



HUMAN  
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WATCH

## “No Control, No Choice”

Lack of Access to Reproductive Healthcare in Sudan’s Rebel-Held Southern Kordofan



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Lack of Access to Reproductive Healthcare in Sudan’s  
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## Summary

Four years ago, after 14-year-old Hassina Soulyman spent two days in labor at home, weak from loss of blood and falling in and out of consciousness, her family knew something was terribly wrong. They set her on a motorcycle—the only transport in her village—with two men holding her between them for a two-hour ride to a larger village. There they waited hours for a car to take her to one of only two hospitals in the rebel-held areas of Sudan’s Southern Kordofan state. When they finally got her there, a doctor delivered her stillborn baby by cesarean section and told Hassina that her cervix was too narrow to give birth vaginally.

Without adequate health information or access to contraception, Hassina became pregnant two more times. Her second baby was delivered at the hospital but died before reaching six months. During the last weeks of her third pregnancy, when she was 18, Hassina and her family fled her village to escape aerial bombing by the Sudanese government. She went into labor in the riverbed where her family was sheltering and endured three days of obstructed labor, during which the body of the baby cleared the birth canal but the separated head was stuck in her womb before she could get transport to a hospital for medical assistance. She survived another operation, but as of December 2016, when Human Rights Watch met her, Hassina still did not have access to family planning assistance.

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Women and girls living in rebel-held areas of the Nuba mountains of Southern Kordofan, Sudan have little or no access to contraception, adequate antenatal care, or emergency obstetric care—leaving them unable to control the number and spacing of their children, and exposing them to serious health complications and sometimes death.

Reduced access to health services is one of the many devastating consequences of six years of armed conflict between Sudanese government forces and the armed wing of the rebel Sudan People’s Liberation Movement/Army-North (SPLM/A-North), a spin-off of the former southern Sudanese liberation movement and now ruling party of independent South Sudan.

Healthcare access was low in the four areas currently under the control of rebels— and worse than in other parts of Sudan because of marginalization by Sudan’s government and earlier conflicts— even before the current war began in 2011. The poor humanitarian situation there cannot be entirely blamed on the conflict. However, unlawful government bombardment, destruction of clinics including by bombing, poor distribution of medicines, and hard-to-cross frontlines have all further reduced access.

A United Nations-led humanitarian aid effort to improve the humanitarian situation has not been put in place. Both parties to the conflict have failed to agree on a joint modality for a sustained humanitarian effort, despite 15 rounds of African Union-moderated talks over six years, and many proposals and other efforts by UN officials and diplomats. Hundreds of thousands of people live in the rebel-controlled areas without the health services, food aid, and other basic assistance that a full UN-coordinated humanitarian response would attempt to provide. Humanitarian aid workers in the area are concerned that civilians in some areas may now be facing the worst food shortages since 2011 and 2012, when food shortages contributed to massive displacement and people reportedly died of hunger.

In December 2016, two Human Rights Watch researchers interviewed 90 people in rebel-held areas of Heiban, Delami and Um Dorein counties, including 25 in-depth interviews with women and girls about their access to reproductive healthcare. Researchers also spoke with witnesses and victims of abuse, local rebel authorities, and humanitarian aid workers. This research builds on findings from five earlier Human Rights Watch investigations in the Nuba Mountains region, hilly areas of Sudan’s Kordofan area where communities from different Nuba tribes live, between 2011 and 2015.

While civilians living in Southern Kordofan, especially in the rebel-held areas, face a myriad of human rights abuses, this report focuses on limited access for women and girls to sexual and reproductive healthcare in the hope that highlighting this will draw the attention of the Sudanese government, SPLM/A-North, and the international community to this particularly neglected aspect of humanitarian needs in the area. The report also describes how many years of negotiations and various efforts by diplomats, the African Union (AU) and the UN have all failed to provide humanitarians with unfettered access to communities in the rebel-held areas.

When the conflict began in June 2011, Sudan's government banned international aid workers, including from UN agencies and international non-governmental organizations, from traveling to rebel-held areas of Southern Kordofan. This travel ban remained in place as, year after year, the two parties failed to agree on arrangements for humanitarian access or implement agreements. Restrictive national regulations for humanitarian groups, closures of NGOs, and expulsions of staff from Khartoum, including senior UN staff, created a climate in which humanitarian groups chose not to push hard for access (in rebel-held areas of Southern Kordofan). These restrictions meant that few international aid workers were allowed to work even in government-held areas of Southern Kordofan, and their activities were limited. Sudan's government has also consistently forbidden aid workers to cross international borders into rebel-held Sudan from neighboring South Sudan or Ethiopia.

The SPLM/A-North have— despite these restrictions—encouraged and allowed aid workers to cross these borders into areas they control to deliver assistance. These programs, unauthorized by the Sudanese government, offer life-saving medical care and humanitarian assistance to civilians, but they only reach part of the population and their supplies are limited. Recently, the SPLM/A-North have asked for further negotiations rather than accepting a late-2016 offer from the United States government to deliver medical assistance from government-controlled areas within Sudan. The rebels have continued to insist that they will only accept a proposal that allows for at least some cross-border aid, both so they can safely transport wounded fighters to medical assistance in neighboring countries, and because they have little trust that Khartoum will not interfere with any flow of assistance originating from within Sudan, as the government has in the past. Human Rights Watch found that civilians living in the rebel areas, many of whom have lived through two wars and faced terrible violations by government forces, also do not trust the Sudanese government not to interfere in delivery of aid.

According to the World Health Organization (WHO), Sudan's maternal mortality rate has fallen from 744 per 100,000 live births in 1990 to 311 in 2015. However, women and girls in conflict-affected areas like rebel-held Southern Kordofan do not have access to the key government health services, supported by donor money, that have contributed to this decline. No recent data on maternal mortality is available for the region, but a joint research effort by the UN and the Sudanese government in 2006 put Southern Kordofan's

maternal mortality rate at 503 per 100,000 live births, compared to 91 per 100,000 births in Northern state and 213 in Southern Kordofan's neighboring Northern Kordofan state. In rebel-held Nuba areas of Heiban, Delami and Um Dorein, antenatal care from skilled and equipped health workers is available at two hospitals and their outreach clinics, both operating without government authorization. However, many women and girls live too far away to access emergency care or live on the other side of frontlines of the conflict, making it too hazardous to travel to the facilities. Most pregnant women must rely on local birth attendants who have no formal training, or trained midwives who have not been able to acquire new or sterile equipment since the conflict began. Women and girls experiencing complications during labor may have to travel for days, often on dangerous routes, including across frontlines, to get emergency obstetric care.

Family planning is not available except in rare instances. The rebel SPLM/A-North administration provides the bulk of health care through a network of some 175 clinics, but these do not distribute contraception, including condoms. One agency provides three-month injectable contraception but restrictions imposed on them by the local rebels require patients' husbands to give permission before they can provide the contraception to women.

Most of the women we interviewed did not know what a condom was and had not heard about other options for contraception. NGO workers, health workers and authorities told Human Rights Watch that condoms are rarely available in markets despite an increase in gonorrhea and syphilis cases over the past two years and high percentages of pregnant women testing positive for hepatitis B. Women and girls are unable to protect themselves from sexually transmitted infections or control their fertility.

In January 2017, the United States government, through a presidential order, lifted its economic sanctions on Sudan, citing the government's cooperation on counterterrorism, its role in addressing regional conflicts, reduced fighting in the conflict zones, and an easing of restrictions on humanitarian access. US policy makers are due to report on Sudan's continued performance in these respects in July 2017, and to decide whether to make the sanctions suspension permanent. Human Rights Watch has urged US policy makers to adopt a clear set of human rights benchmarks in this assessment. These should include respect for international humanitarian law, and in particular an end to indiscriminate bombing; demonstrable and tangible improvements to humanitarian access in conflict zones; releasing individuals arbitrarily detained without charge by the

National Intelligence and Security Services; ending use of lethal force to suppress protests; and reforms to key legislation.

Human Rights Watch urges the US to postpone its evaluation of Sudan's progress from July 2017 to a later date, as meaningful progress will take longer than the six months prescribed in the executive order. Also, more time is needed to assess Sudan's commitment to making broader human rights improvements.

Since the government declared a unilateral ceasefire in June 2016, large-scale fighting has not been reported in Southern Kordofan, but shelling has been reported in some of Sudan's conflict zones. In 2017, aerial bombardment, which has marked much of the conflicts in Southern Kordofan, Blue Nile state and the Darfur region, appears to have been paused, or at least greatly reduced. This year Sudan has allowed humanitarian agencies to conduct an assessment and deliver some aid in a previously inaccessible part of government-held Darfur, and allowed more UN staff in the government-held areas of Southern Kordofan and Blue Nile. Humanitarian organizations have welcomed improvements but government travel restrictions remain, especially in conflict-affected areas like Southern Kordofan.

Unimpeded humanitarian aid across all conflict areas is critical. Unless the Sudanese government, the SPLM/A-North, and the international community act to ensure humanitarian aid reaches rebel-held areas, the ability of hundreds of thousands of civilians to secure food and access healthcare—including comprehensive reproductive healthcare—may continue to deteriorate.

Even with limited available resources, all governments have obligations to provide access to essential medicines as defined by WHO, and to make reproductive and maternal healthcare available and accessible.

Obstructing the delivery of desperately-needed healthcare by impartial humanitarian aid groups in rebel-held areas, as the Sudanese government has done in the past, is a violation of Sudan's obligations under international humanitarian law, a violation of the right to health, and discriminates against the Nuba people who are the population directly impacted. The SPLM/A-North also has violated its obligations as a party to the conflict by arbitrarily refusing to accept international aid to be delivered impartially from within Sudan.

The policies and actions of authorities on both sides— Sudan’s government and the SPLM/A-North – in preventing the delivery of life saving humanitarian assistance to communities in need, should be investigated by the UN's Independent Expert on Sudan and other special rapporteurs, including experts on the right to health and the rights of internally displaced persons, to determine whether they constitute prosecutable offenses of war crimes or crimes against humanity. In conducting such investigation, consideration should be given to the context in which the actions to obstruct humanitarian assistance have taken place, such as the Sudanese government’s aerial bombardment of populated areas, in order to determine the potential scope of crimes that may have been committed.

The UN Security Council should impose individual sanctions against commanders or leaders determined to be responsible for clear obstruction of aid or any serious violations of international humanitarian law and human rights law in Southern Kordofan and Blue Nile, and it should extend the arms embargo that currently exists on Darfur to Southern Kordofan and Blue Nile states. It should authorize a panel of experts to continue to monitor the situation in both areas. Currently, the Security Council maintains a sanctions regime on Sudan, which only covers violations that occur in Darfur.

Sudan should allow the UN and other international agencies to operate unobstructed in conflict areas, including Southern Kordofan and Blue Nile states. The SPLM/A-North should agree to access by impartial aid providers, and not withhold agreement for delivery of humanitarian assistance arbitrarily.

International law protects women’s right to healthcare, including access to family planning services. Along with provision of food and other essential health services, humanitarian programming in rebel-held Southern Kordofan should include improving women’s access to reproductive health services that allows them to exercise autonomy and control over their bodies and lives.

# Recommendations

## To the Government of Sudan

- Immediately stop all indiscriminate attacks on civilians and civilian objects, including the use of unguided fragmentation bombs and cluster bombs.
- Immediately pledge to cease use of cluster munitions, in line with the international ban on cluster munitions.
- In accordance with obligations under international law, urgently facilitate unimpeded access by UN agencies and national and international humanitarian aid groups to deliver impartial assistance, including sexual and reproductive healthcare, to civilians in need in all parts of Sudan, including areas under rebel control; expedite entry visas and travel authorization for humanitarian aid organizations and workers, and fully cooperate with such organizations.
- Cancel arbitrary regulations on the operations of national and international nongovernmental organizations that place unnecessary obstacles and constraints on humanitarian assistance, and stop all bureaucratic and other obstruction of such operations.
- Agree on modalities for impartial humanitarian aid to be delivered into rebel-held parts of Southern Kordofan and Blue Nile states, both cross-line and cross-border. Allow international monitoring of the aid delivery.
- Investigate, charge and prosecute commanders responsible for unlawful attacks on civilians and civilian objects, including schools, hospitals and places of worship;
- Invite investigators from the African Union and the United Nations and their respective human rights bodies, and allow them to carry out impartial investigations into human rights abuses in Sudan, including in Southern Kordofan, by both parties to the conflict.
- Ratify and implement the UN Convention on the Elimination of All Discrimination Against Women and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo protocol).

## **To the Sudan People's Liberation Army-North**

- In accordance with obligations under international law, urgently facilitate unimpeded access by UN agencies and national and international humanitarian aid groups to deliver impartial assistance, including sexual and reproductive healthcare, to civilians in need in all parts of areas under SPLA-North control; allow international monitoring, expedite travel authorization for all humanitarian aid organizations and workers, and fully cooperate with such organizations.
- Working with international humanitarian partners, provide, in all clinics, comprehensive sexual and reproductive healthcare, including information about family planning and sexually transmitted infections, as well as contraception methods that protect against HIV/AIDS and other sexually transmitted infections.
- Cancel any local regulations, whether formal or informal, requiring women to obtain permission from their husbands to access contraception, make a public announcement of the change, and conduct information campaigns about family planning.
- Conduct public awareness campaigns about family planning, female genital mutilation, child marriage, and maternal mortality.
- Promote and ensure participation of women in peace talks and in senior positions in the civilian administration of rebel-held areas.
- Adopt strategies to end child marriage and female genital mutilation and ensure perpetrators of domestic violence are punished within the law.
- Publicly commit to respect the Convention on the Elimination of All Discrimination Against Women and the Maputo protocol.

## **To Humanitarian Organizations and Donors, including the European Union, the United States, the United Kingdom and Norway**

- Advocate with parties of the conflict and the United Nations Security Council to ensure that civilians affected by conflict in Sudan, including those living in rebel-held areas, can access humanitarian aid services that meet international standards and press for access to these areas with both parties.
- Conduct a full, independent humanitarian needs assessment once access to rebel-held Southern Kordofan and Blue Nile is possible, and address the urgent sexual and reproductive healthcare needs of women and girls.



- Ensure that all health services provided in the rebel-held areas adequately address the sexual and reproductive health needs of women and girls.

## **To the United Nations Security Council**

- Demand that the parties to the conflict ensure safe and unhindered access for impartial humanitarian aid to rebel-held areas of Southern Kordofan and Blue Nile states, across both conflict lines and borders. Follow through with additional measures under Article 41 of the UN Charter, in the case of non-compliance, as outlined in Security Council resolution 2046.
- Impose targeted sanctions such as asset freezes and travel bans against Sudanese government and SPLM/A-North or SPLA-North officials deemed to be responsible for serious crimes, including indiscriminate bombing and other violations, and for willful obstruction of impartial humanitarian assistance to Southern Kordofan and Blue Nile states in violation of international law;
- In view of the significant evidence of serious violations of international humanitarian law against civilians by the Sudanese armed forces since 2011, expand the existing arms embargo on Darfur to apply to Southern Kordofan and Blue Nile.
- Authorize an independent inquiry into serious breaches of the laws of war by both sides in Southern Kordofan and Blue Nile.

## **To the Independent Expert on Sudan**

- Travel to rebel-held areas of Southern Kordofan and Blue Nile states to monitor limitations on women's right to health. If access is not possible due to obstruction by the government of Sudan or the SPLM/A-N, conduct interviews in refugee camps in South Sudan and Ethiopia to collect this information.
- Include a review of women's health in next report.

## **To the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health**

- Travel to rebel-held areas of Southern Kordofan and Blue Nile states to monitor limitations on women's right to health. If access is not possible due to obstruction by the government of Sudan or the SPLM/A-N, conduct interviews in refugee camps in South Sudan to collect this information.

## **To the United States Government**

- Monitor progress made by the Sudanese government against a concrete set of human rights benchmarks to evaluate its eligibility for continued sanctions relief. Key among these benchmarks is whether Sudan allows unimpeded access by humanitarian aid groups to all conflict affected areas, including rebel-held Southern Kordofan and Blue Nile. Include access to maternal health care and family planning as a key indicator of access to humanitarian assistance;
- Delay formal evaluation of Sudan regarding the US sanctions to allow sufficient time for real progress to occur. The US should also re-evaluate the sanctions regime with an eye to imposing “smart” sanctions and designate new individuals against whom there is credible evidence, for targeted sanctions.

## Methodology

This report is based on an 11-day fact-finding mission to Sudan and South Sudan in December 2016. Two Human Rights Watch researchers visited villages and displaced communities in Heiban, Delami, Buram and Um Dorein counties in Sudan's SPLM/A-North controlled areas of Southern Kordofan, as well as the Yida refugee camp in Unity state, South Sudan. Through interviews with local communities, humanitarian aid workers, and authorities, as well as site visits, Human Rights Watch assessed the impact of Sudan's humanitarian blockade on the civilian population, and documented other human rights violations committed during the armed conflict, including the impact of the conflict on women's reproductive rights.

Human Rights Watch interviewed more than 90 people in Southern Kordofan and South Sudan, including displaced people, refugees, victims, witnesses, local authorities, and humanitarian and health workers. We interviewed 25 women to understand obstacles to reproductive healthcare and the other human rights challenges confronting women. All but one of the women interviewed had children or had given birth, and most had done so recently. We interviewed 25 humanitarian aid workers and civil society members, including ten doctors and other health workers. Human Rights Watch also spoke to five people of authority in SPLM/A-N. Interviews were conducted mainly in English or in Arabic (and in one case in the local Turo Nuba language), through translators. Human Rights Watch researchers conducted most interviews individually, but sometimes, because of the preference of the interviewee or with their permission, in groups. Interviews took place in towns, villages, settlements, and in the Yida refugee camp.

We informed all interviewees of the purpose of the interview, its voluntary nature, and the ways in which data would be collected and used. We have withheld the names and other identifying information of some of those interviewed, and in some cases replaced them with pseudonyms due to their preference for anonymity. Interviewees were also told that they could end the interview at any time, and choose to answer only the questions they wanted to.

Human Rights Watch was unable to access many SPLM/A-North controlled areas that are harder-to-reach or lie across frontlines. Access to healthcare is, by all accounts, far worse in these other areas.

