    III. **Endorsement of the new national strategy for abandonments of FGM, with a road map for implementing the amendments of the criminal code for FGM and including new amendments in the civil code for a zero tolerance policy.**

Additional References:

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