FGM IN SOUTH SUDAN: SHORT REPORT

June 2020

Key Findings and Indicators[1]

Prevalence: UNICEF has previously reported prevalence at 1% among women aged 15–49 years, but there are no recent surveys to confirm this figure*

Geography: FGM has been reported in the northern regions of the country, including in Bahr el Ghazal and Upper Nile

Age: Unknown

Type: Unknown

Agent: Unknown

Attitudes: UNICEF has previously reported that 80% of the population of South Sudan disapprove of FGM

HDI Rank: 186 out of 189 countries (2018)

Gender Index Rating: 187 out of 189 countries (2017)

Population: 15,054,653 (May 2020 est.)

Infant Mortality Rate: 63.7 deaths per 1,000 live births (2019)

Maternal Mortality Ratio: 1,150 deaths per 100,000 live births (2017)

Literacy: 34.5% of the total population aged 15 and over can read/write

**** Please note that there are no recent surveys on FGM prevalence and practice in South Sudan.***

Background

South Sudan ceded from Sudan in 2011. Prior to that it was fully integrated into the Republic of Sudan. A referendum on independence of the south was held in January 2011,[2] which resulted in a 98.8% vote in favour of independence from the north. The former president of Sudan, Omar Bashir agreed to honour the result. On 9 July 2011 independence was declared and South Sudan became the 54th African State, with Juba as its capital. It comprises ten states, which were created from three former provinces of Sudan. These ten states are further divided into 86 counties.[3]

Tensions over oil continued with Sudan following independence, as oil is South Sudan's main source of revenue. A deal on the oil was eventually reached in March 2013, with South Sudan taking three-quarters of the combined countries' output. Output fell, however, over the following years due to the continuing conflict with Sudan and only started to rise again in 2017.[4] Despite the oil revenue, South Sudan has little infrastructure: less than 2% of the population has access to electricity, and 41% lacks access to potable water.[5]

South Sudan has a young population and therefore a low median age of 18.1 years; 42% of the population is under 15 years of age and 21% is aged between 15 and 24.[6] Perhaps because of the high infant and maternal mortality rates, the average fertility rate is 7.5 children per woman.[7]

The majority of South Sudanese are Christian: 37.2% are Roman Catholic, and 36.5% are Episcopalian or other forms of Christianity. 19.7% follow traditional African and animist beliefs, and 6.2% are Muslims.[8]

South Sudan is home to around 60 indigenous ethnic groups and 80 languages or dialects (English is the official language). A significant majority of the population belongs to either the Dinka (35.8%) or the Nuer (15.6%) ethnic groups.[9]

The Role of Women in Society

Although various laws in South Sudan have attempted to protect women's and girls' rights, including addressing harmful customs and ensuring the right to own and inherit land and property, in reality women remain unprotected by laws, and inequality persists. Women often lack an awareness of their rights (due to educational disadvantages and poor literacy), and there are social and economic barriers to accessing legal services, as well as social norms that underpin the position of women in patriarchal societies.

The legal age of marriage is 18 years, yet 52% of girls in South Sudan are married by the age of 18 and 9% by the age of 15.[10]

Physical violence and sexual harassment are widespread problems for women in South Sudan. United Nations Human Rights Office of the High Commissioner describes such abuses as 'endemic'.[11] Domestic violence and forced marriage against women and girls are also common. It has been claimed that women in South Sudan have experienced sexual violence at twice the level of the global rate, largely as a result of the ongoing conflicts, displacement and living in camps.[12]

Since South Sudan's independence in 2011, five out of 29 government ministerial positions, and ten out of 28 deputy ministerial positions have been occupied by women.[13]

Women's Health

Women's access to adequate healthcare in South Sudan is severely limited due to ongoing conflict in the country. More than half of primary care facilities are no longer functional.[14] Lack of infrastructure and resources, shortage of qualified health workers and poor supply chains and drug availability severely limit the delivery of a sustainable health service.[15] There are only a few hospitals outside state capitals.

This, alongside shortages of skilled birth attendants, means both child mortality and maternal mortality rates are among the highest in the world; the maternal mortality rate in South Sudan was an estimated 1,150 per 100,000 in 2017. According to the South Sudan Household Health Survey of 2010,[16] the under-five mortality rate was 108 deaths per 1,000 live births and the infant mortality rate was 79 deaths per 1,000 live births. 55% of the infant mortality rate is classified as 'neonatal', meaning that these deaths occur during the first 28 days of a child's life.

