

Submission to the Special Rapporteur on the Rights of Indigenous Peoples

Historical and Contemporary Violations of the Sexual and Reproductive Health and Rights of Indigenous and Tribal Arab Women in Sudan

Submitted by: Just Access

I. Executive Summary

This submission is made on behalf of Indigenous and tribal Arab women from Darfur and Kordofan, including women from the Baggara (Missiriya, Beni Halba, Awlad Rashid), Rezeigat, Jawama'a, and related tribal communities, many of whom now reside in urban centres such as Omdurman, and who have suffered grave violations of their sexual and reproductive health and rights (SRHR) at the hands of the Sudanese Armed Forces (SAF) and SAF-affiliated militias, including Kataib al-Bara (Al-Baraa Ibn Malik Brigade).

While international attention has appropriately focused on atrocities committed by the Rapid Support Forces (RSF), violations perpetrated by SAF and SAF-affiliated actors against ethnically Arab tribal women remain significantly under-documented and under-recognized. This invisibility contributes to selective accountability, narrative distortion, and exclusion from reparation processes. The present submission seeks to correct that imbalance and to ensure that accountability mechanisms and future peace frameworks reflect the full spectrum of harms suffered by Indigenous and tribal women, including those who are ethnically Arab.

The annexed cases reveal a recurring pattern: ethnically targeted harassment and abuse at SAF checkpoints; assault of visibly pregnant women resulting in miscarriage; violent raids on homes causing premature labour; militarization and occupation of hospitals; denial or obstruction of emergency obstetric care; neonatal deaths linked to power outages in collapsing health facilities; sexual violence and coercion; forced displacement exposing women and girls to heightened gender-based violence; obstruction of humanitarian aid, including maternal health supplies and food; intimidation of mothers seeking justice; and the systemic collapse of safe and confidential access to SRHR services, resulting in the effective denial of post-rape care and forced motherhood.

These harms are not isolated. They are consistent with broader patterns documented by the Independent International Fact-Finding Mission on the Sudan in its October 2025 report, including attacks on civilian objects indispensable to survival, obstruction of humanitarian access, and conflict-related sexual violence.¹ United Nations Security Council reporting on

¹ Human Rights Council, *Report of the Independent International Fact-Finding Mission for the Sudan*, UN Doc. A/HRC/60/22 (5 September 2025).

conflict-related sexual violence in 2024–2025 confirms widespread rape, sexual slavery, and exploitation across Darfur and Kordofan.² Médecins Sans Frontières (MSF) has documented repeated attacks on medical facilities in Darfur, including SAF drone strikes near MSF-supported hospitals in Zalingei and Nyala in September 2025 and armed assaults that suspended maternity services.³ In Khartoum, airstrikes damaged power infrastructure, disrupting neonatal and pediatric services reliant on electricity and oxygen.⁴

Cumulatively, these violations amount to war crimes under international humanitarian law where medical units and civilians are attacked or access to care is obstructed; violations of the right to health under article 12 of the International Covenant on Economic, Social and Cultural Rights; gender-based violence and discrimination under international human rights law; and violations of Indigenous and tribal women’s collective rights under the United Nations Declaration on the Rights of Indigenous Peoples. Where rape results in pregnancy and abortion is legally or practically inaccessible, forced continuation of pregnancy constitutes ongoing cruel, inhuman, and degrading treatment.

Starvation tactics, obstruction of food and medicine, land seizure, home occupation, and forced displacement further undermine women’s reproductive survival and autonomy, linking territorial dispossession and identity-based targeting directly to SRHR harm.

The submission concludes with targeted recommendations addressing recognition, independent investigation, removal of discriminatory legal barriers—including reform of the 1991 Personal Status Law and abortion framework—accession to CEDAW without reservations and ratification of the Maputo Protocol, demilitarization of health facilities, protection and funding of women-led Emergency Response Rooms, reparations for reproductive harm including land and housing restitution, and meaningful participation of tribal Indigenous women in peace and reconstruction processes.

II. Indigenous and Tribal Status and Legal Framework

Although certain tribes represented in this submission are categorized as “Arab” within Sudanese political discourse and have historically been perceived as part of the national majority, Indigenous status under African human rights law is not determined by ethnicity, racial origin, or numerical minority. Rather, the African Commission on Human and Peoples’ Rights has clarified that in Africa “indigenous” refers to culturally distinct communities whose ways of life, land-based livelihoods, and customary institutions are threatened by dominant political, military,

² United Nations Security Council, *Conflict-related sexual violence: Report of the Secretary-General*, S/2025/389 (2025).

³ Médecins Sans Frontières (MSF), *Deadly attacks across Darfur leave nearly 100 wounded in MSF-supported facilities*, Press Release, 11 September 2025.