While civilians living in Southern Kordofan, especially in the rebel-held areas, face a myriad of human rights abuses, this report focuses on sexual and reproductive healthcare in the hope that highlighting this will draw attention of the Sudanese government and the international community to this particularly neglected aspect of the humanitarian needs in the area.

Human Rights Watch was unable to verify allegations of human rights and international humanitarian law violations by the SPLM/A-North in areas controlled by the Sudanese government, due to lack of access.

# I. Background

## The Protracted Conflict in Southern Kordofan

Civilians in rebel-held Southern Kordofan, estimated to be one million people, have spent most of their lives in conflict.<sup>1</sup> Much of Southern Kordofan is the “Nuba Mountains,” areas characterized by rocky hills where dozens of Nuba tribes live. In 1985, Nuba fighters began supporting the mostly southern Sudanese rebel movement, the Sudan People’s Liberation Movement/Army (SPLM/A), in its long war against the government of Sudan. The conflict was characterized by ethnic cleansing of the Nuba; abusive ground attacks; forced relocation from ancestral lands; widespread arrests, detentions and killings of Nuba individuals; and aerial bombardment.<sup>2</sup> A 2002 ceasefire, followed by the 2005 Comprehensive Peace Agreement between the SPLM and the government of Sudan, brought civilians a temporary respite.<sup>3</sup>

On June 5, 2011, Sudanese government forces and Nuba SPLA forces clashed again in Southern Kordofan’s capital, Kadugli.<sup>4</sup> The fighting followed escalating tensions over security arrangements in the state and the narrow re-election of the governor, Ahmed

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<sup>1</sup> Official population numbers are not available and the conflict has led to mass displacement since a 2010 census took place. Humanitarians working for INGOs in the area estimate that there are 998,780 people living in rebel-held areas. Only roughly 650,000 of them are accessible to aid workers.

<sup>2</sup> Human Rights Watch, Sudan: Eradicating the Nuba, Africa Watch Calls for the United Nations to Investigate Killings, Destruction of Villages and Forced Removals, vol.4, issue 10, September 1992. In this report, Human Rights Watch argued that a systematic campaign by the Sudanese government to remove the Nuba ethnicity from the Kordofan area was in place, and that forced movement of Nuba civilians from their home areas to government-controlled camps, killings and detentions as well as other abuses together amounted to ethnic cleansing. See also Human Rights Watch, Human Rights in Africa and US Policy, July 1994. Human Rights Watch, In the Name of God: Repression Continues in Northern Sudan, vol. 6, no. 9, November 1994.

<sup>3</sup> The Nuba Mountains Ceasefire Agreement (2002), available at <http://www.sudantribune.com/spip.php?article41880> (accessed February 8, 2017). Southern Kordofan, distinguished by its numerous rocky hills, is one of Sudan’s 18 states and had seen on-off conflict for decades. The SPLA-North currently hold four areas in Southern Kordofan and in next door Western Kordofan, all traditional home areas of Nuba tribes, the “Nuba mountains.” The main town of the rebel-held area is Kauda, which lies in the largest rebel-held area, that includes much of Heiban, Um Dorein and Buram counties. Other rebel held areas lie to the north east and north west of this area and a fourth to the south east, bordering South Sudan. The area is poorly developed, even by Sudanese standards.

<sup>4</sup> Human Rights Watch, Under Siege: Indiscriminate Bombing in Sudan’s Southern Kordofan and Blue Nile States, December 2012, <https://www.hrw.org/report/2012/12/11/under-siege/indiscriminate-bombing-and-abuses-sudans-southern-kordofan-and-blue>. For more on the causes of the conflict, see International Crisis Group, “Sudan’s Spreading Conflict (I): War in South Kordofan,” <https://www.crisisgroup.org/africa/horn-africa/sudan/sudan-s-spreading-conflict-i-war-south-kordofan> (accessed February 8, 2017).

Haroun, wanted by the International Criminal Court (ICC) for serious crimes in Darfur.<sup>5</sup> The Sudanese government resumed aerial bombardment on populated rebel-held areas within days.

South Sudan officially seceded from Sudan in July 2011. The South's independence did not address the desire for meaningful political change in the Nuba Mountains and neighboring Blue Nile state. The SPLA forces based there renamed themselves SPLM/A-North.<sup>6</sup> Fighting between the SPLM/A-North and Sudanese government forces spread to Blue Nile state in September 2011. During the first year of the renewed conflict, scores of SPLM/A-North members and perceived sympathizers were arrested and detained.<sup>7</sup>

The “new” war, now almost six years old, has had a devastating impact on civilians. Those living in rebel-held areas have been subjected to heavy bombing from planes and jets, and shelling, including on populated areas by the Sudanese government. These attacks killed at least 292 civilians and injured 749 between June 2011 and November 2016 in Southern Kordofan and Blue Nile states.<sup>8</sup> Civilians repeatedly described to Human Rights Watch researchers the intense terror and distress they experienced as a result of the bombardment. In December 2016, Diana Angelo, an aunt to six children killed in a bombing incident on May 1, 2016, described what she witnessed that day after the children, on hearing the sound of the planes, jumped into one of the large foxholes or ditches dotted all over villages and towns for people to crouch in during bombings:

One of the bombs fell straight into the foxhole and threw the boys outside and cut them to pieces. We found one of their heads past the

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<sup>5</sup> International Criminal Court, Warrant of Arrest for Ahmad Harun, May 1, 2007, <https://www.icc-cpi.int/pages/record.aspx?uri=279813> (accessed February 8, 2017).

<sup>6</sup> Comprehensive Peace Agreement between Government of Sudan and the SPLM/SPLA, available at <http://peacemaker.un.org/node/1369> (accessed February 8, 2017). The Comprehensive Peace Agreement between the SPLA/M and the government of Sudan included a protocol on the resolution of the Southern Kordofan/Nuba and Blue Nile conflicts, signed in 2004. The protocol promised elections, a popular consultation process and mechanisms to deal with wealth sharing, governance and land tenure problems. Both parties failed to fulfil security commitments and the consultative process was indefinitely postponed in 2011.

<sup>7</sup> Human Rights Watch, Under Siege. See also, United Nations Office of the High Commissioner for Human Rights, “Thirteenth periodic report of the United Nations High Commissioner for Human Rights on the situation of human rights in the Sudan, Preliminary report on violations of international human rights and humanitarian law in Southern Kordofan from 5 to 30 June 2011,” August 2011, [http://www.ohchr.org/Documents/Countries/13thSouth\\_Kordofan\\_report.doc](http://www.ohchr.org/Documents/Countries/13thSouth_Kordofan_report.doc) (accessed February 8, 2017).

<sup>8</sup> Compiled from Sudan Consortium reports. See for example, [http://sudanconsortium.org/darfur\\_consortium\\_actions/reports.html](http://sudanconsortium.org/darfur_consortium_actions/reports.html) (accessed February 8, 2017).

fence, and the others were burned beyond recognition. There were pieces of brain, lungs and intestine everywhere. When I got there, the wife of Abdurahman (the mother of the children) kept on shouting: ‘Where are the children? Where are the children?’ She was injured too by the debris and had to be taken to the hospital. Abdurahman wanted to kill himself after the attack.<sup>9</sup>

Nearly 250,000 people have fled both states to refugee camps in South Sudan between June 2011 and November 2016, including about 100,000 from Nuba.<sup>10</sup> While some information about deaths, injuries and displacement is available, there is little detailed information about the effects on education, health, and livelihoods for those who have remained.

The African Union High-level Implementation Panel (AUHIP), a body created to deal with African Union (AU) recommendations on Darfur, as well as implementation of the 2005 Comprehensive Peace Agreement as the South’s secession approached, initiated negotiations between the government of Sudan and the SPLM/A-North a few weeks after the start of the conflict. The AUHIP drafted a framework agreement for political partnership and security arrangements, signed by both sides in August 2011, but later rejected by President Omar Hassan al Bashir. In November 2011, the SPLM/A-North joined two other Sudanese rebel groups and agreed to a unified political and military approach to regime change under the Sudan Revolutionary Front umbrella. This complicated the peace negotiations considerably, as did poor relations between Sudan and South Sudan, especially during and immediately following a short 2012 border war at the Heglig oil fields, and the civil war in South Sudan that began in December 2013.<sup>11</sup>

Fifteen sets of talks between the government and the SPLM/A-North in Addis Ababa, Ethiopia, have failed to produce a permanent, joint cessation of hostilities (both sides have issued temporary unilateral ceasefires), unfettered access for humanitarian agencies,

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<sup>9</sup> Human Rights Watch interview with Diana Angelo, Heiban town, Heiban county, December 12, 2016.

<sup>10</sup> Rocco Nurri, “Five Years Into Conflict, Refugees Still Flee into South Sudan,” United Nations High Commissioner for Refugees news story, <http://www.unhcr.org/news/latest/2016/6/575176254/five-years-southern-sudan-conflict-refugees-still-flee.html> (accessed February 8, 2017).

<sup>11</sup> Human Rights Watch, “Sudan: Repression Intensifies After Border Violence,” media release, May 17, 2012, <https://www.hrw.org/news/2012/05/17/sudan-repression-intensifies-after-border-violence>.

or a hint of lasting peace.<sup>12</sup> UN Security Council resolution 2046 of May 2012, following the border violence, stated that both parties in Southern Kordofan and Blue Nile should allow unhindered humanitarian access or face punitive measures; but both sides have ignored the resolution and the Security Council has not taken any further action.<sup>13</sup> Diplomats from the US, the European Union, Germany, the United Kingdom, and Norway, as well as AU officials, have supported the peace process and urged both sides to end fighting and allow for unhindered delivery of humanitarian assistance.

The government signed the AUHIP's 'roadmap for peace' on March 16, 2016, promising to urgently resume negotiation on humanitarian access, and a cessation of hostilities, followed by a permanent ceasefire; however, the SPLM/A-North refused to sign until August.<sup>14</sup> Within days of their unilateral signing of the roadmap, the government launched several large-scale land offensives, preceded by aerial bombing and shelling, to capture important SPLM/A-North controlled agricultural areas, Al-Mardes in Delami county, Al-Azraq in Heiban county and Karkaraya in Um Dorein.<sup>15</sup> Two of those areas were successfully captured by government forces, but Karkaraya was later reclaimed by the rebels. When these areas were under their effective control, government forces and allied militias killed civilians and destroyed civilian property.<sup>16</sup> The attacks continued in April and May 2016 and displaced some 50,000 people from fertile areas according to one estimate by a

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<sup>12</sup> Mohammed Amin, "Sudanese Peace Talks Suspended for the 10th Time," *Africa Review*, November 24, 2016. <http://www.africareview.com/news/Sudanese-peace-talks-suspended/979180-2970262-14j5knfz/index.html> (accessed February 8, 2017)

<sup>13</sup> United Nations Security Council Resolution 2046 (2012), S/RES/2046 (2012), <http://unscr.com/en/resolutions/2046> (accessed February 8, 2017). The resolution mostly concerned relations between Sudan and South Sudan but also called for peace negotiations between Sudan and the SPLM/A-North and "to permit humanitarian access to the affected population in the two areas, ensuring in accordance with applicable international law, including applicable international humanitarian law, and guiding principles of emergency humanitarian assistance, the safe, unhindered and immediate access of United Nations and other humanitarian personnel, as well as the delivery of supplies and equipment, in order to allow such personnel to efficiently perform their task of assisting the conflict-affected civilian population."

<sup>14</sup> African Union Higher Implementation Panel, Roadmap, March 21, 2016, <http://www.peaceau.org/uploads/auhip-roadmap-signed-080816.pdf> (accessed February 15, 2017). The roadmap, which was also eventually signed by Darfur rebel groups, restates the parties' intentions to end the conflicts in Southern Kordofan, Blue Nile and Darfur, and sign a cessation of hostility agreement leading to a permanent cessation. The parties agreed to negotiate immediate access for humanitarians at the same time as the cessation of hostilities.

<sup>15</sup> Human Rights Watch interviews with witnesses, displaced people, SPLM/A-North army and administrative officials, December 2016.

<sup>16</sup> For example, government forces stayed in Karkaraya village, Um Dorein county, for seven days after an attack in March 2016 and killed elderly residents who were unable to flee, broke into the town's small clinic then looted and partly destroyed the premises. The forces also destroyed Karkaraya's secondary school by driving over it with tanks, and looting the town's primary school. In nearby Um Serdiba, the primary school was reportedly destroyed by government forces around the same time. Human Rights Watch interviews with civilians, including witnesses and victims, and local authorities in Heiban, Um Dorein, Buram and Delami counties, December 7-14, 2016.



humanitarian agency. President al-Bashir announced an initial four-month unilateral ceasefire in June 2016, which he subsequently extended until the end of June 2017.

There have been very few reports of aerial bombardment since the June 2016 ceasefire and, in comparison to earlier years, the dry season has arrived without government attacks. However, Human Rights Watch has received reports of some indiscriminate shelling on civilian areas by Sudanese armed forces.<sup>17</sup>

## US Sanctions Relief in 2017

In January 2017, then-US President Barack Obama issued an executive order lifting longstanding US sanctions on Sudan.<sup>18</sup> According to a statement released by the US Treasury, the decision was “the result of sustained progress by the Government of Sudan on several fronts, including a marked reduction in offensive military activity, a pledge to maintain a cessation of hostilities in conflict areas in Sudan, steps toward improving humanitarian access throughout Sudan, and cooperation with the United States on counterterrorism and addressing regional conflicts.”<sup>19</sup>

Within six months or by July 2017, the Secretary of State, in consultation with the US Agency for International Development (USAID) and government intelligence community members, will issue a report with recommendations to current US president Donald Trump on whether the sanctions revocation should become permanent. The order did not identify clear benchmarks for progress or explicitly require improvements to the human rights situation — a remarkable oversight considering Sudan’s long, violent and extensively documented record of abuses against civilians.

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<sup>17</sup> Human Rights Watch interviews, December 2016. For example, in July, SAF-aligned militias attacked the Lima village, west of Kadugli town, on two occasions. In late November, at least two bombs were dropped by Sudanese air force planes near civilian houses in Hajar Bako, and shelling took place in the Ard’Kanan and Nyakima villages, reportedly in retaliation for a SPLA-North attack on government positions in Al-Azraq. During HRW’s visit in December, Antonov aircrafts could be heard circling above Heiban and Delami counties and ongoing shelling was reported in Um Dorein county.

<sup>18</sup> The United States first imposed “comprehensive economic, trade and financial sanctions against Sudan due to its support for international terrorism, ongoing efforts to destabilize neighboring governments, and the prevalence of human rights violations.” Further sanctions against individuals who were allegedly complicit in violence in Darfur and on government owned or managed companies were then imposed in 2007. See: US Department of State, US Relations with Sudan, <https://www.state.gov/r/pa/ei/bgn/5424.htm> (accessed February 8, 2017).

<sup>19</sup> “Treasury to Issue General License to Authorize Transactions With Sudan,” US Treasury Department Office of Public Affairs news release, [https://www.treasury.gov/resource-center/sanctions/Programs/Documents/sudan\\_fact\\_sheet.pdf](https://www.treasury.gov/resource-center/sanctions/Programs/Documents/sudan_fact_sheet.pdf) (accessed February 8, 2017).

Some progress on the ground, described later in this report, in terms of humanitarian access, has been made since the US and the Sudanese government began new negotiations over the US sanctions in 2016. Sudan's Humanitarian Aid Commission (HAC) issued new regulations on December 15, 2015, which promised that humanitarian work would be facilitated and expedited.<sup>20</sup> However, it is not yet clear how far this access will extend or for how long. At the time of writing, there has not yet been any new access to rebel-held Southern Kordofan or Blue Nile, although Sudanese officials have told at least one senior UN official that she may travel to Kauda, the main town in the rebel-held areas.<sup>21</sup>

Human Rights Watch has urged the US to adopt a set of human rights benchmarks to guide its assessment of Sudan, and to delay the final assessment to provide meaningful opportunity to determine if there has been real, lasting progress.<sup>22</sup> Six months is not sufficient time for meaningful progress in the areas mentioned in the executive order, or for improvements in the human rights situation. The benchmarks to measure Sudan's progress should include an end to indiscriminate bombing and shelling, tangible improvements in humanitarian access, release of arbitrarily-held prisoners by the National Intelligence and Security Services, an end to use of lethal force to suppress protests and various law reforms. Regardless of decisions on broad economic sanctions, US relations should not be normalized without significant progress on human rights.

US government officials should also carefully review the sanctions policy, with an eye on more effective measures over the long term, continuing to enforce existing individual targeted sanctions against those deemed responsible for serious abuses and consider additional designations, particularly in light of the overwhelming evidence of abuses by the Rapid Support Forces and National Intelligence and Security Service.<sup>23</sup>

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<sup>20</sup> Amended Directives and Procedures, Humanitarian Aid Commission, December 15, 2016, On file with Human Rights Watch.

<sup>21</sup> Human Rights Watch interview with senior UN official based in Khartoum, name withheld, February 27, 2017. The visit, connected with UN efforts to prevent the use of child soldiers in conflicts, had still not taken place by mid-May 2015, apparently because negotiations with the SPLM/A-North were still ongoing.

<sup>22</sup> Human Rights Watch, *Human Rights Benchmarks for Sudan: Eight Ways to Measure Progress*, April 2017, <https://www.hrw.org/news/2017/05/03/human-rights-benchmarks-sudan>

<sup>23</sup> Human Rights Watch, 'Sudan's Human Rights Record and US Sanctions, Testimony of Jehanne Henry at the Tom Lantos Human Rights Commission', April 4, 2017, <https://www.hrw.org/news/2017/04/04/sudans-human-rights-record-and-us-sanctions>.

## Obstruction of Humanitarian Aid

The food situation here is terrible, sometimes we have nothing to eat; if there is, we eat once a day, even the children.

— Khaltouma Bashir, a 20-year-old woman currently nursing a breastfeeding baby, December 2016.<sup>24</sup>

In protracted conflicts all over the region, civilians depend on humanitarian assistance to ensure they can secure sufficient food and access health care, and rely on assistance to provide basic schooling.

