

CICRED'SEMINAR S

Fundamentalism and poverty :  
health reproductive on Implications

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## ***"Fundamentalism and Poverty: Implications on Reproductive Health"***

*A paper presented by*  
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## **Executive Summary**

Sudan is a war torn multi ethnic and multi cultural country with a population of 3 millions (2002 estimate). This paper attempt to discuss the interlinks between polices stemming from fundamentalism, come to power with the 1989

### ***Health***

According to 1999 data of the Ministry of Health (1996) expenditure on health as a proportion of GDP decline from 0.5 percent in 1986/87 to 0.1 percent in 1993/94. Data from the Ministry of Health show that access to health declined measured by the number of hospitals, hospital beds, primary health care units and health centers per 100,000 people. More recent data confirm that primary health care facilities and rural hospitals are poorly staffed and lack essential medical equipment. The high population growth rate 3.8% (1983-1993 intercensal rate) The prevalence rate is 23 percent in the north and 37 percent in the urban centers under Government control in the south, in the Red sea and northern States it is less than 12 percent and 46 percent in the Blue Nile State. It is estimated that 65 percent of all children under the age of five who consult health facilities have malaria.

The Blue Nile State shows the highest rate at 40 percent. The national prevalence rate of malnutrition in Sudan is quite significant and rose from 18 percent in 1995 to 23 percent in 1999 (with 19 percent in northern states and 17 percent in juba, Malkal and Wau). The situation is more serious in southern Sudan, where the level is 28 percent of which about 15 percent have severe malnutrition. MICS 2000 data show that 30 percent of all newborn babies were of low birth weight indicating low status of mothers.

Poverty as a cause taking low quality of food and inadequate knowledge of nutrition

high physical vulnerability (due to low vaccination coverage and poor access to and poor availability of good health facilities)

poor access to safe water and sanitation services

The national goiter rate is 22 percent. Vitamin A deficiency is a serious health problem that contributes significantly to high mortality rates. According to MICS data, Vitamin A deficiency rates are highest in West and South Darfur, Malakal and West Kordofan.

### ***Reproductive Health***

Population growth in Sudan is estimated at 2.6 percent per year and is higher in rural areas than in urban areas where education and access to basic social services is better. Patterns and age of marriage contraceptive practice or population age structure do not support a much lower level of fertility in rural areas. The high population growth and apparently stagnant or slightly decreasing fertility rates

have to be seen in conjunction with the increasing poverty, low level of education, high IMR and malnutrition.

The level of knowledge and practice of family planning among married women seems to have played a minor role in fertility rates. Sudan Demographic and health survey (SDHS) 1989-90, which Enquire about this knowledge more than ten years ago, found that 71 percent of women knew of at least one modern family planning method and 39 percent of them use at least one traditional method.

	SMS 1999	SDHS	
<b>Any method</b>	54.1	60.8	71.4
Condom	8.4	13.6	17.8
Female sterilization	11.1	20.0	44.1
<b>Any traditional method</b>	16.4	25.3	38.7
Other methods	1.3	2.0	4.1
Number of women	14836	14836	5400

Eighty- two percent of women from urban areas know at least one method of modern contraception, with 49 percent in rural areas. Earlier health surveys show that knowledge of any family planning methods among the youth is relatively high, with 98 percent of youth in urban areas and 91 percent in rural areas. Availability of contraceptives is poor. Major public outlets for procuring family planning methods are health centers, family planning clinics, Government hospitals and maternal and child health centers while users in rural areas seem to rely more on private agencies than those in urban areas. Safe motherhood practices contribute directly to a reduction in maternal morbidity levels. In all, 71 percent of births received antenatal care (90 percent in urban against 62 percent in rural areas). The breakdown of antenatal care based on professional level of carer is; doctor (32 percent), health visitors (26 percent), village midwives (23 percent) and trained traditional birth attendants, TBAs (17 percent). In Northern Sudan, 86 percent of births were delivered at home, only 12 percent of births were delivered in Government hospitals and one percent of births were delivered in private hospitals. Even in urban areas, institutional births account for only 30 percent of deliveries.