⁴ Médecins Sans Frontières (MSF), *Deadly attacks across Darfur leave nearly 100 wounded in MSF-supported facilities* (2025) (reporting RSF airstrikes in Khartoum that damaged power stations affecting MSF-supported hospitals).

or economic structures and who experience marginalization, exclusion, and dispossession.⁵ This interpretation is consistent with the Commission’s jurisprudence in *Endorois* and *Ogiek*, which emphasize vulnerability and erosion of traditional livelihoods rather than demographic status.⁶

The tribal communities covered here possess defining characteristics consistent with protections afforded to “indigenous and tribal peoples”: distinct customary governance (including Native Administration structures), land- and resource-based livelihoods (pastoralism and agro-pastoralism), communal systems of tenure and access (including customary *hakura* and grazing routes), strong self-identification, and culturally distinct social norms within broader Sudanese society.⁷ In the current conflict, these communities have been subjected to militarization of their territories, forced displacement, and discriminatory targeting by identity and imputed affiliation—circumstances that engage the protective framework of UNDRIP.⁸

Importantly, even where Arab tribal communities are not nationally marginalized as ethnic groups, women within those communities experience structural subordination grounded in patriarchal customary governance and Sudan’s Sharia-based personal status regime. The Muslim Personal Status Law (1991) institutionalizes male guardianship, unequal marital authority, and child marriage, reinforcing gender hierarchy within tribal systems.⁹ CEDAW General Recommendation No. 39 recognizes that Indigenous women experience intersecting discrimination arising both from external marginalization and from internal gendered power structures within their communities.¹⁰ Accordingly, Arab tribal women may simultaneously belong to a socially dominant ethnic category in national discourse while remaining marginalized as women within patriarchal tribal and legal systems.

UNDRIP affirms that Indigenous Peoples have collective and individual rights to life and security (art. 7), freedom from forced assimilation and destruction of culture (art. 8), participation in decision-making (arts. 18–19, 23), health without discrimination (art. 24), and rights to lands, territories, and resources traditionally owned, occupied, or otherwise used (arts. 25–29).¹¹ These rights have clear gendered dimensions. Where Indigenous territories are militarized or occupied, the resulting deprivation of food systems, shelter, and mobility has foreseeable and gender-specific impacts on maternal health and reproductive autonomy. Such

⁵ African Commission on Human and Peoples’ Rights, *Report of the African Commission’s Working Group of Experts on Indigenous Populations/Communities*, adopted 2005, paras. 87–92.

⁶ ACHPR, *Endorois Welfare Council v. Kenya*, Communication 276/2003 (2010), paras. 149–162; African Court on Human and Peoples’ Rights, *Ogiek v. Kenya*, Application No. 006/2012 (2017), paras. 107–110.

⁷ Sudan Peacebuilding Fund (PBF), *Thematic Brief No. 5: Land Tenure in Sudan*, 2021; UNDP, *Nomads’ Settlement in Sudan*, 2006; Takana et al., *Darfur Pastoralist Groups: New Opportunities for Change and Peacebuilding*, 2012.

⁸ United Nations Declaration on the Rights of Indigenous Peoples, GA Res 61/295 (2007).

⁹ Sudan, Muslim Personal Status Law (1991); UNDP, *Gender Justice & the Law: Sudan*, 2018.

¹⁰ CEDAW, General Recommendation No. 39 (2022), paras. 3, 16–18.

¹¹ United Nations Declaration on the Rights of Indigenous Peoples, arts. 7, 8, 18–19, 23–29.

harms are legally relevant under articles 7, 21, 24, and 26–29 of UNDRIP and must be assessed as collective rights violations, not merely incidental humanitarian consequences.¹²

The Special Rapporteur's call further engages CEDAW General Recommendation No. 39 (2022), which recognizes that Indigenous women and girls experience intersecting discrimination affecting access to health, land, participation, and protection from gender-based violence.¹³ The Committee affirms that violations of collective land and territorial rights directly undermine Indigenous women's rights to health, culture, and self-determination.¹⁴ In Sudan, the intersection of discriminatory personal status and criminal laws, militarized control of movement and services, and the collapse and targeting of health infrastructure has created conditions in which Indigenous and tribal women, including women from Arab pastoralist communities, are unable to realize these rights in practice.

III. Structural Discrimination and Historical Barriers to Sexual and Reproductive Health (Pre- April 2023)

The violations described in this submission did not arise in a vacuum. They were enabled by a pre-existing system of discriminatory law, unequal service provision, and regional marginalization that had already restricted Indigenous and tribal women's reproductive autonomy long before April 2023.