The fertility rate in South Sudan is 7.5 children per woman, with lower rates among educated women (5.3) and those in the richest quintile (6.9).[17] 31% of women begin childbearing by the age of 19.[18] A 2017 report states that there are 'cultural expectations for women to begin reproducing at a young age' in South Sudan.[19] According to the Household Health Survey 2010, in South Sudan, only 4% of women who are married or in a union use any form of contraception; 26% of women aged 15–49 have an unmet need for contraception.[20]

While it is recommended that a woman receive a minimum of four antenatal visits during her pregnancy, in the two years preceding the Household Health Survey,[21] only 40% of women aged 15–49 who had given birth in this period had received at least one antenatal care visit by a skilled health professional, only 17% had received four or more visits, and 54% of women received no visits at all. Only around 19% of women aged 15–49 who had given birth in the two years prior to the survey were assisted by skilled personnel during the delivery, and 12% of women gave birth in health facilities.

The combination of early childbirth (26% of girls aged 15–19 have already given birth and a further 5% are pregnant), poor access to healthcare facilities and limited skilled care leaves many girls and women in South Sudan vulnerable to obstetric fistula.[22]

Approximately 85% of the two million internally-displaced persons *(IDPs*) in South Sudan are women and children, and around 280,000 of these are pregnant women. The United Nations Population Fund has provided reproductive and maternal health services to this population since 2013.[23]

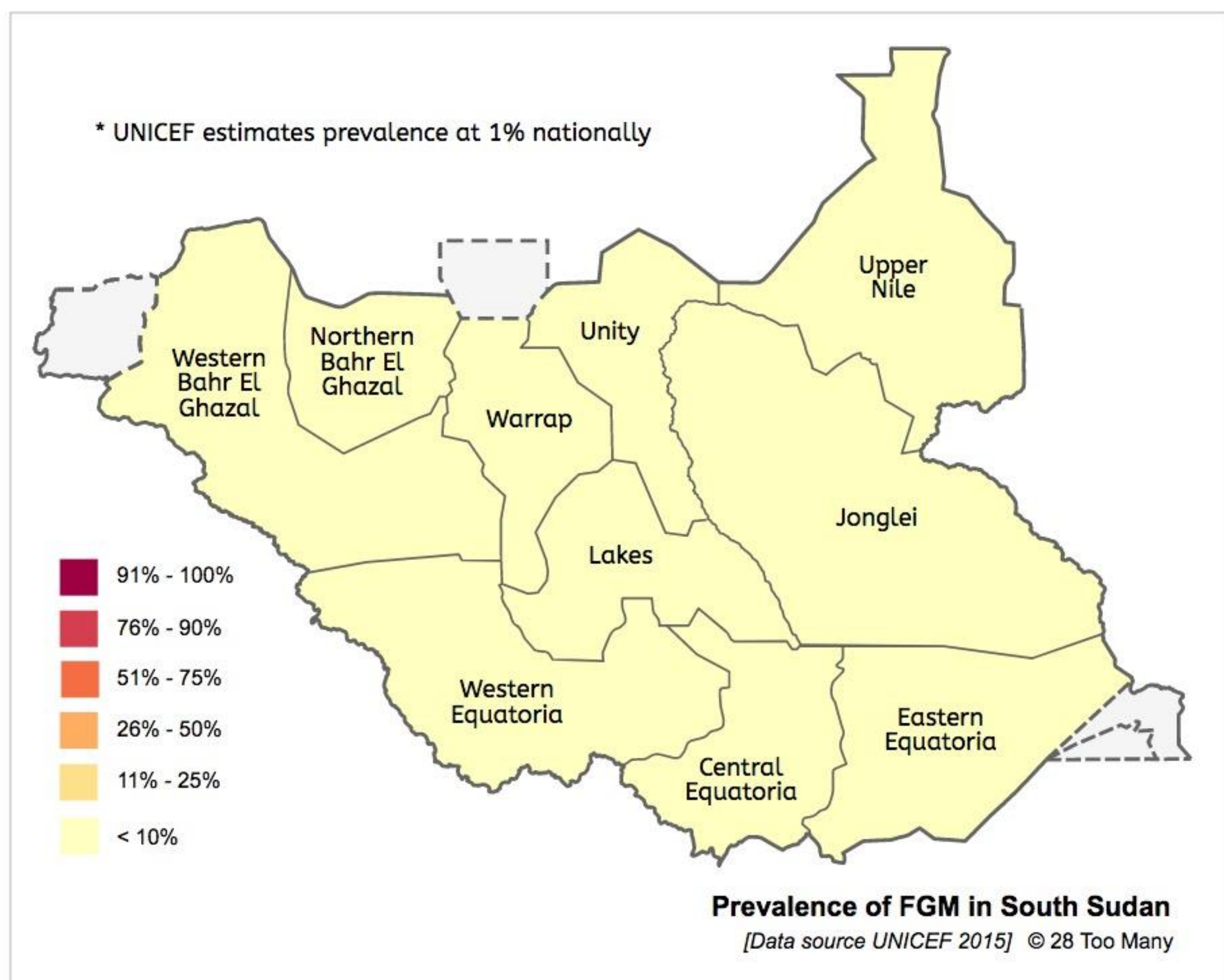
The Government of South Sudan is trying to address health challenges through various initiatives and aims in the South Sudan National Health Policy 2016–2025.[24] These include 'reduction of maternal and neonatal mortalities and morbidities through effective delivery of maternal, sexual and reproductive health services and rights with particular attention to vulnerable population groups.'[25]