The SMS data show that a midwife (44 percent), a TBA (31 percent), a doctor (6 percent) or health visitor and trained functionaries (10 percent) attended births. Doctors, health visitors and other health functionaries attended less than one-third of deliveries in urban areas.

Sudan is the second lowest ranked Arab country on HDI, just above Mauritania and below Djibouti. Amongst African countries it ranked 25 th out of 49 countries. According to available data Sudan ranked 58 th out of 90 countries in the new index of Human Poverty in developing Countries.

### *Face of poverty*

Below state level there are important disparities such as the urban-rural divide of Red Sea State. Women are more acutely affected by poverty than men in Sudan are and this is clearly shown by the data. There are 43.4 percent literate women against 68 percent literate men; women have less than one third of men's income; one in five women is unemployed as opposed to one in eight men. In addition, Sudan is marred by one of the highest maternal mortality rates in the world of 509 maternal deaths per 100.000 births; and 89 percent of women undergo FGM. The 1993 census showed that 22.3 percent of all households in northern states were female headed. A conservative policy of fundamentalism also cuts the rates of women participation in the informal sector.

Reproductive health is targeted in all its basic policy trends. Poor women, poverty being limited options in front of human and material development, consider their children, a tool made by themselves to erase their poverty. The later were 62% of women.

So one can infer that the fundamentalist policy of women stay home is the most forcing hidden derive behind such decision of curtailing the women right to work, the women right to access to health services and reproductive services in particular.

3- An expansion in the reproductive health services, especially for urban poor must be given to women CBOs themselves.

# **"Fundamentalism and poverty: implications on reproductive health"**

## **1. BACKGROUND**

### ***1.1. Geography:***

Sudan is the largest country in Africa its size is about 2.5 million square kilometers, in the North western side, of Africa between longitudes 21o 7o' East and 38o 5o' its width from North to South is about 2100 kms and its breadth is 1800 kms from West to East at the broadest parts. It neighbors nine countries namely, Egypt, Libya, Chad, Central Africa, Congo, Uganda, Kenya, Ethiopia and Eritrea.

The major climatic and vegetation regimes from north to south are the deserts, semi desert, Savana belt and Equatoria Forests.

The River Nile and its tributaries, The White Nile, The Blue Nile, The Atbara River, The Sobat , Bahr El Arab, The Dindir and Rahad, represent the permanent sources of fresh water. The rains in the country fluctuate from as low as, 1 mm in the extreme north to 1000 - 15000 mm in the south.

Sudan is an agricultural country and this sector provides the people with the staple food and foreign currency earning products. 80% of the labour force is involved in this sector. Agriculture utilizes only 13% of land possible to cultivate which is estimated at 200 million feddans.

This sector found a quick expansion during the 1991/92 (31,0% of the GDP) and in 1992/93 it was 27,1% of the GDP.

### ***1.2. Population: Ethnicity, Religions and Culture:***

Sudan is a multi ethnic and multi cultural country. This ethnic diversity is a source of conflict because it is accompanied by a low process of development. About 597 tribes inhabit the country and it is divided into three main categories. The Arabic- speaking tribes, the bilingual and the non Arabic speaking. The Arabic speaking dwell the northern part of the country with some pockets in the extreme north of bilingual tribes (in the extreme north, east and west). Most of these bilingual groups share with the Arabic speaking tribes the belief in Islamic religion. The Centre of the country represents the dominant ruling caste culture of the Arabic speaking and Muslim groups.

In the South, The predominantly composed of animist tribes represent most of the groups designated as the Nilotics, the Congo basin and the Absysinian plateau foot-tribes .