All the women interviewed for this report, as well as NGO workers, other humanitarians and authorities in the rebel-held areas were especially concerned about current food shortages, a result of poor rains, conflict in high food-production areas, increasing restrictions on traders from government-held areas and South Sudan's massive currency inflation, which has led to much-increased prices for basic commodities in markets in South Sudan. There is general agreement that food shortages by mid-2017 may be as bad as those in late 2011 and 2012, when people reportedly died of hunger.<sup>25</sup> A report issued in early 2017 has warned that crop production in 2017 may be even lower than in 2016, when poor rains led to small harvests.<sup>26</sup>

Independent monitors projected 2017's harvest to only provide enough food in some areas to last through March in South Kordofan and through May in Blue Nile.<sup>27</sup> The USAID-funded Famine Early Warning Systems Network has predicted that areas currently in "crisis" status, including rebel-held Southern Kordofan, will deteriorate to "emergency," one level above famine, between June and September 2017.<sup>28</sup> Hard-to-reach areas that are controlled by the SPLM/A-North may be particularly impacted. A news release issued by

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<sup>24</sup> Human Rights Watch interview with H.S., Lula village, Heiban County, December 9, 2016.

<sup>25</sup> Human Rights Watch, *Under Siege*.

<sup>26</sup> Southern Kordofan, Blue Nile Coordination Unit, Flash Update #14 – February 11, 2017, "Deteriorating Food Security Outlook Following Poor Harvest Assessment." On file with Human Rights Watch. "Sixteen percent of the population of Blue Nile and 6% of the population of the central region of South Kordofan were identified as severely food insecure during the traditional early harvest season."

<sup>27</sup> Ibid.

<sup>28</sup> Famine Early Warning Systems Network, "Emergency (IPC phase 4) likely in parts of Southern Kordofan, Jebel Mara," February 2017, <http://www.fews.net/east-africa/sudan/food-security-outlook/february-2017> (accessed April 26, 2017).

the humanitarian wing of the rebel movement in March 2017 said that people in the Kau-Nyaru area only have roots and leaves to eat.<sup>29</sup>

Some interviewees said that they were already running low on food and unable to afford the little food available in markets. “We had planted and harvested but when we fled attacks [including bombing], we did not bring any of it with us. We used to produce surplus but now we have almost nothing,” Nur Amin, 40 years old and displaced from the high-production area of Mardais, said.<sup>30</sup>

Volunteer teachers have kept schools open but most have few or no supplies.<sup>31</sup> Civilians have continued to flee bombardment and move to escape hunger. For example, in the first half of 2016, 7,500 people left Southern Kordofan for overcrowded refugee camps in South Sudan.<sup>32</sup> Within the area, tens of thousands of people are living in displacement.

The government repeatedly denied access to rebel-held areas to United Nations and international non-governmental organizations (INGOs) requesting permission to assess needs and provide aid from within Sudan (“cross line,” i.e. across front lines, assistance), despite multiple requests by the UN, especially in the first six months of the conflict. In August 2011, after two months of UN requests for better access, President al-Bashir said that no international agencies would be allowed to work in rebel-held areas.<sup>33</sup> The government has also insisted, citing sovereignty, that aid agencies cannot enter rebel-held Sudan bordering South Sudan and Ethiopia in the form of “cross-border” aid.

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<sup>29</sup> Sudan Relief and Rehabilitation Agency (SRRA) SPLM/A-North controlled areas, “Food Shortage in Kau and Warne”, March 11, 2017 (on file with Human Rights Watch). The news release also called “upon United Nation and to the people of good heart and all humanitarian agencies to get and intervene to rescue the needy people in Kau and Warne, and indeed to put more pressure on both parties in Sudan to give humanitarian access to the affected people in SPLM-A/N held areas, in Nuba Mountains, Southern Kordofan and Blue Nile states.”

<sup>30</sup> Human Rights Watch interview with S.O.B, (name withheld), Tongoli town, Delami county, December 10, 2016.

<sup>31</sup> “Sudan: Bombing Campaign’s Heavy Impact on Children,” Human Rights Watch news release, May 6, 2015. Government bombing has damaged or destroyed at least 22 schools since the conflict began. Only 400 students were in secondary education in the entire region, because of a lack of secondary schools. Human Rights Watch did not research the impact of the conflict, abusive tactics such as aerial bombardment by the government of Sudan and obstruction of humanitarian aid on education but Nuba civil society, authorities and interviewees repeatedly expressed concern that a generation of children were missing out on education. One humanitarian estimated, using figures from a 2010 census, that some 400,000 children in Southern Kordofan and Blue Nile state are out of education or are unable to access quality education.

<sup>32</sup> Rocco Nurri, “Five Years into southern Sudan conflict, refugees still flee.”

<sup>33</sup> “Sudan: Southern Kordofan Civilians Tell of Air Strike Horror,” Human Rights Watch news release, August 30, 2011, <https://www.hrw.org/news/2011/08/30/sudan-southern-kordofan-civilians-tell-air-strike-horror>; see also “Sudan Announces Truce in Southern Kordofan,” Al Jazeera, August 23, 2011 <http://www.aljazeera.com/news/africa/2011/08/2011823151035653492.html> (accessed February 8, 2017).

These restrictions created a *de facto* blockade of international humanitarian aid to rebel-held areas of both Southern Kordofan and Blue Nile. The government has also made travel to rebel-held areas difficult and stopped flights and cars from traveling to those areas. It bombed two key airstrips in rebel-held towns in the first month of the conflict.<sup>34</sup>

Staff from UN agencies also struggled to get the required permits to travel to government-held areas of the state and only a few UN international staff could work there, and sometimes no international staff from international NGOs were allowed to visit or live there.<sup>35</sup> In May 2016, the government issued a new set of directives putting further onerous restrictions on aid agencies seeking access to government-held areas. These include establishing three layers of permission for travel to government-held areas of Darfur and requiring that humanitarian NGOs “shall commit not to disseminate information, data and statistics relating to humanitarian work reports and surveys without returning to the government Humanitarian Aid Commission (HAC).”<sup>36</sup>

The Sudanese government under President al-Bashir’s National Congress Party has a long history of obstruction and hostility toward independent humanitarian agencies seeking to provide impartial and life-saving humanitarian assistance in Sudan. The government repeatedly used an array of strategies to delay, limit and deny access by humanitarian agencies to civilians in need of assistance during the long civil war from the 1980s to 2005. Flight bans, denials or massive delays in the processing of travel permits, limitations on the numbers of staff and unnecessarily bureaucratic or arbitrary procedures for importing and transporting relief materials have all been common Sudanese government tactics to restrict aid to civilian populations.

These policies contributed to the deaths of hundreds of thousands of people from famine and diseases, and led to international pressure on the Sudanese government to cooperate with Operation Lifeline Sudan (OLS), a cross-border UN-led relief operation that accessed

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<sup>34</sup> Ibid, Human Rights Watch. After fighting subsided in the government-controlled Southern Kordofan state capital Kadugli, the government did not permit international humanitarian groups, including UN agencies, to conduct assessments of displaced people even within the town. International humanitarian workers were forbidden from traveling out of government towns to assess humanitarian needs.

<sup>35</sup> Human Rights Watch telephone and Skype interviews with humanitarians (names withheld), November 2016 to February 2017.

<sup>36</sup> Humanitarian Aid Commission (HAC), “Directives of Humanitarian Action 2016,” May 5, 2016, on file with Human Rights Watch.

much of southern Sudan in the 1990s.<sup>37</sup> The Nuba Mountains was, however, excluded from the OLS operation; even during the OLS years, agencies were only able to operate clandestinely. In the 1990s, a famine there killed thousands of people.<sup>38</sup> In May 2006, Human Rights Watch reported on widespread intimidation, arbitrary obstruction and denials of access by the Sudanese government, including its Humanitarian Aid Commission, during the conflict in Darfur.<sup>39</sup> In March 2009, the government of Sudan expelled 13 international agencies and revoked the permits for three national NGOs working in Darfur.<sup>40</sup> In June 2012, the Sudanese government expelled another four agencies from eastern Sudan.<sup>41</sup> The government expelled four senior UN workers between 2014 and 2016, including the head of the Office for the Coordination of Humanitarian Affairs (OCHA).<sup>42</sup> These examples represent only some of a broader pattern of expulsions. International and national NGOs, including humanitarian providers, have also been shut down.

Although this tense environment was a disincentive for individual aid agencies to seek improved access to rebel-held Southern Kordofan, significant efforts were made by international actors collectively. On February 9, 2012, the United Nations, the African Union, and the Arab League jointly proposed a “Tripartite Agreement” for the provision of international humanitarian assistance to the civilian populations in South Kordofan and Blue Nile. Both sides finally agreed to the deal in August 2012 with their own conditions, but no serious progress on implementing the accord was ever made. UN and US

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<sup>37</sup> Human Rights Watch, *Famine in Sudan, 1998: The Human Rights Causes*, (New York: Human Rights Watch, 1999), and “Darfur: Humanitarian Aid Under Siege” (Human Rights Watch, May 2006) at <https://www.hrw.org/report/2006/05/08/darfur-humanitarian-aid-under-siege>; Mark Duffield, Susanne Jaspers et al, *Operation Lifeline Sudan: A Review* (July 1996). Operation Lifeline Sudan was established following the 1988 famine and was viewed as a groundbreaking model for cross-border humanitarian assistance during ongoing conflict.

<sup>38</sup> Alex de Waal, “Food and Power in Sudan, A Critique of Humanitarianism,” (*Africa Rights*, 1997), p183-193. Civilians who fled hunger and bombardment into other areas of Sudan were forced to live in ‘peace villages’ where they were starved, tortured, indoctrinated and forced to work on large farms. See also, Human Rights Watch, *Human Rights in Africa and US Policy*. ‘Despite the residents’ desperate need for assistance, the Nuba Mountains have been placed off limits to all but those allied with the government’s counterinsurgency scheme.’

<sup>39</sup> Human Rights Watch, *Darfur: Humanitarian Aid Under Siege*.

<sup>40</sup> “Sudan: Expelling Aid Agencies Harms Victims,” Human Rights Watch news release, March 5, 2009, <https://www.hrw.org/news/2009/03/05/sudan-expelling-aid-agencies-harms-victims> The government made the announcement shortly after the ICC issued arrest warrants for President al-Bashir for war crimes and crimes against humanity.

<sup>41</sup> “Khartoum expels Foreign Aid Agencies from Eastern Sudan,” *BBC*, June 1, 2010, <http://www.bbc.com/news/world-africa-18296430> (accessed February 21, 2017). The agencies were allowed to continue to operate in other areas of Sudan.

<sup>42</sup> “Statement attributable to the Humanitarian Country Team in Sudan on the de facto expulsion of UN senior official and OCHA Head of Office Mr. Ivo Freijse,” United Nations Office for the Coordination of Humanitarian Affairs news release, May 22, 2016, [https://docs.unocha.org/sites/dms/Sudan/Press\\_Releases/2016/Sudan\\_HCT\\_Statement\\_on\\_the\\_de\\_facto\\_expulsion\\_of\\_UN\\_senior\\_official\\_and\\_OCHA\\_Head\\_of\\_Office\\_Mr.\\_Ivo\\_Freijse\\_22\\_May\\_2016\\_EN.pdf](https://docs.unocha.org/sites/dms/Sudan/Press_Releases/2016/Sudan_HCT_Statement_on_the_de_facto_expulsion_of_UN_senior_official_and_OCHA_Head_of_Office_Mr._Ivo_Freijse_22_May_2016_EN.pdf) (accessed February 21, 2017).

government officials blamed the Sudanese government for this failure.<sup>43</sup> In November 2012, the agreement expired without facilitating any assistance. In the same month, a senior Sudan government official stated: “there is no humanitarian crisis in war-torn South Kordofan and Blue Nile.”<sup>44</sup>

In 2013, OCHA, the UN Fund for Children (UNICEF) and the World Health Organization initiated a new effort to vaccinate children in the rebel-held areas.<sup>45</sup> The agencies estimate that some 162,000 children under five years of age live in the rebel-held areas of Southern Kordofan and Blue Nile and have not had access to routine vaccinations since the conflict began in 2011. The UN Security Council backed the plan.<sup>46</sup> The parties initially agreed in theory to a two-week cessation of hostilities in November 2013, but ultimately failed to agree on modalities for the transport of vaccines. “I think it is fair to say both sides have made a lot of effort, but neither side took the last mile in order for it all to happen”, a senior UN official told Human Rights Watch in 2014.<sup>47</sup> Negotiations have continued, but no further progress has been made.

Sudan has offered some humanitarian aid to the rebel-held areas of Southern Kordofan, but, at least in the first years of negotiations, only via government assistance or NGOs closely affiliated to the government, such as the Sudan Red Crescent.<sup>48</sup> The SPLM/A-North

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<sup>43</sup> “Ambassador Rice at U.N. on Sudan, Syria and Russia: Remarks by Ambassador Susan E. Rice, U.S. Permanent Representative to the United Nations, at the Security Council Stakeout on Sudan,” United States at the UN press release, January 17, 2012. <https://geneva.usmission.gov/2012/01/18/ambassador-rice-at-u-n-on-sudan-syria-and-russia/> (accessed February 8, 2017). See also, “UN relief chief voices concern over worsening humanitarian situation in Sudan”, UN news release, <http://www.un.org/apps/news/story.asp?NewsID=42355#.WJuHmDsrKUK> (accessed February 8, 2017). During this press briefing the then-head of OCHA, Valerie Amos, said: “the Government has laid out operational conditions that do not allow for the delivery of assistance by neutral parties in SPLM/A-North-controlled areas.”

<sup>44</sup> “No Crisis in South Kordofan, Sudan Says as Aid Deal Lapses,” *French Press Agency*, November 6, 2012, <http://www.dailynewsegypt.com/2012/11/06/no-crisis-in-south-kordofan-sudan-says-as-aid-deal-lapses/> (accessed February 8, 2017).

<sup>45</sup> The main aim was to provide polio vaccinations, but humanitarians hoped they would get a window of opportunity to also vaccinate against measles. In 2015, more than 4 million children under five years of age were vaccinated against polio in other parts of Sudan. See OCHA, Humanitarian Bulletin Sudan, Issue 47, 16-22 November 2015. [http://reliefweb.int/sites/reliefweb.int/files/resources/OCHA\\_Sudan\\_Weekly\\_Humanitarian\\_Bulletin\\_Issue\\_47\\_\(16\\_-\\_24\\_November\\_2015\).pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/OCHA_Sudan_Weekly_Humanitarian_Bulletin_Issue_47_(16_-_24_November_2015).pdf) (accessed February 8, 2017). Children in Sudan are at risk of the polio virus which remains active in the area in recent years; 196 polio cases were reported in the horn of Africa region in 2013, for example.

<sup>46</sup> “Security Council Press Statement on Polio Vaccination in Sudan,” UN news release, October 11, 2013, <http://www.un.org/press/en/2013/sc11145.doc.htm> (accessed on February 8, 2017).

<sup>47</sup> Human Rights Watch telephone interview with senior UN official (name withheld), December 18, 2014.

<sup>48</sup> Human Rights Watch telephone and in person interviews with UN and NGO workers, January – April 2017, all names withheld.

has rejected this form of assistance saying it is not impartial.<sup>49</sup> The government indicated some willingness to allow international agencies into the areas in recent years, on the condition of controlling all service delivery.<sup>50</sup> However, none of these negotiating positions were ever tested.

The SPLM/A-North has however encouraged international NGOs and Nuba NGOs to operate in the rebel-held areas. These groups have brought critical medical assistance in from across international borders. Although patchy, these services—operating outside of officially sanctioned channels—represent the only services civilians and injured rebel fighters can access without leaving their homes for a refugee camp or becoming displaced in government-controlled Sudan.

In early to mid-2015, the head of the AUHIP, former South African president Thabo Mbeki, proposed another way to break the deadlock. He suggested that both parties agree that a proportion of aid would enter the rebel-held areas from within Sudan, and a proportion from Ethiopia, cross-border. The SPLM/A-North agreed to as much as 80 percent of humanitarian aid entering the area cross-line, i.e. from within Sudan, and 20 percent from Ethiopia. The SPLM/A-North told Human Rights Watch that they considered this to be a major concession.<sup>51</sup> The Sudan government rejected the deal, and said again that no aid could enter from other countries into rebel-held areas.<sup>52</sup>

In late 2016, in response to this deadlock, the US government offered to provide humanitarian assistance from within Sudan, consisting of only US government aid, delivered by US government-funded international humanitarian groups.<sup>53</sup> However, the SPLM/A-North did not accept this offer, instead asking for further negotiations and again

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<sup>49</sup> Under international humanitarian law, consent for delivery of assistance that is exclusively humanitarian, impartial in character and conducted without any adverse distinction, cannot be arbitrarily withheld. However, consent is not arbitrarily withheld if a party to the conflict can prove that the assistance offered is neither exclusively humanitarian or is partial.

<sup>50</sup> For example, “One step forward, two steps back: understanding Sudan’s collapsed peace talks”, Nuba Reports, August 18, 2016 <https://nubareports.org/one-step-forward-two-steps-back-understanding-sudans-collapsed-peace-talks/> (accessed April 27, 2017).

<sup>51</sup> Human Rights Watch interview with SPLM/A-North head, Yassir Arman, Whatsapp conversation, March 8, 2017.

<sup>52</sup> *Nuba Reports*, “Hopes of Possible Peace Dashed as Latest Negotiations Collapse,” August 15, 2016, <https://nubareports.org/hopes-of-peace-dashed-as-latest-negotiations-collapse/> (accessed February 19, 2017).

<sup>53</sup> For more on the proposed deal, see Steven Koutsis, Charge d’Affaires, U.S. Embassy, Khartoum, “We urge the SPLM-North to allow humanitarian assistance”, editorial, *Sudan Tribune*, March 3, 2017, <http://www.sudantribune.com/spip.php?article61783> (accessed April 27, 2017),



demanding cross border aid.<sup>54</sup> Rebel leaders say cross border aid is important because, firstly, they want to be able to safely transport wounded fighters to medical assistance in neighboring countries. Rebel leaders said, secondly, that Sudan’s history of aid obstruction and human rights violations against Nuba has meant that both the rebel leadership and civilians have lost trust that aid controlled by Khartoum will be safe—one doctor told Human Rights Watch that he believes many Nuba civilians would, for example, refuse vaccinations from Sudan— or reliable, i.e. not subject to further obstruction and interference. Following the US decision to provide sanctions relief, the Sudanese government also said that it would allow UN staff to travel to rebel-held areas and it appears that at the time of this report’s publication that the major impediment to UN access to rebel-held areas is the SPLM/A-North.