Prevalence of FGM

In 2015 the United Nations Population Fund estimated that almost 32,000 women in South Sudan had been affected by gender-based violence in the two years since conflict broke out.[26] As well as victims of sexual and physical violence, victims of FGM and child marriage were included in this estimate.

UNICEF previously reported the prevalence of FGM in South Sudan to be 1% among women aged 15–49, but there are no recent surveys to confirm this figure.[27]

FGM has been reported in both Christian and Muslim communities, particularly in the northern regions of the country, including Bahr el Ghazal and Upper Nile, both of which border Sudan, where the prevalence of FGM is 86.6%. These are also the regions where camps for displaced Sudanese are located, and it is therefore likely that this accounts for the higher prevalence in these regions.



A 2014 study by the Danish Refugee Council looked at FGM in refugee populations in Maban County and Upper Nile.[28] The purpose of the study was to look at FGM across four IDP camps, including differences in practice between ethnic groups, reasons for the practice of FGM, knowledge of the practice and attitudes towards it.

The IDP camps studied were:

- **Doro**, which at the time of the study hosted the largest number of ethnic groups of all the camps in the county. They can be roughly divided into Uduk communities, which are majority Christian, and other smaller groups, which are majority Muslim. There is a diversity in prevalences and attitudes in relation to FGM because of the large number of ethnic groups.
- **Batil**, which comprises mainly Ingassana people and some other minority groups. The inhabitants of this camp are largely Muslim. Education levels in this camp are lower than in Doro, and Batil had little exposure to health or awareness-raising campaigns.
- **Kaya** and **Gendrassa** have similar characteristics to Batil, as they host the same ethnic groups.[29]

Data was collected from interviews and focus-group discussions. There was a large variation in responses depending on interviewees' ethnic groups, their levels of awareness of FGM and other dynamics within their communities. Key findings included the following:

- Reasons for the practice of FGM mainly revolve around health issues or tradition. Women also mentioned that FGM was necessary for marriage.[30]
- Some religious leaders interviewed in the camps stated that FGM is not a Muslim tradition or directed by the Koran.[31]
- Some respondents mentioned that, while infibulation (Type 3 FGM) has previously been more common, it is now practised less, and 'sunna' is becoming more common.[32] This is in line with some other studies in Sudan.[33]
- Some respondents stated that FGM is becoming a hidden practice within communities, carried out in secret.[34]
- There has been a decline in the practice among some ethnic groups due to greater levels of awareness about associated health complications.[35] This was less so in the camps with larger Muslim populations.
- There are disparities between the level of knowledge of FGM among men and women. Some men interviewed did not know the types of FGM practised in their communities, although they were aware of it taking place. In some instances, men were vague about the reasons for performing FGM.
- In the Batil camp, all the men who were asked supported the continuation of FGM as they considered it to be a good practice.[36] Some of the women interviewed were reluctant to voice their views on the continuation of FGM, although others stated health reasons and complications as reasons to stop it. Religious reasons were also cited in some instances as a reason for continuing the practice.[37]

Overall, it is difficult to make definitive conclusions about the prevalence of FGM in South Sudan because of the very limited availability of data. While studies such as the one undertaken by the Danish Refugee Council provide some useful insights on beliefs about and attitudes towards FGM, more research is needed to further understand prevalence and attitudes among women and men.