Arabic language is the lingue Franca. The West African Muslim migrants moving into Sudan since the 17<sup>th</sup> century, as a stage in their pilgrimage route. This became an exodus since 1925. By the establishment of the Gezira Scheme, when

cotton picking became added incentive which have influenced the ethnic and cultural composition. By their maliki Muslim sect they have the potential to invigorate the fundamentalist attitude. This type of immigration have provided the grass roots support for fundamentalism. Another emigration type was that to the oil producing countries by the educated elites who have provided the rank and file for fundamentalists leadership. These two elements completed their cycle to become a political support base for the 1989 military coup. Most of the traditional Islamic traits in the country are from the sufi sects. Two major diaties; the Ansar and the Khatmiyya, representing the small holder tenants in the North and the herders in the East and West. The country is arrested in a civil war that ravaged since 1983. The 1989, fundamentalist government installed by a military coup, had added fuel to the fire.

### ***1.3. The ugly face of Fundamentalism:***

The intolerant and dogmatic interpretation of religion represents the essence of fundamentalism. When it comes to rights the fundamentalist does not think that rights are any thing but what he/she thinks and allow others. When it comes to women rights in general and reproductive rights in particular the conflict is intractable. The only standard method to apply this unitary viewpoint whether in politics or oppressing women reproductive rights is terrorism. In politics all violent methods to submit the "Fao" to the will of the dogma. The 11<sup>th</sup> September twin towers incident was what appeared from the Ice burg of fundamentalism. In confrontation of women rights only the right to get children as a well of "god".She is not allowed to space by modern means or resent mortal violence nor have the right to end this misery when her husband multiply wives. She will enjoy power and influence only when she is a sociological male who share with them the coercion of the rest of women.

## **2. Poverty global social development indicators**

Human poverty cannot be reduced to economic figures but needs to take into account other factors as well such as IMR, life expectancy, nutritional status, literacy levels, employment opportunities and other socio-political conditions. Some key social indicators and international development goals for poverty reduction were endorsed by the UN Millennium Summit in 2000. In order to offset the weak information base and lack of reliable commonly accepted data of the country, the government, with UNFPA, carried out the Safe Motherhood Survey (SMS) and, with UNICEF, the Multiple Indicator Cluster Survey (MICS). These surveys provide important 1999 and 2000 social data of Sudan, which have been officially endorsed by the Government. According to these data and the draft Poverty Reduction Strategy Paper (PRSP), the following table could be compiled



<b>Global targets</b>	<b>National targets</b>	<b>Current levels</b>
Halves proportion of poor by 2015	Reduce percentage below national poverty line (sufficiency) from the current level of 50% to 25% by 2015	No reliable figure available since 1978, when 54% fell below national poverty line
Reduce chronically undernourished by 2015	Not defined	22.3% (1999)
Reduce IMR by one third of 1990 level and below 35/1000 by 2015	Reduce from 108 to 45 by 2002	66 (2000)
Universal access to safe contraceptive methods	30% access to contraception by 2002	10% (1999)
Reduce maternal mortality by 50 percent of 1990 level by 2015	Reduce from 600 to 22/10.000 by 2002	509 (2000)
Increase percentage of deliveries attended by skilled personnel to 85 percent by 2006	Not defined	54%
Skilled reproductive health care providers at ratio of 1:3.000 by the year 2006	Not defined	1:3,000 (SMS)
Universal access and competition of primary school by 2015	Make primary education accessible to 100% of eligible children by 2015	48% (2000)
Reduction of adult illiteracy to at least half of its 1990 level	Reduce adult (over 15) illiteracy rate 25% by 2005	43% & (1999) 47% (1993)
Universal access to safe water by 2015	Achieve 100% access to safe water in both rural and urban areas by 2010	47% (rural), 79% (urban)

### **3.Human Development Indicators**

According to the 2001 UNDP Human Development report (HDR) which uses data from 1999, Sudan is ranked 138 th out of the 162 on its Human Development Index (HDI). This puts it within the brackets of low human development countries though near to the top of that grouping. Sudan is the second lowest ranked Arab country on HDI, just above Mauritania and below Djibouti. Amongst African countries it ranked 25 th out of 49 countries. The HDR makes an adjustment for gender sensitive data and on this Gender related Development Index (GDI) Sudan ranks 129 th out of the 146 countries based on data available. According to available data Sudan ranked 58 th out of 90 countries in the new index of Human Poverty in developing Countries.