Regarding access to government-held areas, Sudan has made nominal progress. Sudan’s HAC issued new regulations on December 15, 2016. These promised that humanitarian work would be facilitated and expedited.<sup>55</sup> However, government-approved travel permits are still necessary for conflict-affected areas and humanitarians must notify government authorities before traveling to any location outside of the capital.

International humanitarians have subsequently been able to assess needs and deliver assistance in parts of Darfur’s Jebel Mara area now controlled by the government. At the time of writing, there has been not yet been any change to actual access to rebel-held Southern Kordofan or Blue Nile.

## Women’s Rights in Rebel-Held Areas of Southern Kordofan

You are told to hush, not to talk.

— Zeinab Mohammed displaced and living in Lula village, Heiban County,  
December 2016.<sup>56</sup>

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<sup>54</sup> Human Rights Watch interview with Yassir Arman. See also “Sudan Envoys fail to convince SPLM/A-North to accept U.S. humanitarian proposition,” *Sudan Tribune*, January 16, 2017. <http://www.sudantribune.com/spip.php?article61419> (accessed February 19, 2017),

<sup>55</sup> Amended Directives and Procedures, Humanitarian Aid Commission, December 15, 2016, on file with Human Rights Watch; “USA welcomes Sudan’s new humanitarian directives,” *Dabanga*, <https://www.dabangasudan.org/en/all-news/article/usa-welcomes-sudan-s-new-humanitarian-directives>

<sup>56</sup> Human Rights Watch interview with S.M. (name withheld), Lula village, Heiban County, December 9, 2016.

Women have no voice. We have no voice here. You could get into politics, maybe, but only if you are educated.

— Afaf Saeed, displaced and living in Lula village, Heiban County, December 2016.<sup>57</sup>

As described below, women and girls in rebel-held Southern Kordofan face discrimination and violence, and have limited avenues for redress. All the women interviewed for this report felt that women's rights were either at a standstill, or were going backward. Often women said they felt undervalued, including in their lack of voice or influence in their family lives, communities or in the SPLM/A-North administration. Women face multiple barriers to full participation in public life, including in the peace processes.

The people we interviewed said that in rebel-held Southern Kordofan child marriage is common and families often value educating their sons over their daughters. In some areas, many families still practice female genital mutilation (FGM). Women experiencing domestic violence lack legal protections, including against rape in marriage.

A 2016 NGO report on women's rights and gender in the rebel-held areas of Southern Kordofan concluded that "the SPLM/A-N remains a traditional male-dominated and militarized movement with no clear agenda for delivering on their rhetorical commitments to gender equality and the empowerment of women and girls ... (they are) to a large extent gender-blind and with strong patriarchal tendencies."<sup>58</sup>

### *Political Participation*

There are three women represented at the intermittent peace talks.<sup>59</sup> Only one of the women interviewed in the rebel-held areas had information about what was happening with the peace process, and all said they felt there was no way for women's voices to influence the talks.

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<sup>57</sup> Human Rights Watch interview with N.S., Lula village, Heiban County, December 9, 2016.

<sup>58</sup> The Sudan Consortium, African and International Civil Society Action for Sudan "Gender Under Bombardment: Gender Disparities in SPLA/M-N Controlled Areas of Nuba Mountains, Southern Kordofan," 2016, p17, [http://sudanconsortium.org/darfur\\_consortium\\_actions/reports/2016/GenderUnderBombardmentPR.pdf](http://sudanconsortium.org/darfur_consortium_actions/reports/2016/GenderUnderBombardmentPR.pdf) (accessed April 27, 2017). The authors of the report also found that despite women taking on additional work in the home and as farmers because many men were on the frontline, added responsibilities have not led to any social recognition or additional power in decision-making at home or in the public sphere.

<sup>59</sup> Human Rights Watch interview with Yassir Arman. See also, UN Security Council, Resolution 1325 (2000), S/RES/1325 (2000) <http://www.un.org/womenwatch/osagi/wps/> (accessed February 8, 2017). The resolution called for all parties to conflicts to ensure "women's meaningful inclusion at all levels in further peace negotiations and state-building initiatives."

Nuba women fight in the rebel army and occupy some positions in local government, including leading two of the secretariats in the civilian administration; however, none of the seven commissioners or top leadership are women, and the SPLM/A-North's 25 percent quota for administrative positions for women has not been met. Some women said they felt many men now consider 25 percent as a ceiling rather than a floor for female participation. "We are so far behind, there are no women's rights here. Women have no respect, the [SPLM/A-North] promises are all just talk," a Nuba female social worker working with an NGO said.<sup>60</sup>

There have not been any elections in the area since the war began and there are unlikely to be any soon. The SPLM/A-North women's association is large and widespread but there are no independent women's rights organizations or networks.<sup>61</sup>

### *Early Marriage*

In the rebel-held areas families often marry off their daughters early, especially if the family cannot afford to send some or all of their children to school. Some interviewees said that sometimes, especially when they were displaced from villages, there was no nearby school available. "Early marriage is common. No one is trying to stop it. About 14 or 15 is normal, much worse since the war because there's no money," Hanasi Mohsin, who works for the social development secretariat in Heiban town, said.<sup>62</sup> Of the 25 women interviewed, 14 of them had married before they were 18 years of age, most guessed or said they were around 15 years of age, and two of them were married as soon as they had started menstruating. All over the world, child marriage often leads to early childbearing with attendant health risks and disrupts or ends a girl's formal schooling.<sup>63</sup> Sudan's law allows marriage at 14 years for both boys and girls.

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<sup>60</sup> Human Rights Watch interview with NGO worker (name withheld), Kauda, Heiban county, December 13, 2016.

<sup>61</sup> This association has worked on domestic violence, advocated against child marriage, and supported women farmers. See also "Gender Under Bombardment," p38-9.

<sup>62</sup> Human Rights Watch interview with Hanasi Mohsin, Social Development secretariat, Heiban town, Heiban county, December 12, 2016.

<sup>63</sup> Girls not Brides, "An information sheet: child marriage around the world," November 2016, <http://www.girlsnotbrides.org/wp-content/uploads/2017/01/Child-marriage-around-the-world-Nov-2016.pdf> (last accessed March 30, 2017).

### *Access to Education*

Interviewees said that when resources are limited, they prioritize education of boys over girls. “I’ve had 11 children, five girls are surviving and three are married, they are 15, 16 and 17 years old. They were not able to go to school because we have no money. The boys are going to school,” 41-year-old Aisha Hussein said.<sup>64</sup> “Boys are treated better, because when he grows up he will provide for the family through a job while the girl will marry into another family,” Afaf Saeed, a mother of two children, said.<sup>65</sup> Khaltouma Bashir, who was uncertain of her age but looked around 15 or 16 years of age, married a soldier in part because there was no money for her to go to school. “My brothers did go, but there was not enough for me. I was just idle so decided to go for marriage,” she said.<sup>66</sup>

Several of the women interviewed identified education as the most important path for women to get authority and influence. “Education is the one thing that has to change for us to get our rights,” Amal Tutu, mother of five children, said.<sup>67</sup> A 30-year-old NGO worker, well-known in the Nuba humanitarian community, and newly-married, said, “I wanted to be able to finish my schooling and then get a job which is why I didn’t get married. No other way.”

### *Female Genital Mutilation*

The civilian administration has done some work to end female genital mutilation (FGM), which is common in some areas closer to government-controlled parts of Southern Kordofan.

All women and girls interviewed in Hadara village, Delami county, said that they, their sisters, and all the women and girls they knew, had clitorodectomies as young children.<sup>68</sup> (FGM was not reported in any of the other sites of research.) Sudan has a startlingly high national prevalence of FGM, just under 87 percent according to joint UN and government research.<sup>69</sup> Restrictions on access to aid have meant that women and girls in the rebel-held

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<sup>64</sup> Human Rights Watch interview B.B. (name withheld), Tongoli village, Delami county, December 10, 2016.

<sup>65</sup> Human Rights Watch interview N.S. (name withheld), Lula village, Heiban county, December 9, 2016.

<sup>66</sup> Human Rights Watch interview H.S. (name withheld), Lula village, Heiban county, December 9, 2016.

<sup>67</sup> Human Rights Watch interview S.A. (name withheld), Heiban town, Heiban county, December 12, 2016.

<sup>68</sup> Individuals interviewed in other locations did not talk about female genital mutilation, and when asked said that they did not know of any recent cases of FGM in their communities.

<sup>69</sup> Sudan Central Bureau of Statistics/Ministry of Health, “Sudan: Multiple Indicator Cluster Survey 2014, Key Findings,” April 2015, <http://reliefweb.int/report/sudan/sudan-multiple-indicator-cluster-survey-2014-key-findings> (accessed February 15, 2017). According to the UN Fund for Population (UNFPA), most women and girls undergo FGM before their twelfth birthday.

area have been unable to benefit from efforts by the government and the UN Population Fund (UNFPA) and partners to end the practice.

### *Domestic Violence*

The SPLM/A-North Secretariat of Social Development and Women's Rights, together with the women's association, has worked to tackle domestic violence in at least Heiban and Delami counties, including through holding meetings with the community and asking senior people from the civilian administration to address the issue in public.<sup>70</sup> "There was a gathering and we were all warned by the chief," Rabha Yabus, a 30-year-old from the area, said, "I was beaten but now my husband has stopped."<sup>71</sup>

However, domestic violence cases are still reported to local organization staff and civil servants. One woman who worked for the local civilian administration said that she had to find transport to hospital up to six times a month for women who had been seriously beaten by their husbands.<sup>72</sup> "Recently a woman was cut badly on her skull, another one the skull was dented," she said. Six of the 25 interviewees, from different counties, said that their husbands beat them. One of them, Amal Tutu, said:

Women's rights are going backwards. Even when you want to express yourself you are not listened to. Even when you're very tired your husband can make you get up and do your work. I have been beaten when I resist many times.<sup>73</sup>

Five others said that their neighbors, relatives or women they knew well were also beaten.

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Infibulation, the most severe form of FGM, was banned in 1946 through a change in the penal code. Other forms of FGM are not addressed in Sudan's laws.

<sup>70</sup> Human Rights Watch interview with Ali Nour, acting head, Social Development and Women's Rights Secretariat, Kauda, December 8, 2016

<sup>71</sup> Human Rights Watch interview with G.I. (name withheld), Hadara village, Delami county, December 11, 2016.

<sup>72</sup> Human Rights Watch interview with Hanasi Mohsin.

<sup>73</sup> Human Rights Watch interview with S.A. (name withheld), Heiban town, Heiban county, December 12, 2016.

### *Lack of Legal Protections*

The SPLM/A-North areas use the “New Sudan” laws and penal code, which punishes rape with up to 14 years of imprisonment and a fine. There are no other provisions in force that specifically protect women against gender-based violence.<sup>74</sup>

The justice system in rebel-held areas is mostly staffed by volunteers with little or no training. There are about 1,500 volunteer police working in the rebel-held Nuba mountains—only a small proportion of whom are women—and they have had no specific training or protocols on handling or investigating gender-based violence.<sup>75</sup> The rebel-held region has 21 volunteer judges who have not had any recent training, but no prosecutors or lawyers.<sup>76</sup> The head of the judiciary, Kodi Abd Rahman Harik, said that as far as he was aware, there had been no trials of perpetrators of domestic violence since 2011 and only one case of rape.<sup>77</sup>

International doctors working in the area said that they had treated a few rape cases over the years. Women’s rights advocates said they believe rape in marriage is fairly common, and six of the 25 women interviewed said that they had no choice but to have sex when their husbands wanted to. “You can say no if you’re menstruating, otherwise you have to do it,” a 35-year-old woman, Amal Ali, said.<sup>78</sup> “You have to have sex when he wants, if you refuse you might be caned. This has happened to my neighbors. For me, whether you like it or not, you do it,” another woman explained.<sup>79</sup>

Under the “New Sudan” laws, non-consensual sex, or sex against a woman’s will, is not rape if the man is married to the woman.<sup>80</sup> Only one health NGO provides post-rape care that

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<sup>74</sup> Laws of the New Sudan, The Penal Code, 2003, section 317, [https://www.unodc.org/tldb/pdf/Sudan/Penal\\_Code\\_2003.pdf](https://www.unodc.org/tldb/pdf/Sudan/Penal_Code_2003.pdf) (accessed February 15, 2017). The “New Sudan” laws were used during Sudan’s long north-south civil war in areas controlled by the Sudan People’s Liberation Army/Movement (SPLA/M) in defiance of Sudanese Islamic law, before the south Sudanese rebel SPLM/A-North and the government of Sudan signed a peace deal in 2005, which eventually led to South Sudan’s secession. The SPLM/A-North have continued to use these laws in areas they control.

<sup>75</sup> Human Rights Watch interview with Col. Hassan Idris, head of police, Dec 8, 2016

<sup>76</sup> Human Rights Watch interview with Kodi Abd Rahman Harik, head of judiciary, Dec 8, 2016.

<sup>77</sup> In general, women facing domestic violence first turn to other family members and then to community chiefs. Police get involved only when men seriously injure their wives. Some men have been jailed, sometimes for the period the victim is in the hospital.

<sup>78</sup> Human Rights Watch interview with Z.M. (name withheld), Tongoli village, Delami county, December 10, 2016.

<sup>79</sup> Human Rights Watch interview with N.S. (name withheld), Lula village, Heiban county, December 9, 2016.

<sup>80</sup> Laws of the New Sudan, The Penal Code, 2003, section 316, [https://www.unodc.org/tldb/pdf/Sudan/Penal\\_Code\\_2003.pdf](https://www.unodc.org/tldb/pdf/Sudan/Penal_Code_2003.pdf) (accessed February 15, 2017).

includes the provision of emergency contraception if requested as outlined by World Health Organization standards.<sup>81</sup> None of the women interviewed knew that seeking medical attention is important after rape. There is no counselling or long-term psychological support available in rebel-held areas, including for survivors of sexual violence.

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<sup>81</sup> World Health Organization, Guidelines for Medico-Legal care for Victims of Sexual Violence, (Geneva: World Health Organization, 2003), <http://apps.who.int/iris/bitstream/10665/42788/1/924154628X.pdf> (accessed February 15, 2017), p64.

## II. A Weak Health System

Decades of conflict and marginalization by Sudan's government left Southern Kordofan state's health system underdeveloped even before the current war began. Subsequent obstruction of humanitarian aid has meant that there has been no coordinated humanitarian relief effort to ameliorate the negative impact of an abusive conflict on the healthcare services available to the population there. Humanitarian organizations estimate that there are some 900,000 people living in rebel-held areas of Southern Kordofan (and a small area of neighboring Western Kordofan state).<sup>82</sup> Only roughly 650,000 of them are accessible to aid workers.<sup>83</sup> Largely volunteer-run clinics in the rebel-held area often lack supplies, and health workers, including midwives, have little formal training or capacity. Hospitals and clinics, which appear to have been specifically targeted, have also been damaged by aerial bombardment by Sudanese government planes.

### Weak Health Infrastructure in Rebel-Held Southern Kordofan

In many clinics, there's not even Tylenol.

—Hospital Director, Mother of Mercy Hospital, Heiban county, December 2016.<sup>84</sup>

Women, men and children living in rebel-held Nuba mountains have not had access to Sudanese government health services or unhindered humanitarian aid since the conflict began in 2011.

The availability of health care facilities and skilled health care providers in rebel-held South Kordofan falls far short of the need. In 2006, the World Health Organization set the standard for delivery of essential maternal and child health services at a minimum of 23 doctors, nurses and midwives per 10,000 people, while the International Labour Organization (ILO) sets the standard at 34.5 skilled health professionals per 10,000.<sup>85</sup> In 2013, research by WHO

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<sup>82</sup> Population figures in the two areas, estimates from local authorities and service providers in the area, September 2015. On file with Human Rights Watch.

<sup>83</sup> Ibid.

<sup>84</sup> Human Rights Watch interview with a medical doctor (name withheld), Heiban county, December 8, 2016.

<sup>85</sup> World Health Organization, "Universal Truth: No Health Without a Workforce", 2014, p. 17, [http://www.who.int/workforcealliance/knowledge/resources/GHWA-a\\_universal\\_truth\\_report.pdf?ua=1](http://www.who.int/workforcealliance/knowledge/resources/GHWA-a_universal_truth_report.pdf?ua=1) (accessed March 31, 2017).



and the US Agency for International Development said 59.4 skilled health professionals per 10,000 were needed to end preventable maternal deaths.<sup>86</sup> For an estimated population of about a 900,000 people, the rebel-held areas of Southern Kordofan has only five doctors. There is no gynecologist or obstetrician in the rebel-held area.<sup>87</sup>

There are only two working hospitals, the Mother of Mercy Hospital run by the Diocese of El Obeid, also known as “Gidel,” (435 beds) and the smaller Cap Anamur - German Emergency Doctors’ (GED) hospital in Loweri (70 beds).<sup>88</sup> Both hospitals are in Heiban county, which can be a long journey—several hours or even two days—even by car from other parts of the rebel-held areas. Sometimes, because of active frontlines, the hospitals are entirely inaccessible.<sup>89</sup> These hospitals are the only facilities with the staff and equipment for surgery, treatment of serious wounds, and medical testing. Doctors working in these hospitals told Human Rights Watch that they regularly treat civilians or combatants who had reached the hospital only after lengthy journeys.

There are no ambulances in the rebel-held areas and very few civilian cars. As discussed later in this report, this is a major problem for women trying to access healthcare, including in emergencies such as complications during labor.

The SPLM/A-North secretariat of health runs around 175 clinics across the area that provide basic health care. None of the secretariat staff receive a salary. While this network of clinics means that, in theory, most communities are served by one, the clinics are typically staffed by volunteer nurses or community health workers, who often have no or

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<sup>86</sup> Ibid

<sup>87</sup> Human Rights Watch interview with Tutu Mustapha Turkash, head of Health Secretariat, Kauda, Heiban county, December 9, 2016.

<sup>88</sup> Ibid.