Cross-Border FGM

In some countries where FGM has become illegal, the practice has been pushed underground and across borders to avoid prosecution. South Sudan shares borders with other countries where the prevalence of FGM and the existence and enforcement of anti-FGM laws vary, including Ethiopia, Kenya, Sudan, Central African Republic and Uganda.

It is not known to what extent movement across national borders for FGM is an issue for South Sudan.

Medicalised FGM

There is no recent data on whether medicalised FGM takes place in South Sudan.

Anti-FGM Legislation

South Sudan gained independence in 2011, having been subject to the jurisdiction of Sudan, the legal system of which is based on a mix of Islamic and English law. Under the **Transitional Constitution of the Republic of South Sudan (2011)**,[38] laws that applied in the ten states of Southern Sudan before it separated from Sudan are still in force. In South Sudan, both the **Penal Code Act 2008**[39] and the **Child Act 2008**[40] criminalise FGM and, therefore, remain in force as per the Transitional Constitution.

The Child Act gives a comprehensive definition of FGM and criminalises all forms of FGM performed on children under the age of 18. The Penal Code does not specifically define FGM, but under Section 259 criminalises the practice and punishes anyone who 'makes or causes a Female Genital Mutilation to be performed' (at any age). It is not known to what extent the laws against FGM under the Child Act or Penal Code have been used in South Sudan. There is an absence of information on any cases brought to court and their outcomes.

Additionally, in 2016 the East Africa Community (including Kenya, South Sudan, Tanzania and Uganda) enacted the **East African Community Prohibition of Female Genital Mutilation Act** (the *EAC Act*)[41] to promote cooperation in the prosecution of perpetrators of FGM through the harmonisation of laws, policies and strategies to end FGM across the region. The EAC Act aims to raise awareness about the dangers of FGM and provide for the sharing of information, research and data.

For further information, see 28 Too Many's report **South Sudan: The Law and FGM**.

Work to End FGM

The Ministry of Gender, Child and Social Welfare[42] is responsible for the promotion of gender equality and the protection and welfare of women and children in South Sudan. Within the Directorates of Gender and of Child Welfare there are ranges of policies and programmes to tackle gender-based violence and to support women and girls' empowerment. Although a specific government strategy to end FGM has not been identified, as a harmful practice, FGM is currently addressed through the overall approach to cultural and religious practices that are harmful to women and girls, and the **National Action Plan 2015–2020**[43] sets out measures such as conducting research to inform community sensitisation campaigns.

In the absence of publicly available information specifically on government and non-governmental organisation (*NGO*) work to end FGM in South Sudan, limited studies such as the one in 2014 by the **Danish Refugee Council** (see above) suggest that some health and awareness-raising activities in relation to FGM have taken place in IDP camps in the north of the country.

The Directorate of Public Prosecution and the **South Sudan Police Service** are responsible for upholding the national law against FGM, and the **United Nations Mission in South Sudan**[44] runs programmes to address harmful practices, including child and forced marriage and FGM.

While there are laws in place criminalising FGM in South Sudan, there are challenges to enforcing the legislation. Civil society has urged national and regional governments to bring perpetrators to justice and communities to abandon harmful practices. However, as many of those reportedly still practising FGM are IDPs residing in UN refugee camps, there are challenges in terms of raising awareness, fully engaging communities, and thus avoiding the practice being driven underground and performed in secret.

Although many of the country's health services are dependent on support from local and international NGOs, South Sudan remains one of the most dangerous countries for aid workers.[45] Likely as a result, the number of organisations working in healthcare declined from 100 in 2016 to around 40 by mid-2018.

Further research is needed on current FGM practices and prevalence to inform and efficiently target programmes in future and to fully understand the impact of efforts to end the practice in South Sudan.

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Cover image: punghi (2014) *South Sudanese children watch their mother cook in a refugee camp.* Shutterstock ID 287374577.

Please note that the use of a photograph of any girl or woman in this report does not imply that she has, nor has not, undergone FGM.

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