## Main Human Development indicators 1997 and 1999

Human Development indicator	Female %	Male %	Average %
Life Expectancy at Birth (years) 1999	57.0	54.2	55.6
Adult literacy Rate (percent) 1999	44.9	68.9	56.9
Educational enrolment ratio 1999	31	36	34
Real GDP per Capita (PPPS) 1999	308	1016	664
<b>Gender Empowerment Measures</b>			
State in parliament (percent) 1999	9.7	90.3	
Administration and managers (percent) 1997	2.4	97.6	
Professional and technical workers (percent) 1997	28.8	71.2	

Source: Human Development Report 1999 and 2001

### **4. Face of poverty**

The SMS and MICS data show that within the national context, there is a range of regional, sub-regional and crosscutting differentials in poverty among people. The Southern States and the States of Blue Nile, South Kordofan and South and West Darfur are the worst off according to an array of indicators. Below state level there are important disparities such as the urban-rural divide of Red Sea State. The poorest and most vulnerable groups of the population are the poor rural communities, war-affected and displaced populations including the mobile pastoralists, who cut across geographic boundaries and among those the children and the women in particular.

Women are more acutely affected by poverty than men in Sudan and this is clearly shown by the data. There are 43.4 percent literate women against 68 percent literate men; women have less than one third of men's income; one in five women is unemployed as opposed to one in eight men. In addition, Sudan is marred by one of the highest maternal mortality rates in the world of 509 maternal deaths per 100,000 births; and 89 percent of women undergo FGM. The 1993 census showed that 22.3 percent of all households in northern states were female headed. This percentage is even higher for urban centers in the south. A major survey by Save the Children /Denmark amongst the displaced in Khartoum in 1998-99 showed that 34 percent of households were female headed. Some of these are formed after girls and young women become pregnant, are abandoned by men and confronted with disapproval and censure by their elders. It is likely that as a result of the heavy displacement and the conflicts, the proportion of southern households headed by females is at least of this order. With pronounced double burdens of productive and reproductive responsibility falling on the women, these households are amongst the poorest in Sudan. A conservative policy of fundamentalism also cuts the rates of women participation in the informal sector.

## **5. Health**

### ***5.1 Current status***

According to 1999 data of the Ministry of Health (1996) expenditure on health as a proportion of GDP decline from 0.5 percent in 1986/87 to 0.1 percent in 1993/94. Data from the Ministry of Health show that access to health declined measured by the number of hospitals, hospital beds, primary health care units and health centers per 100,000 people. There are, however, large disparities between relatively better off states (such as Khartoum) and worse off states (such as West Darfur and Bahr El Ghazal).

The regional skewing of the distribution of health workers is even more pronounced than that of facilities, with Darfur and the 'Kordofans' being worst off. The majority of the health personnel are concentrated in the urban areas, particularly in the capital city and other big cities, to the detriment of rural areas. More recent data confirm that primary health care facilities and rural hospitals are poorly staffed and lack essential medical equipment. The medical doctor to population ratio ranges from one specialist for every 5,000 people in Gazira State, to one for every 700,000 in West Darfur State. The Pattern is similar for other medical staff. Hospital beds per population in West Darfur amount to one per 7,000 against one per 400 in the Northern State.

The increased investment in higher education for the health sector has not led to the desired increase in the total number of general practitioners. Inadequate remuneration and incentives is the primary cause for 90 percent of an estimated 800 medical graduates annually, to seek employment overseas, especially in the neighboring gulf-states. In rebel held region, they are under-equipped and ill prepared for the provision of quality health care. The disintegration of the health system, often due to the destruction of health facilities, has curtailed the provision of basic medical services to these war- affected communities.