<sup>89</sup> The rebel-held areas are not contiguous, there are four ‘islands’ of control. Some areas have even fewer clinics and schools than areas visited by Human Rights Watch and no on-ground international support at all. The deputy governor of the rebel-held area, Sulieman Jabon, said that perhaps as many as 300,000 people live in the ‘Western Jebels’ area, a small area controlled by the SPLM/A-North to the north-west of Kauda, and perhaps 30,000 people live in the Rashad/Abasia/Tagali area and some 35,000 in the Abu Jubeiha area, to the north of Kauda. The Western Jebel area is accessible in the dry season by car but the other two areas are extremely hard to access. Tutu Mustapha Turkash, the rebel civilian administration’s secretariat of health head told Human Rights Watch that medicines are only delivered to some of these two areas once or twice a year and are often carried in on volunteers’ backs, including over front lines. In December 2016, he said that some 50 clinics in the Western Jebels areas have all run out of medicines after the last delivery in June 2016 and that he expects that clinics in Abu Jubeiha area have also run out as no deliveries there have been possible since January 2016.

only basic training.<sup>90</sup> The clinics lack basic equipment like weighing scales or test kits. Rapid tests for malaria are the exception.

Chronic shortages of medicines and difficulties in transporting them mean that basic medicines to treat malaria, worm infections and respiratory diseases are often not available. “In 2015 for a period we ran out of malaria drugs, seven people died, they came to the clinic but we had nothing to give them,” Gadam Ali, who runs the health secretariat in Delami county as a volunteer, said. “We never have any drugs for TB or leprosy.” All the community clinics that Human Rights Watch researchers visited in December 2016 were experiencing shortages of essential medicines or key equipment.<sup>91</sup> “The amoxicillin [an important antibiotic] is finished and we have no more medicines for urinary tract infections, which are very common here,” James Atai, a trained nurse in charge of the Hadara clinic, in Delami county, little more than a room with medicines on a table, said.<sup>92</sup>

The inadequacy of health services extends to key preventive care. Only a few facilities provide vaccinations, and child vaccination coverage is extremely low in part because of a lack of refrigerators.<sup>93</sup> In Hadara village, for example, health workers and local women leaders said almost none of the children have been vaccinated because the village is located far away from clinics with vaccinations. A major outbreak of measles in 2014 and 2015 involved at least two thousand suspected cases, and killed at least 30 children.<sup>94</sup>

The Sudanese government, UNICEF, and WHO conduct mass vaccination campaigns in non-conflict areas of Sudan. No such campaign has been conducted in rebel-held Southern Kordofan since 2010.<sup>95</sup>

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<sup>90</sup> Human Rights Watch interviews with health staff from SPLM/A-North administration and NGOs, December 2016.

<sup>91</sup> For example, a clinic near Lula village only had amoxicillin and some vitamins for children. The main clinic in Heiban town had run out of all drips and injections. Staff there said they often ran out of key medicines such as antibiotics or antimalarial medicines.

<sup>92</sup> Human Rights Watch interview with James Atai, nurse and head of clinic, Hadara town, Delami county, December 11, 2016.

<sup>93</sup> Human Rights Watch interviews with health staff from SPLM/A-North administration and NGOs, December 2016.

<sup>94</sup> These cases were only those collected by the Mother of Mercy Hospital, and in two of the clinics the hospital supports. “Sudan: Bombing Campaign’s Heavy Impact on Children”, Human Rights Watch news release, May 6, 2015.

<sup>95</sup> “Security Council Press Statement on Polio Vaccination in Sudan,” UN news release, October 11, 2013, <http://www.un.org/press/en/2013/sc11145.doc.htm> (accessed on February 8, 2017).

## Attacks Targeting Health Services

Human Rights Watch documented six attacks on hospitals and clinics, including all the major health providers in the SPLM/A-North controlled area, between April and June 2014.<sup>96</sup> The pattern of the attacks on healthcare facilities and the presence of drones over the facilities ahead of the attacks on three occasions, suggests that the hospitals may have been deliberately targeted, which would constitute a war crime. In these strikes, two patients were killed.

These attacks also had an impact on available health services. Soon after attacks on their hospital in Buram county in 2014, the medical NGO Médecins Sans Frontières (MSF) (Doctors Without Borders) pulled out staff, eventually forcing their Buram hospital to close.

Another major clinic, one of the few providing obstetric care, also closed in 2014 following the attacks.

In total, around 20 medical facilities have been damaged or destroyed in bombing raids over towns since 2011, according to the SPLM/A-North health secretariat. Johannes Plate, a health worker at the Loweri hospital, said that airplanes attacked the hospital area in 2014, 2015 and 2016. He said that these incidents scared people away from seeking health services: “There would be an immediate drop in outpatients, from about 200 a day to none, for about a week and then forty to fifty people a day in the following weeks. Even inpatients leave,” he said.<sup>97</sup>

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<sup>96</sup> Ibid. In a series of aerial attacks in April and June 2014 on eight separate locations of health facilities and humanitarian supply storages, the circumstances suggest deliberate targeting.

<sup>97</sup> Human Rights Watch interview with Johannes Plate, health worker Cap Anamur - German Emergency Doctors, Loweri, Heiban county, December 13, 2016.

### III. Lack of Access to Reproductive Healthcare

I had a miscarriage at five months, of twins. They came out and then there was a lot of bleeding, a lot of pain. There was no car, no painkillers. I had to walk to the hospital because the bleeding would not stop.

— Amal Tutu, who lives in a village in Heiban County, said her home is about a day’s walk from the nearest hospital, December 2016.<sup>98</sup>

The conflict has resulted in a further weakening of already sparse women’s healthcare services in the area, with tragic consequences for girls and women.

The women and girls that Human Rights Watch interviewed have few options for controlling their fertility, and many go through multiple pregnancies beginning at a young age, including as a result of child marriage. These factors raise the risk of pregnancy-related complications, as do overall poor health, including poor nutrition and Infibulation, a form of FGM common in Sudan, where the vagina is stitched or otherwise narrowed. This form of FGM can cause obstructed labor and is a main cause of obstetric fistula and maternal mortality in Sudan.

Pregnant women have extremely limited access to skilled health providers, vitamins and essential medicines, quality antenatal care, and emergency obstetric care. These factors increase the risk of being injured or dying from complications due to pregnancy and childbirth.<sup>99</sup>

Using population estimates from humanitarian groups working in the area and WHO estimates for Sudan’s birth rates (not disaggregated by region), we can estimate that perhaps around 33,500 births are taking place every year.<sup>100</sup> Bombing raids have stopped women from accessing care, including making antenatal visits. Four women interviewed by Human Rights Watch also said that they believed they had had miscarriages late in

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<sup>98</sup> Human Rights Watch interview with S.A. (name withheld), Heiban town, Heiban county, December 12, 2016.

<sup>99</sup> World Health Organization, Maternal Mortality factsheet, updated November 2016, <http://www.who.int/mediacentre/factsheets/fs348/en/> (accessed April 26, 2017).

<sup>100</sup> Figure calculated using estimated fertility rates from Sudan, and rough estimates of population of rebel-held areas. World Health Organization, Global Health Observatory data repository, last updated June 17, 2015, <http://apps.who.int/gho/data/node.main.CBDR107?lang=en> (accessed April 3, 2017).

their pregnancies due to the stress and hardships they underwent when they experienced aerial bombardment. However, we were unable to confirm the medical causes of their miscarriages.

Human Rights Watch also found that women and girls had almost no access to contraception to prevent pregnancies and sexually transmitted infections.

## Sexual and Reproductive Health in Protracted Crises

Hunger: this is the thing people worry about most, this and the bombing deaths and injuries they say is the ‘emergency.’ But women are dying in childbirth and there is very little healthcare, the schools are getting worse; six years of bad education is a crisis for this generation. Much more is needed to alleviate serious suffering.

— Nuba humanitarian aid worker.<sup>101</sup>

For situations of both acute and protracted crises such as armed conflicts or natural disasters, when regular health services may be compromised or ineffective and assistance is required to ensure access to health care, humanitarian groups have developed minimum standards of care to seek to ensure an appropriate and quality humanitarian response. The standards for sexual and reproductive healthcare are outlined below.<sup>102</sup>

The Minimum Initial Service Package for Reproductive Health (MISP) is “a priority set of lifesaving activities to be implemented at the onset of every emergency” recognized as a Sphere standard in 2004.<sup>103</sup> MISP provides that a reproductive health officer should be in place to coordinate efforts and help collect information; that reproductive health kits (containing medicines and equipment) should be available and used; that clinical care is available for rape victims; and that visibly pregnant women should be given clean delivery equipment. Referral systems for emergencies for women in labor and for newborns should

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<sup>101</sup> Human Rights Watch interview with Nuba humanitarian aid worker, Juba, South Sudan, December 6, 2016

<sup>102</sup> These are standards for humanitarians to determine the extent and quality of any response, not as assessment of government obligations.

<sup>103</sup> UNFPA, “What is the Minimum Initial Services Plan?” undated, <http://www.unfpa.org/resources/what-minimum-initial-service-package> (accessed February 19, 2017); The SPHERE Charter and Minimum Standards, have global “soft law” status according to the International Federation of the Red Cross, Code of Conduct, 1994, <http://www.ifrc.org/en/publications-and-reports/code-of-conduct/> (accessed February 19, 2017). The Sphere Project, Humanitarian Charter and Minimum Standards in Humanitarian Response, 2017, <http://www.spherehandbook.org/en/what-is-sphere/> (accessed December 19, 2017).

be established and blood transfusions made available. Condoms should also be freely available. (See appendix for more).

While the standards foresee that these minimum services should be implemented within the first weeks of a humanitarian response, six years into Southern Kordofan's conflict, these services do not exist.

The Sphere minimum standards in health action set out five benchmarks to assess whether minimum standards are being met:

1. Whether all health facilities have trained staff, sufficient supplies and equipment for clinical management of rape survivor services based on national or WHO protocols.
2. Whether all pregnant women in their third trimester have received clean delivery kits.
3. Whether there are at least four health facilities per 500,000 people with basic emergency obstetric care and newborn care that women can be referred and transported to.<sup>104</sup>
4. Whether there is at least one health facility with comprehensive emergency obstetric care and newborn care per 500,000 population. Comprehensive emergency obstetric care includes surgery under general anesthesia and safe blood transfusions.
5. Whether the proportion of deliveries by caesarean section is not less than 5 percent or more than 15 percent.

In the rebel-held areas of Southern Kordofan, only one of these indicators is being met, and only partially. The Mother of Mercy (in Gidel) and the GED (in Loweri) hospitals both provide comprehensive emergency care, but neither are easily accessible, or sometimes at all accessible, for most of the population. As shown below in more detail, the other minimum indicators are not being met. There are no delivery kits in the area. Aside from clinics run by either the Diocese of El Obeid or GED, few facilities have basic obstetric medicines or equipment. Authorities and doctors told Human Rights Watch that probably over 99 percent of births take place at home, without skilled or equipped providers. Only

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<sup>104</sup> All primary healthcare facilities should have basic emergency obstetric care – including parenteral antibiotics, parenteral (uterotonic drugs oxytocin), parenteral anticonvulsant drugs (magnesium sulfate), manual removal of retained products of conception, manual removal of placenta, assisted vaginal delivery (vacuum or forceps delivery).

two health providers perform caesarean surgeries in their facilities. Between them, the two facilities perform about 100 caesarean sections a year, about 0.2 percent of our roughly estimated number of births in the rebel-held areas, significantly below the Sphere minimum standard benchmark of 5 percent.<sup>105</sup>

Humanitarian organizations should – and increasingly do – work to provide not only emergency services but also help restore or create working healthcare systems.<sup>106</sup> Sexual and reproductive healthcare should be included in these efforts.<sup>107</sup>

## Maternal Mortality and Morbidity

My aunt died in childbirth, they took her to the hospital and she died on the way with the baby in her womb, it was an hour by car.

— Aisha Hussein, Tongoli village, Delami county, December 2016.<sup>108</sup>

Low women’s status and poor access to health care has a devastating effect on maternal health. This is accentuated in conflicts: maternal mortality in humanitarian crises and in fragile settings is 1.9 times the world average, and represents 61 percent of the total number of maternal deaths worldwide.<sup>109</sup>

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<sup>105</sup> Figure for number of births calculated using estimated fertility rates from Sudan, and rough estimates of population of rebel-held areas, numbers of caesarean sections from Mother of Mercy Hospital and Cap Anamur- German Emergency Doctors. See World Health Organization, Global Health Observatory data repository, last updated June 17, 2015, <http://apps.who.int/gho/data/node.main.CBDR107?lang=en> (accessed April 3, 2017).

<sup>106</sup> The “Granada consensus” emerged after a meeting of the World Health Organization (WHO), the UN Population Fund (UNFPA) and the Andalusian School of Public Health. Four priority areas were developed to improve long-neglected sexual and reproductive healthcare in protracted crisis and recovery. See World Health Organization, “Sexual and Reproductive Health During Protracted Crises and Recovery”, Geneva, 2011, [http://www.who.int/reproductivehealth/publications/emergencies/hac\\_bro\\_2011/en/](http://www.who.int/reproductivehealth/publications/emergencies/hac_bro_2011/en/) (accessed February 19, 2017).

<sup>107</sup> World Health Organization, Sexual and Reproductive Healthcare during Protracted Crises and Recovery, Granada Report, 2011, [http://apps.who.int/iris/bitstream/10665/70762/1/WHO\\_HAC\\_BRO\\_2011.2\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/70762/1/WHO_HAC_BRO_2011.2_eng.pdf) (accessed March 1, 2017).

<sup>108</sup> Human Rights Watch interview with B.B, name withheld, Tongoli village, Delami county, December 10, 2016

<sup>109</sup> United Nations Population Fund (UNFPA), Maternal Mortality in Humanitarian Crises and in Fragile Settings, factsheet, November 12, 2015, [https://www.unfpa.org/sites/default/files/resource-pdf/MMR\\_in\\_humanitarian\\_settings-final4\\_o.pdf](https://www.unfpa.org/sites/default/files/resource-pdf/MMR_in_humanitarian_settings-final4_o.pdf) (accessed February 16, 2017). In conflict or other crisis situations, healthcare infrastructure breaks down and often continues to corrode even after the worst violence is over; communities are forced into displacement away from services, states often are unable (because of access problems or resource shortages), or are unwilling, to provide comprehensive services. A woman’s lifetime risk of maternal death is 1 in 4900 in developed countries, versus 1 in 180 in developing countries. In countries designated as fragile states, the risk is 1 in 54; showing the consequences from breakdowns in health systems. See World Health Organization, Maternal Mortality factsheet, November 2016.

Access to antenatal care, skilled healthcare during labor, and emergency obstetric care are critical for preventing maternal deaths and injuries. In the Nuba region, unless pregnant women live within reach of one of the two hospitals or the clinics these two institutions support with staff visits, supplies, and training, these services are out of reach.

There are no reliable recent estimates of the number of women and girls dying in childbirth (maternal mortality), or experiencing long-term infections, pregnancy or childbirth-related injuries or disabilities (maternal morbidity), for the rebel-held areas of Southern Kordofan.<sup>110</sup> However, previous estimates show elevated rates in the state. A joint research effort by the UN and the Sudanese government in 2006 put Southern Kordofan's maternal mortality rate at 503 per 100,000 live births, compared to 91 per 100,000 births in Northern state and 213 in Southern Kordofan's neighboring Northern Kordofan state.<sup>111</sup> Maternal mortality decreased nationally in Sudan from 744 per 100,000 live births in 1990 to 311 in 2015, but there is little reason to believe that the figure would have declined to the same extent in war torn, rebel-held Southern Kordofan.<sup>112</sup>

The little information that is available suggests that maternal mortality remains high. The Mother of Mercy Hospital documented two maternal deaths at their hospital in 2016 and three in 2015, out of about 260 to 280 births a year.<sup>113</sup> GED recorded two maternal deaths at their hospital in 2016, out of 193 deliveries and six maternal deaths that took place at women's homes in areas near their outreach clinics.<sup>114</sup> Johannes Plate from GED wrote to Human Rights Watch that, "to get confirmed numbers is quite a challenge. But I had a meeting with the SoH [the SPLM/A-North Secretariat of Health] recently, and they showed

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<sup>110</sup> Globally, most maternal deaths are caused by direct obstetric causes including hemorrhage, sepsis (severe infection spreading through the bloodstream), eclampsia (a pregnancy complication characterized by seizures or coma), unsafe abortions, and prolonged or obstructed labor. Other indirect causes include malaria, tuberculosis, and HIV/AIDS. See World Health Organization, Maternal Mortality factsheet, November 2016, <http://www.who.int/mediacentre/factsheets/fs348/en/> (accessed February 15, 2016).

<sup>111</sup> Government of National Unity and Government of South Sudan, "Sudan Household Health Survey," December 2007, file:///C:/Users/wheel/Downloads/SHHS%202006-%20Final%20Report%20(English).pdf (accessed April 26, 2017).

<sup>112</sup> "Maternal Mortality Ratio," The World Bank Group, Maternal Mortality Ratio, 2016 <http://data.worldbank.org/indicator/SH.STA.MMRT?locations=SD> (accessed 16 February 2017). Research in 2006 suggested that in two parts of Southern Kordofan state MMR, during peacetime, was about 680 per 100,000 births. See A. Bayoumi, "Maternal and childhood mortality in the Nuba mountains, Sudan: A pilot study", January 2006, <http://www.popline.org/node/197013> (accessed February 20, 2017).

<sup>113</sup> The causes of death included "eclampsia, sepsis/shock following prolonged labor at home, shock following ruptured uterus after prolonged labor at home in a multigravida mother." Email from director of the hospital, Diocese of El Obeid, Mother of Mercy Hospital, Gidel, to Human Rights Watch, April 1, 2017.

<sup>114</sup> Most of the maternal deaths were attributed to infection and hemorrhage. Email from Johannes Plate, Cap Anamur - German Emergency Doctors, to Human Rights Watch, April 14, 2017.



me a statistic. There [sic] have confirmed, that around 350 women died in 2016, and were guessing that most of them were pregnant.”<sup>115</sup>

Most maternal deaths are preventable. Johannes Plate from GED said:

Unfortunately, most cases are arriving in the hospital too late; an unknown number is dying at home or on the road... We figured out, that the main complication is prolonged delivery. That is caused by many reasons, but most of them would be treatable, if the woman previously had been examined by a midwife or would come to deliver at the hospital.