As a result of the poor access to and quality of health facilities, malaria, diarrhoeal disease and acute respiratory infections (ARI) are widespread and head the list of endemic diseases, accounting for 70 percent of all hospital admissions. Poor sanitation, unsafe water, and over- crowded and poorly ventilated living conditions are also contributing factors. The level of education is generally regarded as one of the prime determinants of maternal and child health. The high population growth rate 3.8% (1983-1993 intercensal rate)

The prevalence rate is 23 percent in the north and 37 percent in the urban centers under Government control in the south, in the Red Sea and northern States it is less than 12 percent and 46 percent in the Blue Nile State. It is estimated that 65 percent of all children under the age of five who consult health facilities have malaria.

The prevalence rate nationally for diarrhea related illness is 28 percent among children under five years old. The Blue Nile State shows the highest rate at 40 percent. According to WHO up to 40 percent of deaths in children under the age of five years in least Developed Countries (LDCs) are caused by diarrhea. Only 25 percent of diarrheal cases are treated with Oral Rehydration Solution (ORS).

Multi indicator cluster survey (MICS) is done by the National Beareua of Statistic & (NBS) and UNICEF.

The MICS 2000 Survey showed an ARI prevalence rate of 17 percent during the two-week period preceding the survey and the case fatality rate of ARI of 3.6 percent makes it the third major contributing factor to the high IMR and U5MR. Immunization coverage 2000

<b>DPT3</b>	<b>OPV3</b>	<b>Measles</b>	<b>BCG</b>	<b>TT2+</b>
65.4%	65.4%	60.5%	66.3%	34.5%

## **5.2 Nutrition**

In relation to nutrition, the Government's four - year 1999-2002 health strategy aims to reduce severe and moderate malnutrition among children of five years and less by 12 percent and to eliminate iodine deficiency disorders, vitamin A and iron deficiency by 2001

The national prevalence rate of malnutrition in Sudan is quite significant and rose from 18 percent in 1995 to 23 percent in 1999 (with 19 percent in northern states and 17 percent in juba, Malkal and Wau). The situation is more serious in southern Sudan, where the level is 28 percent of which about 15 percent have severe malnutrition. In the SPLM/A controlled areas, moderate to severe malnutrition rates seem to have dropped from 25 percent in 1998 to 7 percent in 1999. The moderate level of aggregate per capita food in-take provides less than their minimum energy requirements. Furthermore, low birth weight is common. MICS 2000 data show that 30 percent of all newborn babies were of low birth weight indicating low status of mothers.

Emergency situations can lead to a dramatic rise in malnutrition. however, is not only caused by low food intake (due to drought, displacement and lack of food security) but also by:

- Poverty as a cause taking low quality of food and inadequate knowledge of nutrition •

- high physical vulnerability (due to low vaccination coverage and poor access to and poor availability of good health facilities) •

- poor access to safe water and sanitation services •

The restricted access to pasture for cattle, often accompanying the displaced, affects milk production, which is in many cases the main source of food . the 1-2year age group is most at risk . Recurring drought and associated food shortages and emergency conditions in western Sudan have over the two decades increased the incidence of stunting.

Low adherence to exclusive breast feeding for the first three months (only 20 percent) early introduction of supplementary feeding and inappropriate complementary feeding, both of low nutritional value, lead to poor nutritional status among infants. These practices also suppress breast milk production and introduce organisms causing diarrhoeal diseases further lowering the nutritional status.

. Since more than 80 percent of all deliveries occur at home there is a need to redesign strategies for dealing with the nutritional status of infants, e.g. a community - based strategy.

Micro - nutrient deficiency is particularly worrying in Sudan. Iodine deficiency is a serious public health problem leading to mental retardation, goiter and lower resistance against infection. The national goiter rate is 22 percent. A 1997 survey in seven states in northern Sudan showed a range in goiter of between 5- 42 percent, with the problem being most serious in the Darfur Region. Major challenges stand in Port Sudan and Nyala producing iodized salt face difficulties in sustaining continuous production, resulting on negligible levels of household consumption.

Vitamin A deficiency is a serious health problem that contributes significantly to high mortality rates. According to WHO, Vitamin A deficiency can increase mortality rates by up to 30 percent. According to MICS data, Vitamin A deficiency rates are highest in West and South Darfur, Malakal and West Kordofan.