To sort out high-risk pregnancies, like twin pregnancies, suspected eclampsia, narrow pelvic, teen pregnancies or multipara, regular ANC's [antenatal care] are needed. But most of the women are only visiting the ANC, once they are feeling sick. The undiscovered cases will deliver at home, in case of a complication the next health unit is too far and the means of transport are rare.<sup>116</sup>

### *Lack of Access to Adequate Antenatal Care*

Pregnant women in rebel-held Nuba Mountains who live within access of either the GED hospital or Mother of Mercy Hospital, or one of their outreach clinics, can access antenatal care from trained and equipped providers.<sup>117</sup> Others must make do with little or no care at all.

Between a third to half of all maternal deaths are due to causes, such as hypertension (pre-eclampsia and eclampsia) and hemorrhage, directly related to inadequate care during pregnancy.<sup>118</sup> The World Health Organization recommends that during each pregnancy

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<sup>115</sup> Email from Johannes Plate, Cap Anamur - German Emergency Doctors, to Human Rights Watch, April 14, 2017.

<sup>116</sup> Email from Plate, April 14, 2017.

<sup>117</sup> The Diocese of El Obeid (who also run the Mother of Mercy Hospital) and Cap Anamur – German Emergency Doctors (GED), each support six outreach clinics. The GED outreach clinics are located in Debbi, Nyukur, Ard Kanan, Korongo, Cambarra and Kororak.

<sup>118</sup> Khan KS, Wojdyla D, Say L, Gulmezoglu AM, Van Look PF, “WHO analysis of causes of maternal death: a systematic review,” *Lancet* 2006; 367:1066-1074.

women make a minimum of four antenatal care visits that provide them with essential evidence-based interventions.<sup>119</sup>

Essential medical assistance includes identification and management of obstetric complications such as pre-eclampsia, tetanus toxoid immunizations, treatment for malaria and sexually transmitted infection identification and management (for example, syphilis). A visit at the end of the pregnancy is important to help find and manage complications such as multiple births and abnormal positions of the baby. Antenatal care is also important to connect the pregnant woman to healthcare providers and to provide her with information on where contraception is available, the importance of skilled attendance at birth, breastfeeding, early care for the baby, and birth spacing. In Nuba, most village clinics (run by the rebel administration) in the rebel-held area lack the staff, the vitamins and medicines (at least in consistent supply), and the equipment to provide full antenatal care.

Almost half of the interviewed women that had given birth in the last four years said they had relied on village midwives for antenatal care, or did not have any antenatal care at all during their pregnancies. Most of the midwives in the area are traditional birth attendants, rather than trained midwives.<sup>120</sup>

None of the midwives or traditional birth attendants who treated the women interviewed in their home villages had equipment such as stethoscopes. “[The midwife] has no equipment, only her hands. She did not listen to the baby. I had no medicines or vitamins and she did not have anything to give me either,” Samia said.<sup>121</sup> In some cases, midwives had advised women interviewed that they should go to the hospital to give birth, either because of the patient’s history or because the midwife was able to determine that she might face problems. “Sometimes [midwives or traditional birth attendants] can feel that the baby is not in the right place and then can send mother to Gidel [Mother of Mercy Hospital],” Hadara village clinic manager, James Atai, said. “But normally when they decide to go to Gidel, the mother already has problems.”

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<sup>119</sup> Women who are unwell or need specialist care should have more antenatal visits. See also World Health Organization and others, “Opportunities for Africa’s Newborns”, Geneva, <http://www.who.int/pmnch/media/publications/oanfullreport.pdf> (accessed February 20, 2017).

<sup>120</sup> Human Rights Watch interview with Tutu Mustapha Turkash, December 9, 2016.

<sup>121</sup> Human Rights Watch interview with S.M. (name withheld), Lula village, Heiban county, December 9, 2016.

Health officials said that folic acid, a vitamin supplement in pill form, is the only supplement delivered regularly to the secretariat of health clinics; iron and other vitamins are provided irregularly. Anemia from a lack of iron, often a cause of maternal mortality, may be very common, one doctor said, based on high rates of anemia amongst his patients.<sup>122</sup> Clinics are also usually supplied with quinine, which can be given to women in their first trimester for malaria. However, the main doctor in Loweri hospital said that malaria was still suspected to be the main cause of stillbirths at his facility.

Hypertension, pre-eclampsia or eclampsia is another major cause of illness and death during pregnancy (as well as delivery).<sup>123</sup> But very few clinics have instruments to measure blood pressure; for example, in Delami county, none of the secretariats of health clinics have a sphygmomanometer, which uses an inflatable cuff wrapped around the patient's upper arm.<sup>124</sup> None of the clinics have received basic instruments such as weighing scales, stethoscopes, or fetoscopes since the war began.

Most women we interviewed said they experienced hunger at least at some point during their pregnancy. A lack of food and nutrition during pregnancy can cause illnesses in pregnant women, including anemia, and lead to low birth weights and poor early development for their babies.<sup>125</sup> There are no supplemental feeding programs in the rebel-held areas.<sup>126</sup> "Because of the fighting, we had to flee. I was often hungry in the last three months [of my pregnancy]," Afaf Saeed, a 25-year-old former cleaner said, "many days there was only a handful of food."<sup>127</sup>

Women who live close to one of the two hospitals or their outreach clinics, or who can find transport or walk to visit the facilities, said they received antenatal care. GED recorded

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<sup>122</sup> Human Rights Watch interview with health staff from Cap Anamur - German Emergency Doctors, Loweri, Heiban county, December 13, 2016.

<sup>123</sup> World Health Organization, "WHO Recommendations for Prevention and Treatment of Pre-eclampsia and Eclampsia," Geneva, 2011, [http://apps.who.int/iris/bitstream/10665/44703/1/9789241548335\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44703/1/9789241548335_eng.pdf) (accessed February 20, 2017).

<sup>124</sup> Human Rights Watch interview with Gadani Ali, head of health secretariat for Delami county, Delami county, December 10, 2016.

<sup>125</sup> World Health Organization, "Essential Nutritional Actions: Improving Maternal, Newborn, Infant and Young Child Health and Nutrition," 2013, [http://apps.who.int/iris/bitstream/10665/84409/1/9789241505550\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/84409/1/9789241505550_eng.pdf) (accessed February 20, 2017). In emergencies, supplementary feeding with vitamin-fortified foods are often offered to women and children where possible.

<sup>126</sup> Human Rights Watch interview with Tutu Mustapha Turkash, December 9, 2016.

<sup>127</sup> The John Hopkins and the International Federation of the Red Cross and Red Crescent Societies, "Public Health Guide for Emergencies," chapter 4, reproductive healthcare, 2007, <http://reliefweb.int/sites/reliefweb.int/files/resources/Forward.pdf> (accessed February 20, 2017).

14,371 antenatal visits to its hospital and outreach clinics in 2016.<sup>128</sup> The Mother of Mercy Hospital said they had 777 admissions to their maternity ward in 2016, mostly commonly for miscarriage, prolonged labor, antepartum bleeding, malaria and neonatal sepsis.<sup>129</sup>

Several of the women interviewed ensured they got checkups, despite considerable distances to hospitals. Ten of the women interviewed went to about four checkups during their pregnancies, and had waited for cars or walked to Mother of Mercy Hospital or the Cap Anamur - German Emergency Doctors (GED), – which is usually around a day there and a day back walking.

“Gidel [Mother of Mercy] is about one or two hours if you can get a car from Heiban to there. I was hungry a lot at the time [when walking and staying there],” Afaf Saeed, a 25-year-old woman with two children said, but added it turned out to have been crucial, perhaps life-saving, that she made this strenuous effort. She found out during the checkups that she should give birth in the hospital because her blood was “too weak” to safely deliver at home.<sup>130</sup>

Of all the 25 women interviewed, only those who had used the Mother of Mercy’s antenatal care had slept under a mosquito net, given to them at their first visit, while pregnant. No other organization provides subsidized or free nets, in large part because of the high cost of transporting these bulkier items.<sup>131</sup>

Sonograms are available in both hospitals. Khadija el Hajj told Human Rights Watch that visiting the Mother of Mercy Hospital for a sonogram might have saved her life. The doctor was able to see that her baby had a swollen head. Under his advice, she went to the hospital for a cesarean section where she had a safe delivery. At the time of the interview, the baby was still in treatment.

Babies born in the GED Loweri hospital receive a Hepatitis B vaccine when they are born – as well as the usual early childhood vaccines – because health workers found after testing

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<sup>128</sup> Email from Plate, April 14, 2017.

<sup>129</sup> Email from hospital director, April 1, 2017.

<sup>130</sup> Human Rights Watch interview with N.S. (name withheld), El Dorein, December 14, 2016.

<sup>131</sup> Human Rights Watch interviewed all the medical providers working in the area.

that 12.5 percent of women using the facility over nine months in 2016 have the disease.<sup>132</sup> The Mother of Mercy Hospital in Gidel recently began testing all pregnant women for hepatitis B in their antenatal clinic and found about 20 percent of these women were positive.<sup>133</sup> “We immunize those babies immediately after birth and are encouraging their mothers to deliver at the hospital,” said the senior doctor working there.<sup>134</sup>

Pregnant women or girls who visit Diocese of el Obeid facilities, including six outreach clinics, have checkups that include measuring the mother’s weight and blood pressure, testing (and if necessary, treatment) for HIV and hepatitis B, and provision of medicines to prevent malaria and tetanus immunization.<sup>135</sup> Six GED outreach clinics also provide consultations that include blood pressure and weight measurements and most also provide tetanus vaccines and anti-malarials.<sup>136</sup> Vaccinations are not available in most places as few clinics have refrigerators to store them.

Human Rights Watch spoke to four women who attributed their miscarriages and early births to the hardships and stress they underwent while experiencing aerial bombardment. The causes of miscarriage are complex and Human Rights Watch does not have the information or medical expertise to assess what happened in these cases. However, many people in the community said they felt there was a link.

A medical organization working in areas in Syria where aerial bombardment is common told Human Rights Watch “our field teams have documented both miscarriages and pre-term births as a result of ongoing bombing.”<sup>137</sup> A doctor from another medical organization was more circumspect, saying “traumatic events like bombings and attacks are creating stressful situations leading to early births, that occasionally can result in miscarriages.”<sup>138</sup> A 2013 news release from Médecins Sans Frontières said that “amongst pregnant women, miscarriages and pre-term births are on the rise because of the stress caused by the

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<sup>132</sup> Email from Plate, April 14, 2017.

<sup>133</sup> Email from hospital director, April 1, 2017.

<sup>134</sup> Ibid.

<sup>135</sup> Ibid.

<sup>136</sup> Email from Plate, April 14, 2017.

<sup>137</sup> Email to Human Rights Watch interview (name withheld), medical NGO working in Syria, April 18, 2017.

<sup>138</sup> Email to Human Rights Watch interview (name withheld), medical NGO working in Syria, April 25, 2017.

conflict,” but did not directly attribute the increase in miscarriages to bombardment, although this stressor was mentioned.<sup>139</sup>

“It happened to me, in 2013, I was seven months pregnant. I ran to the foxhole when the plane came, came out and two days later I gave birth,” 41-year-old Aisha Hussein said, “the baby died.”<sup>140</sup> Another woman, Mujuma Hamad, working as a medicine dispenser in Hadara village in Delami county, said she miscarried immediately after an Antonov attack when she was eight months pregnant.<sup>141</sup> She said that she knew six other women in the village who miscarried at or around the time when aerial bombardments had taken place.

A social development administration worker in charge of women’s affairs in Heiban town said that since the war began in 2011, she knew at least seven women who had miscarried soon after aerial bombardment. The information manager for the secretariat of health said that she recorded three miscarriages in Kauda town in 2014 that had taken place when planes flew over threatening an attack, and that she also received a report that four women miscarried during aerial bombardment attacks in Mendi in 2015.<sup>142</sup>

### *Emergency Obstetric Care: The Three Delays*

Hundreds of thousands of women live too far from the GED hospital or Mother of Mercy Hospital to be able to access emergency obstetric care. But even for those who do live within reach of the two hospitals, delays stop them from accessing these services.

Health experts highlight the importance of having a skilled health care provider during and after childbirth, and typically explain the contributing factors to maternal deaths and morbidity using the “three delays model.”<sup>143</sup>

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<sup>139</sup> “Syria: Women and children paying a high price in conflict” Medecins Sans Frontieres press release, January 28, 2013, <https://www.msf.ie/article/syria-women-and-children-paying-high-price-conflict> (accessed April 27, 2017).

<sup>140</sup> Human Rights Watch interview with B.B. (name withheld), Tongoli town, Delami county, December 10, 2016.

<sup>141</sup> Human Rights Watch interview with Mujuma Hamad, Hadara town, Delami, December 11, 2016.

<sup>142</sup> Human Rights Watch interview with Fatna Al Nur, head of information gathering in secretariat of health, Kauda, Heiban county, December 13, 2016.

<sup>143</sup> The John Hopkins and the International Federation of the Red Cross and Red Crescent Societies, “Public Health Guide for Emergencies,” chapter 4, reproductive healthcare, 2007, <http://reliefweb.int/sites/reliefweb.int/files/resources/Forward.pdf> (accessed February 20, 2017).

The first delay follows the failure to recognize the need for emergency obstetric care, or when a decision is made, to not access emergency services. Undertrained midwives, or family members in the absence of health workers, can be slower than fully trained personnel to notice danger signs and ensure timely referral. In the rebel-held areas of Southern Kordofan, the extreme difficulties of finding and organizing transport and at times bombing raids, may stop women and their families from quickly choosing to get the patient to a hospital or clinic as soon as possible.

The second delay is when women arrive late to the referral facility, including when the facility is too far away to access quickly or when transportation is unavailable. A woman experiencing postpartum hemorrhage, which accounts for around 25 percent of maternal deaths globally, is at high risk of dying within two hours of onset without immediate intervention.<sup>144</sup> Women experiencing other problems, such as hypertension or obstructed labor, may have a longer window, of up to two days, to reach lifesaving care, in most cases.<sup>145</sup>

In the rebel-held areas, if women and girls face emergency complications during childbirth, they may be many hours or days away from lifesaving assistance. “In many cases women come from far to give birth, sometimes two days walking, sometimes the baby died on the way,” a GED midwife, Dahabaya Khamis, said.<sup>146</sup>

There are no ambulances in the region and mobile phone networks only work on some of the fringes of rebel-held areas. Since the war began, the number of cars has declined and authorities in places Human Rights Watch visited said there are typically only one or two cars even in the main towns and usually no cars in villages. “If I have an emergency when I give birth, if I find a car I am about an hour from the hospital,” Aisha Hussein, one of the women interviewed, said. “There were a lot of cars before the war. Now it’s hard to find one.”<sup>147</sup>

Families often end up carrying women in obstructed labor on a bed, local officials told Human Rights Watch. Four women told researchers that this would be their only option if

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<sup>144</sup> Ibid.

<sup>145</sup> Ibid.

<sup>146</sup> Human Rights Watch interview with midwife Dahabaya Khamis, Cap Anamur - German Emergency Doctors, Loweri, Heiban county, December 13, 2016.

<sup>147</sup> Human Rights Watch interview with B.B. (name withheld), Tongoli village, Delami county, December 10, 2016.

they faced complications in labor. The head of the health secretariat in the county of Delami said this is a fairly common practice. “We can do nothing here ... there is a car usually in Tujur to then go to Gidel, about three hours by foot, by bed, with a group of not less than 10 men. And sometimes the cars are not there, or one is broken down,” he said.

The executive director of Heiban county said:

It is very common that women can't reach in time and die in childbirth at home. To get to Gidel is about six to seven hours if you climb across the hills, a one-day walk if you go through Kauda way. The child often dies. We use a bed to carry the woman to the hospital, a group of men carry her. Sometimes from the villages to here like this, and then they try and find a car. They go to the commissioner, but he's not always here and sometimes he has no fuel. This happens between 5 and 10 times a month. Then we face a lack of blood when they give birth.<sup>148</sup>

“Sometimes we see a woman who has been in labor for three days and she's just arrived,” a foreign doctor told Human Rights Watch.<sup>149</sup> One woman, Amal Tutu, miscarried twins and then had to walk a day to the hospital when the bleeding did not stop even though she was weak.<sup>150</sup> “There was no car, no painkillers. I was in pain but I knew that the local clinic would not be able to deal with it,” she said. She was treated at the hospital. Hawa Zeitoun, who is about 14 or 15 years old, spent the last two months of her pregnancy at the Mother of Mercy Hospital because she had complications, and she feared if she waited at home, she would not be able to manage the one-day walk to reach the facility.<sup>151</sup>

The third delay is caused when the facility does not have sufficiently trained staff or is inadequately equipped. In rebel-held areas of Southern Kordofan, the only facilities fully equipped to handle obstetric emergencies are Loweri or the Mother of Mercy hospitals. The Mother of Mercy Hospital has a blood bank and a team of experts including anesthesiologists, and both hospitals can provide women with transfusions. Both the

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<sup>148</sup> Human Rights Watch interview with the executive director of Heiban county, Heiban town, Heiban county, December 9, 2016.

<sup>149</sup> Human Rights Watch interview (name withheld), Heiban county, December 8, 2016.

<sup>150</sup> Human Rights Watch interview with S.A. (name withheld), Heiban town, December 12, 2016.

<sup>151</sup> Human Rights Watch interview with K.A.H (name withheld), Lula village, Heiban County, December 9, 2016.



Mother of Mercy and GED Loweri can perform cesarean sections as well as provide all basic emergency care, including specialized antibiotics, oxytocin and anticonvulsants, manual removal of the placenta and assisted vaginal delivery.

GED provides support to six outreach clinics and only one does not have a midwife on staff who is trained to manage manual removal of the placenta, umbilical cord prolapse (when the umbilical cord emerges in birth before the fetus), breech delivery and other complications; in two clinics, staff can remove material from inside the uterus.<sup>152</sup> Six other clinics are supported by the Diocese of El Obeid, who also run the Mother of Mercy Hospital in Gidel, where midwives on staff provide manual placenta removal, although they do not perform assisted (i.e. vacuum or forceps assisted) deliveries. Oxytocin and antibiotics are available, including via a drip in one clinic.<sup>153</sup>

Otherwise, few health facilities are equipped to manage emergencies even if women can reach them. For example, misoprostol, which can be a life-saving medicine in cases of post-partum hemorrhage or miscarriage, is generally not available except in the two hospitals and a few clinics.<sup>154</sup> Midwives are often inadequately equipped and trained.