### ***5.3 Reproductive Health***

The International Conference on population and Development in 1994 (ICPD), recognized that effects to slow down population growth, eliminate gender inequality, reduce poverty, achieve economic growth, and protect the environment are mutually reinforcing. Population growth in Sudan is estimated at 2.6 percent per year (1993 census rate) and is higher in rural areas than in urban areas where education and access to basic social services is better. According to the 1999 Safe Motherhood survey (SMS), undertaken by UNFPA, NBS, and ministry of health fertility rates average 5.9 (6.5 in rural areas and 5.1 in urban areas) Earlier surveys (Sudan fertility survey 1979) indicate that overall fertility rates have decreased .This can only be validated by the SMS in the case of urban residences where greater use of contraception and older age at marriage have relatively lowered fertility rates. Apart from the rural - urban dimension, fertility rates show considerable variation according to level of education, age of marriage and standard of living. Education was found to cause the most striking difference in fertility.

Age of marriage and contraceptive practice or population age structure do not support a much lower level of fertility in rural areas. The high population growth and apparently stagnant or slightly decreasing fertility rates have to be seen in conjunction with the increasing poverty, low level of education, high IMR and malnutrition.

The level of knowledge and practice of family planning among married women seems to have played a minor role in fertility rates. SMS data show that the level of knowledge is either stagnant, or declining with time. Sudan Demographic and health survey (SDHS 1989-90,) which enquire about this knowledge more than ten years ago, found that 71 percent of women knew of at least one modern family planning method and 39 percent of them use at least one traditional method. The knowledge of all methods has shown a decline, as shown by the

following table, but the fall has been largest for female sterilization, from 44 to 20 percent.

Percentage of currently married women age 15-49 who know a specific method of family planning, before and after prob, SMS 1999 and SDHS, 1989-90, Northern Sudan

Method of contraception	SMS 1999		SDHS 1989-90*
	Before Probe	After Probe	
<b>Any method</b>	54.1	60.8	71.4
<b>Any modern method</b>	53.7	60.3	70.4
Pill	52.8	59.6	69.9
IUD	28.5	35.6	39.0
Injection	30.0	37.3	45.6
Jelly/Diaphragm	6.7	9.9	7.8
Condom	8.4	13.6	17.8
Female sterilization	11.1	20.0	44.1
Male sterilization	3.8	5.6	5.1
<b>Any traditional method</b>	16.4	25.3	38.7
Periodic abstinence	15.5	24.4	36.0
Withdrawal	6.7	11.1	19.3
Other methods	1.3	2.0	4.1
Number of women	14836	14836	5400

\*Apparently, after prob

Depth of knowledge of contraception is determined by socio-economic factors. Eighty-two percent of women from urban areas know at least one method of modern contraception, with 49 percent in rural areas. Rates differ considerably with level of education, exposure to the media and standard of living. Earlier health surveys show that knowledge of any family planning methods among the youth is relatively high, with 98 percent of youth in urban areas and 91 percent in rural areas. Despite the fact that knowledge about family planning is prevalent among the youth, the actual use of family planning is extremely low. According to data from the safe Motherhood Survey, the average use of contraceptives is very low with 7 percent of respondents using any kind of family planning method or intending to use any during the next 12 months (15 percent in urban areas compared with 3 percent in rural areas). Availability of contraceptives is poor. Major public outlets for procuring family planning methods are health centers, family planning clinics, Government hospitals and maternal and child health centers while users in rural areas seem to rely more on private agencies than those in urban areas. Low availability of contraceptives and cultural barriers are the main causes for low contraceptive use. Fundamentalism is added to these historical hurdles.

Maternal care involves addressing the problems faced by women during pregnancy, during and soon after delivery. Obstetric complications, stemming

from lack of proper care during pregnancy also influenced death or long-term morbidity among women. Safe motherhood practices contribute directly to a reduction in maternal morbidity levels. The reproductive health status has been adversely influenced by certain traditional practices such as female circumcision is frequently associated with obstetric and gynaecological consequences and therefore, under the Safe Motherhood Initiative, all pregnant women are supposed to receive basic but professional antenatal care (ANC).

Antenatal care refers to pregnancy-related health care provided by a doctor, or a health visitor, or other qualified personnel. In all, 71 percent of births received antenatal care (90 percent in urban against 62 percent in rural areas). The breakdown of antenatal care based on professional level of carer is; doctor (32 percent), health visitors (26 percent), village midwives (23 percent) and trained traditional birth attendants, TBAs (17 percent). The socio-economic differentials in utilization of ANC are quite large and can be explained by rural-urban residence, education and standard of living. The SMS data also show that women belonging to higher socio-economic strata received quantitatively and qualitatively better antenatal care (qualified doctor, private clinic, and more frequent antenatal check-ups).

A top priority for maternal care is to ensure that deliveries are safe and clean. The majority of maternal deaths and much of the chronic morbidity resulting from childbirth are due to the failure to get timely help for complications at delivery. In Northern Sudan, 86 percent of births was delivered at home, only 12 percent of births were delivered in Government hospitals and one percent of births was delivered in private hospitals. Even in urban areas, institutional births account for only 30 percent of deliveries.

The SMS data show that a midwife (44 percent), a TBA (31 percent), a doctor (6 percent) or health visitor and trained functionaries (10 percent) attended births. Even in urban areas, women mainly rely on midwives and TBAs for assistance during delivery. Doctors, health visitors and other health functionaries attended less than one-third of deliveries in urban areas. In 14 percent of deliveries, relatives (especially mother's i.e. grand mother of the child) were the only birth attendants. In the SPLM/A controlled areas, a trained person assists only 22 percent of deliveries and only 6 percent of births take place at a health facility. Birth complications and low knowledge of reproductive health are two of the causes of the maternal mortality rate (MMR), which, according to the SMS, is around 509 per 100,000 births (514 in rural against 496 in urban areas). It is one of the highest in North Africa. A recent study by the National Population Council among squatter settlements in Khartoum even estimated MMR to be as high as 850.

#### **5.4. Case study: The reproductive rights between two Worlds**

##### ***The reproductive rights between two Worlds***

*Apok is a Dinka woman from southern Sudan. Due to the war in the south she was compelled to move out of the war zone. In a multilayer trek she and her husband reached Khartoum six years ago. She has four children. She is now pregnant while her last child is only one year. According to Dinka culture, in their homeland, women practice abstinence for two years for lactation. When she discovered that she is pregnant she was quite irritated and started to ask her neighbors about how she can get rid of this. All of them has told her no way as the traditional Islamic/ Christian and animist cultures abhors abortion. When I asked her why she is not conscious to avoid pregnancy. She blamed the new environment that changed men. She said men there at their home land are helpful by not being demanding for sex here he threatens to abandon her and she can not afford to bring up her children in the very expensive environment of Khartoum. There at home many of her female neighbors would have helped her with her husband's sexual needs. The culture will accept those children as hers. Here in Khartoum people have changed and women became with other agenda they will take away her husband. When she is asked why she is not using contraceptives she said it stops lactating and it is not available in private as both the husband and the priest will not allow it.*

#### **5.5. HIV/AIDS Fundamentalist Policy of Inducement**

Fundamentalism's unitary and heavy handed policy is so daring as having limited imagination about practical solution. It goes to the point of crazy when the simplest scientific fact that HIV/AIDS risk reduction depends on prevention advocacy and intermediary of condom. In the eye of fundamentalist ideologies allowing open outlets for condom distribution means increasing/ encouraging adultery. They see in it only the sin but not a neutral commodity. Thus when the minister of Health, a medical physician, declared the need to advocate a policy of condom distribution, his fundamentalist executives insisted to control it . The condom awareness, as child spacing and STI risk reduction intervention, went down from 33% in 1989 (DHS) to 17% (MICS 2000) and the prevalence rate from 10.3% to 6.3%. During the same period HIV/AIDS positive population went up by 500 times. If the civil actors doesn't act fastly. The still manageable state of Hiv/AIDS will slip to the exterminating stage of some African countries. The strict scruting of hetro sexual relations have compelled, especially among sex workers, compelled the sex market to become more on homosexuality. Thus in northern Sudan most of the infected population are males and in southern, Sudan ,where fundamentalism is weak, are females. Annex one shows the links with poverty.