Most women in Nuba give birth at home. All but four of all the women interviewed by Human Rights Watch gave birth where they were living, either permanently or while displaced by fighting, usually on the ground but sometimes on a bed. “There was dust blowing all over me,” Afaf Saeed, who was living in displacement near a riverbed a few hours’ walk from Heiban town because of aerial bombardment at the time, remembered.<sup>155</sup> Often women said in their interviews that they delivered with the assistance of family members, but in about half the cases a midwife was present. “I gave birth at home, I was afraid I would die I was in so much pain, but it was not for too long. The baby was the wrong way around, but the midwife could adjust the baby before the birth,” Samia Mohammed said.<sup>156</sup>

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<sup>152</sup> Email from Plate, April 14, 2017.

<sup>153</sup> Email from hospital director, April 1, 2017.

<sup>154</sup> Human Rights Watch interview with Tutu Mustapha Turkash, December 9, 2016.

<sup>155</sup> Human Rights Watch interview with N.S. (name withheld), Lula village, Heiban county, December 9, 2016.

<sup>156</sup> Human Rights Watch interview with S.M. (name withheld), Lula village, Heiban county, December 9, 2016.

Even when a trained midwife can attend a birth, she often does not have access to equipment, like forceps, sometimes lost or destroyed in the war. For example, the midwife in Hadara village in Delami county said her kit burned with all her possessions when much of the town was burned in May 2015 by government forces.<sup>157</sup> There has been no large-scale training or re-training of midwives in the area, or in neighboring South Sudan, and no large effort to resupply them with equipment since the war began.<sup>158</sup>

In humanitarian crises where women tend to give birth at home rather than in facilities, humanitarian organizations try to provide women who are visibly pregnant with clean delivery kits (containing soap, a razor blade and cloth among other items). There has been no large-scale distribution of delivery kits for pregnant women in the rebel-held areas since the war began.<sup>159</sup> Simple UN-supplied midwife kits that each cover 50 deliveries and contain basic lifesaving equipment and medicines, are also not available in the rebel-held area.

## Access to Contraception and Protection against Sexually Transmitted Infections

No, no condoms here. We've never had them. ... Yes! We know what they are, but we've never seen them here, no family planning since the war.

— Staff members of Heiban town's main clinic, Heiban county, December 2016.<sup>160</sup>

Every year we women get really tired of being pregnant and giving birth and there's not enough food either, not enough vegetables to feed all the children. So, they are hungry and we're worried about the situation all the time, there's no option for a change.

— Raja Ibrahim, women's rights and civil society leader, December 2016.<sup>161</sup>

What is a 'condom'?

— Khadija al Haj, mother of one, Lula village, Heiban county, December 2016.<sup>162</sup>

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<sup>157</sup> Human Rights Watch interview with James Atai, December 11, 2016.

<sup>158</sup> Human Rights Watch interview with Tutu Mustapha Turkash, December 9, 2016.

<sup>159</sup> Cap Anamur – Germany Emergency Doctors (GED), have provided 1, 776 delivery kits to women using their outreach clinics.

<sup>160</sup> Human Rights Watch interviews with staff members of Heiban town's main clinic, Heiban county, December 9, 2016.

<sup>161</sup> Human Rights Watch interview with Raja Ibrahim, KODI organization, Kauda, Heiban county, December 13, 2016.

<sup>162</sup> Human Rights Watch interview with K.A.H (name withheld), Lula village, Heiban County, December 9, 2016.

Family planning, including access to condoms, is largely unavailable in rebel-held Southern Kordofan state, largely due to the overall gaps in health infrastructure and services, and in part because the major healthcare provider is Catholic and does not provide contraception due to their religious beliefs. This has meant that women are unable to control the number and spacing of their pregnancies or plan their families either individually, or together with partners, to the detriment to their well-being and health.<sup>163</sup> The area's apparently high number of early marriages makes the lack of access to contraception even more dangerous; for girls between 15 and 19 years old, complications due to pregnancy and childbirth is the second leading cause of death globally.<sup>164</sup> Multiple births can endanger the mother's health and women who have more than four children are at increased risk of maternal mortality.<sup>165</sup>

The low levels of condom availability in the areas also means men and women are less able to protect themselves from sexually-transmitted infections.

### *Access to Contraception in the Rebel-Held Area*

There is nothing you can do if you don't want to get pregnant.

— Khadija al Haj, Lula village, Heiban County, December 2016.

Human Rights Watch interviewed all the main health providers and found that women and girls have few or no options for controlling their fertility. Overall access to reproductive health information and services is weak. The largest hospital and main health center is run by Catholic providers who do not provide contraception. To the extent that limited quantities

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<sup>163</sup> Being unable to plan families and experiencing multiple pregnancies can negatively impact women's wellbeing in many ways. Becoming pregnant again soon after giving birth, before the body has had a chance to recuperate and build up stores of iron again, can negatively impact a woman's health and make it more likely that a woman dies in childbirth. The World Health Organization recommends a 24-month interval between the birth of one child and the conception of the next "to reduce the risk of adverse maternal, perinatal and infant outcomes. WHO recommends that after a miscarriage or induced abortion, women wait six months before getting pregnant again. Multiple births are dangerous, women who have already had many births are advised to prevent further pregnancies. Evidence suggests that women who have more than 4 children are at increased risk of maternal mortality; World Health Organization, "Contraception and family planning," fact sheet, December 2016, <http://www.who.int/mediacentre/factsheets/fs351/en/> (accessed December 19, 2017); World Health Organization, "Report of a WHO Technical Consultation on Birth Spacing," June 2005, [http://apps.who.int/iris/bitstream/10665/69855/1/WHO\\_RHR\\_07.1\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/69855/1/WHO_RHR_07.1_eng.pdf) (accessed February 19, 2017).

<sup>164</sup> World Health Organization, "Adolescent Pregnancy," fact sheet, September 2014, <http://www.who.int/mediacentre/factsheets/fs364/en/> (accessed February 19, 2017). WHO campaigns to "create understanding and support to reduce pregnancy before the age of 20."

<sup>165</sup> World Health Organization, "Report of a WHO Technical Consultation on Birth Spacing." ;World Health Organization, "Adolescent Pregnancy."

of contraception are available, a local rule and cultural norms dictate that women must first get the permission of their husbands.<sup>166</sup> There is also a social stigma around using contraception, according to NGO workers and some of the women interviewed.

In many settings, women prefer long-acting contraceptives, especially if it is difficult to access health services and supplies easily. Only one provider, GED, provides such services – a three-month injectable contraception.<sup>167</sup> GED also regularly distributes a limited amount of condoms from its small hospital in Loweri, and six outreach clinics.<sup>168</sup> GED recorded 519 visits related to family planning in 2016 in its hospital and outreach clinics.<sup>169</sup> Johannes Plate, who works in the GED hospital, said that women often prefer long-lasting contraception to using condoms but that GED does not provide other options such as intrauterine devices (IUDs) or oral contraceptives as women may be displaced or unable to return to the clinic for other reasons. He also said they do not provide contraceptives in pill form as women often do not use it correctly.<sup>170</sup>

The Mother of Mercy, the region’s main hospital, does not provide any contraception because the organization is Catholic. None of the rebel secretariats of health clinics provide family planning information or services, and only very occasionally stock condoms, which are not included in regular distributions.<sup>171</sup> One SPLM/A-North clinic visited by Human Rights Watch did have some condoms but the manager said that he only gives them away one at a time because he is uncertain when or if he will get more. MSF, which provided family planning services, closed its clinics after they were bombed in 2014 (see above).

Local informal rules stipulate that women cannot access family planning without first getting permission from their husbands, and GED doctors are only able to provide three-month contraception, when women bring their husbands. Men sometimes beat their wives

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<sup>166</sup> Cap Anamur - German Emergency Doctors told Human Rights Watch that because of this rule, they only give injectable contraception to women when their husbands come with them to the clinic and agree. The humanitarian wing of the SPLM/A-North, the Sudan Relief and Rehabilitation Agency, said that this rule is in effect, but Human Rights Watch could not confirm it was formalized into a law or written regulations.

<sup>167</sup> Human Rights Watch interview with health staff from Cap Anamur - German Emergency Doctors, December 13, 2016.

<sup>168</sup> About 5,000 every 6 months.

<sup>169</sup> Email from Plate, April 14, 2017.

<sup>170</sup> Ibid.

<sup>171</sup> Human Rights Watch interview with Tutu Mustapha Turkash, December 9, 2016.

for using contraception, NGO workers in the region said. “This is because women are supposed to take permission from their husbands to get family planning and men don’t want them to. We need awareness to change this,” Leila Karim, the head of the SPLM/A-North women’s association, said.<sup>172</sup>

Condoms are not widely available in the markets, health workers and authorities said, but two women interviewed by Human Rights Watch also reported that they felt ashamed of buying them as, they said, it is widely perceived that only a “bad” woman would need one. “I want family planning. I don’t want to give birth all the time ... (but) condoms are just for women who have affairs with other people,” 19-year-old Rania Haidar, already a mother of two, said.<sup>173</sup> A lack of knowledge and understanding about contraception is also a barrier. “Women are afraid of infertility, that it will be permanent. The other problem is that men are worried about other men, that their wives will go and have sex with other people, especially when he is away,” Umjuma Al Sheikh, one of the midwives working at the Loweri hospital said.

None of the women Human Rights Watch interviewed were currently using or had access to contraception where they lived and only one woman had accessed the GED hospital in Loweri, a day’s walk away for her. None of the other women knew that family planning was available there. Twelve of the 25 women interviewed did not know what a condom was and another three knew what they were but had never seen one.

“There is no way to control, no choice, you just have babies,” Afaf Saeed said.<sup>174</sup> Magda Dorjwaat, also interviewed in the same displaced community, echoed her: “There is no way to control births, you just have to give birth.”<sup>175</sup> Most had given up on trying to control pregnancy but two of the women interviewed were using the “calendar” method.<sup>176</sup>

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<sup>172</sup> Human Rights Watch interview, Leila Karim, head of women’s association, Kauda, Heiban county, December 13, 2016.

<sup>173</sup> Human Rights Watch interview with M.S., Um Dorein county, December 14, 2016.

<sup>174</sup> Human Rights Watch interview with N.S., Lula village, Heiban county, December 9, 2016.

<sup>175</sup> Human Rights Watch interview with S.M., Lula village, Heiban county, December 9, 2016.

<sup>176</sup> The calendar method, also called the rhythm method or the calendar rhythm method, is a form of natural family planning. To use the rhythm method, women track their menstrual history to predict when they will ovulate to determine when they are most likely to conceive.

A few women said that they were uninterested personally in using contraception because they felt they needed to, as one woman put it “replace the people lost in the war.”<sup>177</sup> But all saw the advantages of having family planning available. “Women want fewer children now, four is ideal so that you can feed and educate them,” a former worker at an NGO, said.<sup>178</sup> Fatima Abdelrahman, a 27-year-old woman displaced after government forces attacked and mostly destroyed her village, and struggling to feed her children, said:

Our clinic was looted and destroyed. In Kau there is a clinic, but it is one hour walking from here. But even before they were destroyed there are no condoms here, no family planning. Almost every year I give birth, it would be better if I could space it, it’s tiresome trying to feed all my children already.<sup>179</sup>

More widely available contraception, together with comprehensive sexuality education, could also help prevent early pregnancy leading to marriage or a loss of education for girls and young women.

Women interviewed in December 2016 said that, even though they were already married, they could perhaps complete more of their education if they could space pregnancies. “I would like family planning. I dropped out from school, I would like it so I could go back,” Samia Ramadan, 20 years old and a pregnant mother of two, said sadly.<sup>180</sup> Knowledge of family planning methods was low, and some interviewees did not know that it is possible to space births.

### *Difficulties Preventing Sexually-Transmitted Infections*

The lack of condoms has made fighting sexually transmitted infections (STI), such as syphilis and gonorrhea, more difficult in Nuba. Local authorities have distributed some condoms as protection for both women and men against transmission of some STIs, including HIV, but even at the time of the distribution, supplies were limited. “We gather people and do awareness on HIV. But [because there are so few condoms] all we can

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<sup>177</sup> Human Rights Watch interview with S.W. (name withheld), Heiban town, Heiban county, December 12, 2016.

<sup>178</sup> Human Rights Watch interview with N.S., Lula village, Heiban county, December 9, 2016.

<sup>179</sup> Human Rights Watch interview with S.J. (name withheld), Karkarai, Um Dorein county, December 14, 2016.

<sup>180</sup> Human Rights Watch interview with R.H. (name withheld), Gidel, Heiban county, December 12, 2016.

recommend is abstinence and monogamy,” the rebel secretariat of health head, Tutu Mustapha Turkash, said.<sup>181</sup>

Testing for HIV is available in a few locations but only one place, the Mother of Mercy Hospital, can check white blood cell counts and then provide antiretroviral medicines in the right doses.

The number of syphilis and gonorrhea cases have increased in recent years, according to all the medical and NGO officials interviewed for this report.<sup>182</sup> No information is available about the overall incidence of the diseases, but, for example, the Mother of Mercy Hospital and clinics saw 64 cases in 2012, 74 in 2013, 107 in 2014, 142 in 2015 and 178 in 2016. Gonorrhea cases also increased, even more sharply, from 39 in 2013, 139 in 2014, 296 cases in 2015 and 896 cases in 2016.<sup>183</sup> A health worker at the GED Loweri hospital said that they had seen an increase in both diseases in 2016 compared to the year before, and that they regularly treat newborns with congenital syphilis and conjunctivitis caused by gonorrhea.

In the 40 clinics supported by a local NGO, 3,199 cases of STIs were reported in 2014 and 3,462 cases in 2015. Health officials said they saw a much lower number of cases before 2014. Since none of these clinics have labs, these numbers of syphilis and gonorrhea cases, and patients’ treatment, are based on symptoms alone.

In a small town, Hadara, the local nurse said that he sees about two cases a week of suspected gonorrhea or suspected syphilis, and that last year there were more cases for these two diseases than anything else except for malaria.<sup>184</sup>

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<sup>181</sup> Human Rights Watch interview with Tutu Mustapha Turkash Kauda, December 8, 2016.

<sup>182</sup> Human Rights Watch interview, (name withheld), Heiban county, December 8, 2016.

<sup>183</sup> Email from hospital director, April 1, 2017.

<sup>184</sup> Human Rights Watch interview with James Atai, December 11, 2016,

## IV. National and International Legal Obligations

At all times during the conflicts in Sudan, both international human rights law as well as international humanitarian law – as a *lex specialis* - apply. In this context, Sudan is a party to both the International Covenants – the Covenant on Civil and Political Rights (ICCPR), and the Covenant on Economic, Social and Cultural Rights (ICESCR) – as well as the Convention on the Rights of the Child (CRC), and is a party to the Geneva Conventions and Additional Protocols I and II.<sup>185</sup> Nevertheless, civilians living in rebel-held parts of Nuba mountains have not had access to adequate life-saving humanitarian supplies since the conflict began 6 years ago.

The Sudanese government's obstruction of humanitarian access flouts its obligations under both national and international law. The SPLM/A-North's rejection of impartial humanitarian assistance also contravenes its obligations as a party to the conflict.

### Obligations to Allow Unhindered Humanitarian Aid

The conflicts between the government and rebel forces in South Kordofan, Blue Nile and Darfur are non-international armed conflicts under international law, and governed by the body of international humanitarian law applicable to internal conflicts. Sudan is a party to Additional Protocol II, relating to the Protection of Victims of Non-International Armed Conflict, and is also bound by customary international humanitarian law.<sup>186</sup> Under international humanitarian law, a civilian population suffering undue hardship is entitled to receive impartial humanitarian relief essential to its survival, and consent for provision of such relief may not be arbitrarily withheld.<sup>187</sup> All parties to an internal armed conflict, government forces and non-armed groups alike, must allow and facilitate rapid and unimpeded passage of impartial humanitarian assistance for civilians in need. While international humanitarian law permits parties to a conflict to take certain measures to

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<sup>185</sup> Sudan became a party to the ICCPR and ICESCR in 1986 and the CRC in 1990. Sudan became a party to the Geneva Conventions and their Additional Protocols in 1957 and 2006 respectively.

<sup>186</sup> Sudan became a party to the Additional Protocol (II) to the Geneva Conventions of 1977, on July 13, 2006.

<sup>187</sup> Article 18(2) of Protocol II, applicable in non-international armed conflicts, states: "If the civilian population is suffering undue hardship owing to a lack of the supplies essential for its survival, such as food-stuffs and medical supplies, relief actions for the civilian population, which are of an exclusively humanitarian and impartial nature and which are conducted without any adverse distinction, shall be undertaken subject to the consent of the High Contracting Party concerned."



control the content and delivery of humanitarian assistance, they cannot deliberately or willfully impede its delivery.<sup>188</sup>

Parties to an armed conflict must also ensure that humanitarian workers have the freedom of movement to conduct humanitarian operations. Only in the case of “imperative military necessity” may their movements be restricted; these restrictions should be limited and temporary, such as when relief operations interfere with military operations and could endanger humanitarian workers.<sup>189</sup> The UN Security Council adopted a resolution in 2000 on the protection of civilians in armed conflicts in which it called upon governments and opposition armed groups to “ensure the safety, security and freedom of movement” of humanitarian relief workers.<sup>190</sup>

The rebel SPLM/A-North group’s leadership has the same obligations to allow humanitarian assistance as the government.

Serious violations of the laws of war are war crimes, and in both international and non-international conflicts, attacks deliberately targeted on aid workers or their property are prosecutable as war crimes under the International Criminal Court (ICC) statute.<sup>191</sup> Starvation as a method of warfare, including by willfully impeding relief supplies to deprive civilians of objects indispensable to their survival, is prohibited in all conflicts, although only prosecutable as a war crime before the ICC in an international conflict.<sup>192</sup> Nevertheless, “the intentional infliction of conditions of life, *inter alia*, the deprivation of access to food and medicine, calculated to bring about the destruction of part of a population,” constitutes the crime against humanity of extermination, when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack, also in a non-international armed conflict.<sup>193</sup>

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<sup>188</sup> ICRC, Customary International Humanitarian Law, rule 55.

<sup>189</sup> ICRC, Customary International Humanitarian Law, rule 56.