## **6. Concluding Remarks**

From the above information it is very clear that Fundamentalism policies and programs in general are poverty inducing. The very obvious features of this inducement appear in the feminization of poverty. Reproductive health is targeted in all its basic policy trends. These are pronatalism, weak or no subsidies, at the best cost-sharing of health services.

Obstacles are put on the way for women survival, let alone empowerment.

Contraceptive, though one is reserved about hormonal pills as hazardous for both women and lactation, which is the reason behind poor women reluctance to use it in Sub Sahara Africa. Poor women, having limited options in front of human and material development, consider their children, a tool made by themselves to erase their poverty. Child rearing is a communal responsibility, especially in rural areas. These women uses, observing an intense lactating behavior, coupled with abstinence, for child spacing. The DHS (1989-90) observed that 96% of women lactate for any period from 4 month to 24 months. The later were 62% of women.

An urban poor needs assessment study (1994), using the sister hood method, - shown an 850 in each one hundred thousand deliveries MMR the level of inducement for poverty, structural adjustment program of cost sharing, the drive for privatization was slow. Thus it is expected to be on the rise. The transportation from displaced and urban poor quarters to the nearest night emergency health center, about 15 km, cost by night a one month income of a poor family. In one month (Feb 2002) seven maternal deaths occurred because it happened that the families can not afford to take the deceased to hospital.

The woman right to work was first granted by the British colonizers fastly - consolidated after independence. In 1965, with very few women in the public service, but a very high level of public rights based conscience, the parliament voted for equal pay for similar work, a right not yet achieved by the USA super power. Paradoxically, now with the majority of university students being females, the future labor force asset, yet the government, Khartoum State level, issued a ruling depriving women from working in the service sector, cafes, fuel stations etc. the non-educated or the school drop out, who usually work as food and beverages venders are regularly harassed by the so called "Public order police" as illegal sellers. Even under the pressure. Of civil rights groups, the municipalities started to give them commercial licenses. Yet the police continued to confiscate the tea and food utensiles. A constitutional case was raised against the government for the violation of this basic right.

Although all the procedures have ended two years ago no verdict is made. Even those women who were dismissed were not returned to work yet. So one can infer that the fundamentalist policy of women stay home is the most forcing hidden derive behind such decision of curtailing the women right to work, the women right to access to health services and reproductive services in particular.

Thus the case of feminization of poverty in Sudan, unlike other countries is not, an offshoot of loopholes in the policies of structure of adjustment, but a fully aware fundamentalist ideology that induce these already known practices.

## **7. Recommendations**

- 1- UN agencies and international donors must be aware that all resources put to the GOS institutions is empowering Fundamentalist derive at two levels. It gives them a chance to release funds from social development to fund a war in the south and a multitude of security institutions 85%. The 2001 fiscal year actual expenditure went to defense and security including one hundred and fifty thousands "Public order police" that only hunt down from a subjective materialistic view women, work, dress style and attitudes.
- 2- The funds must go to a door to door campaign of reproductive rights and to subsidies for institutions that are gender sensitive and politically neutral to sustain the campaign
- 3- An expansion in the reproductive health services, especially for urban poor must be given to women CBOs themselves.
- 4- CIRCED may establish a research program on the demographic elements of fundamentalism. This will cover experiences from northern china ,west .east and north Africa . It also include migration across borders and its impact on the spread of HIV/AIDS

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**9. Annex I:**

**Poverty increases the likelihood of HIV infection and AIDS**

*(source: Olusoji Adeyi et.al.)*