<sup>190</sup> U.N. Security Council Resolution 1296 (2000).

<sup>191</sup> Rome Statute of the International Criminal Court articles 8(2)(b)(iii) and 8(2)(e) (iii).

<sup>192</sup> Rome Statute of the International Criminal Court article 8(2)(b)(xxv).

<sup>193</sup> Rome Statute of the International Criminal Court (1998), articles 7(1)(b) and (2)(b).

Actions by the Sudanese government and SPLM/A-North to block independent and impartial aid agencies to civilians in need in the Nuba mountains violate their obligations under international humanitarian law.

## Sexual and Reproductive Health Rights

International and regional laws and treaties ratified by Sudan protect the right to health for all in Sudan, including the rights of women and girls to reproductive healthcare. These include the ICESCR, the African Charter on Human and People's Rights and the CRC.<sup>194</sup>

The ICESCR articulates the right to health as “the right to the enjoyment of the highest attainable standard of physical and mental health.”<sup>195</sup> The 1981 African Charter on Human and People's Rights also recognizes this right.<sup>196</sup> Governments have an obligation to take concrete and targeted steps to realize this right using available resources, including international assistance, as expeditiously and effectively as possible.<sup>197</sup> Governments should also ensure a minimum level of access to the essential material components of the right to health, such as the provision of essential medicines and maternal and child health services.<sup>198</sup>

The UN Committee on Economic, Social and Cultural Rights (CESCR) has identified the provision of maternal health services as a core obligation which cannot be derogated from under any circumstances, and which governments should take immediate steps towards

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<sup>194</sup> Sudan acceded to the International Covenant on Economic, Social and Cultural Rights (ICESCR) on March 18, 1986. See United Nations Treaty Collection, International Covenant on Economic, Social and Cultural Rights page, [https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-3&chapter=4&clang=\\_en](https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&clang=_en) (accessed February 14, 2017); Sudan signed the African Charter on September 3, 1982 and ratified the charter on February 18, 1986. See African Commission on Human and People's Rights, Ratification Table: African Charter on Human and People's Rights, <http://www.achpr.org/instruments/achpr/ratification/> (accessed February 14, 2017); Convention on the Rights of the Child, art. 28. Sudan signed the convention on July 24, 1990 and ratified it the following month, on August 3, 1990. See United Nations Treaty Collection, Convention on the Rights of the Child page, [https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-11&chapter=4&clang=\\_en](https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&clang=_en) (accessed February 14, 2017).

<sup>195</sup> International Covenant on Economic, Social and Cultural Rights (ICESR), article 12 (1), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976.

<sup>196</sup> African [Banjul] Charter on Human and People's Rights, article 16 (1), adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force October 21, 1986.

<sup>197</sup> ICESCR, art. 2 (1), and see General Comment No. 3, The nature of States parties' obligations (art. 2, para. 1, of the Covenant), January 1, 1991.

<sup>198</sup> ICESCR, art. 12.

fulfilling in the context of pregnancy and childbirth.<sup>199</sup> Such steps include safeguarding the freedom to decide if and when to reproduce, having access to safe and affordable methods of family planning and the healthcare services that will enable women to go safely through pregnancy and childbirth.

The CESCR has also articulated to governments the importance of the availability, accessibility, affordability, and acceptability of sexual and reproductive health care. It has outlined the importance of an adequate number of functioning health care facilities, and ensuring availability of trained and skilled health providers, noting that:

...essential medicines should be available, including a wide range of contraceptive methods, such as condoms and emergency contraception, medicines for abortion and for post-abortion care, and medicines, including generic medicines, for the prevention and treatment of sexually transmitted infections and HIV.<sup>200</sup>

And:

Unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services; an adequate number of health care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach.<sup>201</sup>

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<sup>199</sup> UN Committee on Economic, Social and Cultural Rights, “CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art 12), [http://www.ohchr.org/EN/Issues/Education/Training/Compilation/Pages/eGeneralCommentNo14Therighttothehighestattainablestandardofhealth\(article12\)\(2000\).aspx](http://www.ohchr.org/EN/Issues/Education/Training/Compilation/Pages/eGeneralCommentNo14Therighttothehighestattainablestandardofhealth(article12)(2000).aspx), paragraph 14, (accessed March 1, 2017).

<sup>200</sup> UN Committee on Economic, Social and Cultural Rights, “General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)” <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4sIQ6QSmIBEDzFEovLCuW1aoSzabooXTdlmnsJZZVQfQejF41Tob4CvljeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8Tlm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3YlZg>, para.13, (accessed March 1, 2017).

<sup>201</sup> *Ibid.* para 14.

International humanitarian law also highlights that expectant and nursing mothers, together with children, are “particularly vulnerable” and should be provided with specific protection.<sup>202</sup>

Women and girls enjoy a right to access health-related information under the ICCPR and IESCR, while the Convention on the Rights of the Child also has a right to health education that includes access to information on preventing early pregnancy.<sup>203</sup>

The Convention for the Eradication of Discrimination Against Women (CEDAW) protects the right of women and girls to decide the number and spacing of their children.<sup>204</sup> Sudan is not a party to CEDAW and despite advocacy by national and international human rights groups and UN agencies, President al-Bashir has said that Sudan will never join it.<sup>205</sup> Nevertheless, as one of the most widely ratified treaties (one hundred and sixty-five states parties, with only 22 countries including Sudan opting out), parts of the law may be considered to reflect standards of customary international human rights law.

International law stipulates that states should ensure that all can access healthcare without discrimination, for example because of their race or sex.<sup>206</sup> The civilian population in the Nuba mountains are facing discrimination based on their ethnic identity.

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<sup>202</sup> Article 23 GC IV and Article 70 (1) AP1

<sup>203</sup> CRC, art. 28.

<sup>204</sup> CEDAW, art.16 (1)(e)

<sup>205</sup> “Sudan: Bashir says Sudan will not sign CEDAW Convention”, Panafrican News Agency, Dakar, January 14, 2001, <http://allafrica.com/stories/200101140001.html> (accessed February 16, 2017).

<sup>206</sup> Report of the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, February 2004, E/CN.4/2004/49, para. 41; See also CEDAW, ‘States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services including those related to family planning’.

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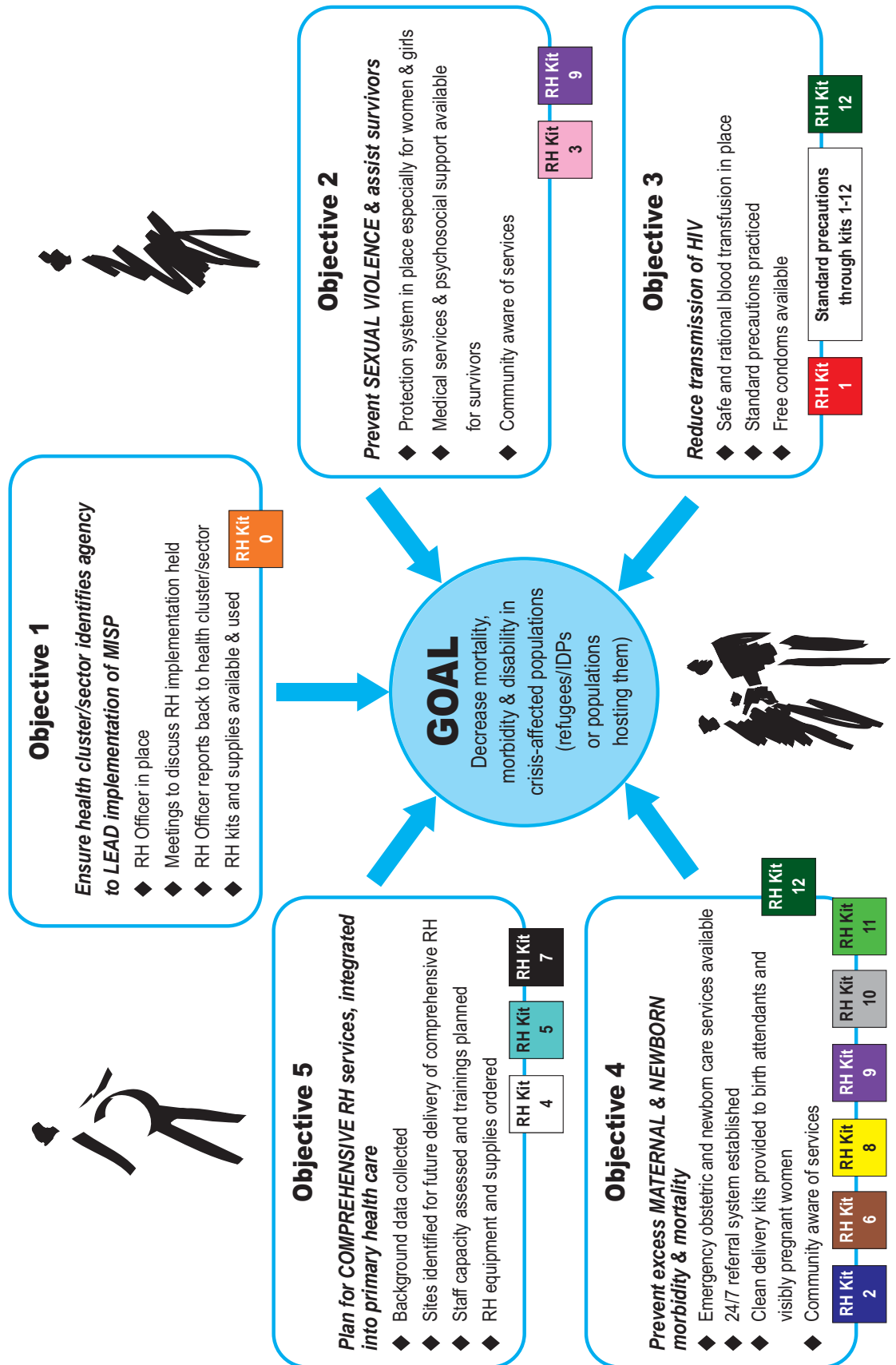
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# Appendix E:

MISP Cheat Sheet

## Minimum Initial Service Package (MISP) for Reproductive Health



The RH Kit is designed for use for a 3-month period for a varying population number and is divided into three "blocks" as follows:

Block 1: Six kits to be used at the community and primary health care level for 10,000 persons / 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 0	Administration	Orange
Kit 1	Condom (Part A is male condoms + Part B is female condoms)	Red
Kit 2	Clean Delivery (Individual) (Part A + B)	Dark blue
Kit 3	Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	STI	Turquoise

Block 1 contains six kits. The items in these kits are intended for use by service providers delivering RH care at the community and primary care level. The kits contain mainly medicines and disposable items. Kits 1, 2 and 3 are subdivided into parts A and B, which can be ordered separately.

Block 2: Five kits to be used at the community and primary health care level for 30,000 persons / 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance (Part A + B)	Brown
Kit 7	IUD	Black
Kit 8	Management of Complications of Abortion	Yellow
Kit 9	Suture of Tears (Cervical and vaginal) and Vaginal Examination	Purple
Kit 10	Vacuum Extraction for Delivery (Manual)	Grey

Block 2 is composed of five kits containing disposable and reusable material. The items in these kits are intended for use by trained health care staff with additional midwifery and selected obstetric and neonatal skills at the health centre or hospital level.

Block 3: Two kits to be used at referral hospital level for 150,000 persons / 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 11	Referral level for Reproductive Health (Part A + B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

Block 3 is composed of two kits containing disposable and reusable supplies to provide comprehensive emergency obstetric and neonatal care at the referral (surgical obstetrics) level. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. Kit 11 has two parts, A and B, which are usually used together but which can be ordered separately.

**NOTE:** Agencies should not depend solely on the inter-agency, RH Kits and should plan to integrate the procurement of MISP/RH supplies in their routine health procurement systems.

**RESOURCES:**

- ▶ Reproductive Health in Humanitarian Settings: An Inter-agency Field Manual: [http://www.iawg.net/resources/field\\_manual.html](http://www.iawg.net/resources/field_manual.html)
- ▶ MISP Distance Learning Module: <http://misp.rhrc.org>
- ▶ SPRINT Facilitator's Manual for SRH Coordination: <http://www.ippfreesaor.org/en/Resources/Publications/SPRINTFacilitatorsManual.htm>
- ▶ UNFFPA/Save the Children Adolescent Sexual and Reproductive Health Toolkit in Humanitarian Settings: A companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: [www.unfpa.org/publications/psid/4169](http://www.unfpa.org/publications/psid/4169)
- ▶ RHRC Monitoring and Evaluation Toolkit: [www.rhrc.org/resources/general\\_fieldtools/toolkit/](http://www.rhrc.org/resources/general_fieldtools/toolkit/)
- ▶ GDC RH Assessment Toolkit for Conflict-Affected Women: <http://www.cdc.gov/reproductivehealth/Refugee/RefugeesProjects.htm>
- ▶ Inter-agency Working Group on Reproductive Health in Crises: <http://www.iawg.net>
- ▶ Reproductive Health Response in Crises (RHRC) Consortium: [www.rhrc.org](http://www.rhrc.org)

April 2011 © IAWG. Based on Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.

	CRISIS	POST-CRISIS
<b>SUBJECT AREA</b>	Crude mortality rate >1 death/10,000/day	Mortality returns to level of surrounding populations
<b>FAMILY PLANNING</b>	<p><b>MINIMUM (MISP) RH SERVICES</b></p> <ul style="list-style-type: none"> <li>◆ Provide contraceptives, such as condoms, pills, injectables and IUDs, to meet demand</li> <li>◆ Coordinate mechanisms to prevent sexual violence with the health and other sectors/clusters</li> <li>◆ Provide clinical care for survivors of rape</li> <li>◆ Inform community about services</li> </ul>	<p><b>COMPREHENSIVE RH SERVICES</b></p> <ul style="list-style-type: none"> <li>◆ Source and procure contraceptive supplies</li> <li>◆ Provide staff training</li> <li>◆ Establish comprehensive family planning programs</li> <li>◆ Provide community education</li> </ul>
<b>GENDER-BASED VIOLENCE</b>	<ul style="list-style-type: none"> <li>◆ Ensure availability of emergency obstetric and newborn care services</li> <li>◆ Establish 24/7 referral system for obstetric and newborn emergencies</li> <li>◆ Provide clean delivery packages to visibly pregnant women and birth attendants</li> <li>◆ Inform community about services</li> </ul>	<ul style="list-style-type: none"> <li>◆ Expand medical, psychological, social and legal care for survivors</li> <li>◆ Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital cutting.</li> <li>◆ Provide community education</li> <li>◆ Engage men and boys in GBV programming</li> </ul>
<b>MATERNAL AND NEWBORN CARE</b>	<ul style="list-style-type: none"> <li>◆ Ensure safe and rational blood transfusion practice</li> <li>◆ Ensure adherence to standard precautions</li> <li>◆ Guarantee the availability of free condoms</li> <li>◆ Provide syndromic treatment as part of routine clinical services for patients presenting for care</li> <li>◆ Provide ARV treatment for patients already taking ARVs, including for PMTCT, as soon as possible</li> </ul>	<ul style="list-style-type: none"> <li>◆ Provide antenatal care</li> <li>◆ Provide postnatal care</li> <li>◆ Train skilled attendants (midwives, nurses, doctors) in performing emergency obstetric and newborn care</li> <li>◆ Increase access to basic and emergency comprehensive emergency obstetric and newborn care</li> </ul>
<b>STIs, INCLUDING HIV, PREVENTION &amp; TREATMENT</b>	<ul style="list-style-type: none"> <li>◆ Establish comprehensive STI prevention and treatment services, including STI surveillance systems</li> <li>◆ Collaborate in establishing comprehensive HIV services as appropriate</li> <li>◆ Provide care, support and treatment for people living with HIV/AIDS</li> <li>◆ Raise awareness of prevention, care, treatment services of STIs</li> </ul>	<ul style="list-style-type: none"> <li>◆ Establish comprehensive STI prevention and treatment services, including STI surveillance systems</li> <li>◆ Collaborate in establishing comprehensive HIV services as appropriate</li> <li>◆ Provide care, support and treatment for people living with HIV/AIDS</li> <li>◆ Raise awareness of prevention, care, treatment services of STIs</li> </ul>

**How to order RH Kits:**

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 Emergency Procurement Team  
 Midtermolen 3  
 2100 Copenhagen  
 Denmark  
 Tel : +45 3546 7368 / 7000  
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[procurement@unfpa.dk](mailto:procurement@unfpa.dk)

**How to order RH Kits for Crisis Situations booklet:**

UNFPA – Contact local country offices or

220 East 42nd Street  
 New York, NY 10017 USA  
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 Fax : +1 212 297 4915  
 Email: [hru@unfpa.org](mailto:hru@unfpa.org)  
[www.rhrc.org/resources/rhkit.pdf](http://www.rhrc.org/resources/rhkit.pdf)





In the isolated, rebel-held areas of the Nuba Mountains in Southern Kordofan state, Sudan, reduced access to health services is one of many devastating consequences of six years of armed conflict between Sudanese government forces and the rebel Sudan People's Liberation Movement/Army-North (SPLM/A-North).

International law protects women's right to healthcare, including access to maternal healthcare and family planning services. However, women and girls of reproductive age in Sudan's rebel held Southern Kordofan have little or no access to contraception, adequate prenatal care, or emergency obstetric care, leaving them unable to control birth spacing and exposing them to serious health complications and sometimes death. *"No Control, No Choice"* examines how the conflict in Southern Kordofan and the obstruction of humanitarian access have affected women and girls.

Both parties to the conflict, the government of Sudan, and SPLM/A-North, have failed to agree on the modality for a sustained humanitarian effort and have obstructed efforts by humanitarian organizations to provide impartial aid.

This report calls on the government of Sudan and the SPLM/A-North to swiftly ensure that impartial aid, including essential reproductive health services, medicines, and contraception, reaches civilian populations. United Nations members should press both parties to the conflict to allow unobstructed humanitarian access, and consider investigating and sanctioning individuals who prevent such aid.

*(above) The remnants of Karkarai village in rebel-held Southern Kordofan, abandoned after it fell under the control of Sudanese army forces in 2016.*

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*(front cover) Mukuma Hamad, a volunteer health worker, holds a container of folic acid, the only assistance she can give pregnant women who visit the lone health clinic in Hadara village, in rebel-controlled Southern Kordofan.*

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