For decades, women from Darfur and Kordofan, including those from Arab tribal communities, have faced structural barriers to maternal health services, contraception, and legal protection from gender-based violence. These inequities were rooted not only in armed conflict but in national laws and governance choices that failed to ensure equal protection and access.

III.A. Law as a System of Reproductive Control

Sudan's Personal Status Law for Muslims (1991) entrenched male guardianship, unequal divorce rights, polygamy, and obedience norms.¹⁵ Marital rape is not expressly criminalized and Sudan lacks comprehensive domestic violence legislation.¹⁶ Marriage was permitted at "tamyeez" (physical maturity), allowing judicial authorization of child marriage.¹⁷ Although the National Child Act (2010) defined a child as under eighteen, it did not override these provisions.¹⁸ In

¹² United Nations Declaration on the Rights of Indigenous Peoples, arts. 7(2), 21(1), 24(1)–(2), 26–29.

¹³ CEDAW, General Recommendation No. 39 (2022), paras. 11, 16.

¹⁴ CEDAW, General Recommendation No. 39 (2022), paras. 18–20, 56–57.

¹⁵ Personal Status Law for Muslims (1991).

¹⁶ UNDP, *Sudan: Gender Justice & the Law* (2018).

¹⁷ Kakal et al., "Intersecting Injustices: Child Marriage and the Law in Conflict-Affected Sudan," *Int. J. Equity in Health* (2025) (legal analysis based on pre-2023 law and practice).

¹⁸ *Ibid.*

practice, courts continued applying the Personal Status Law, normalizing early marriage and adolescent pregnancy in rural regions.¹⁹

The Criminal Act (1991) compounded this framework. It criminalized “zina” (sex outside marriage), with pregnancy serving as evidence.²⁰ Abortion was permitted only in narrow circumstances, including within ninety days of rape.²¹ Research demonstrates that procedural barriers, including police documentation requirements (“Form 8”), and fear of prosecution deterred survivors from seeking care.²²

This legal architecture did more than regulate sexuality: it exposed rape survivors to prosecution, restricted access to post-rape care, and reinforced coercive control over reproduction.

International human rights bodies have recognized that punitive barriers to reproductive healthcare, particularly in cases of sexual violence, may amount to gender-based violence and cruel, inhuman or degrading treatment.²³ CEDAW General Recommendation No. 39 explicitly recognizes the intersecting discrimination faced by Indigenous and rural women in access to health and autonomy.²⁴

Despite recommendations from the Special Rapporteur on violence against women in 2004 to reform discriminatory laws, core provisions remained unchanged.²⁵

This legal regime constitutes a historical injustice: it systematically constrained Indigenous and tribal women’s reproductive agency.

III.B. Unequal Access to Maternal and Reproductive Healthcare (Pre-2023)

Structural inequality extended beyond law into service provision.

National data prior to 2023 documented significant regional disparities in institutional delivery, adolescent marriage, and maternal health indicators in Darfur and other peripheral states compared to national averages.²⁶ Maternal mortality remained uneven across states, with conflict-affected regions recording higher ratios.²⁷

Studies examining maternal health service utilization among nomadic communities in Sudan demonstrate that distance to facilities, seasonal movement, and insecurity significantly reduced

¹⁹ Ibid.

²⁰ Criminal Act (1991), Arts. 145–146.

²¹ Criminal Act (1991), Arts. 135.

²² Tønnessen & Al-Nagar, “The Politicization of Abortion and Hippocratic Disobedience in Islamist Sudan,” *Health and Human Rights Journal* (2019).

²³ Human Rights Committee, General Comment No. 36 (2018); CEDAW Committee, General Recommendation No. 35 (2017).

²⁴ CEDAW Committee, General Recommendation No. 39 (2022), paras 51, 56–57.

²⁵ Report of the Special Rapporteur on violence against women, Visit to Darfur (2004).

²⁶ Sudan MICS 2014 (tables on institutional delivery and early marriage by state).

²⁷ Sudan MICS 2014 (tables on maternal mortality by state).

access to antenatal and emergency obstetric care.²⁸ Human Rights Watch similarly documented that in Southern Kordofan most births occurred at home, emergency transport was scarce, and referral delays were common.²⁹ Family planning services were limited, and in some areas conditioned on spousal approval.³⁰

These were not isolated deficiencies. They reflect a pattern of unequal geographic investment.

Under article 12 of the International Covenant on Economic, Social and Cultural Rights, Sudan is obligated to ensure non-discriminatory access to maternal health services and essential medicines.³¹ The Committee on Economic, Social and Cultural Rights has clarified that equitable geographic distribution of health facilities is a core obligation.³²

Persistent disparities affecting rural and tribal women therefore constituted a structural denial of equal reproductive health access long before the present war.

III.C. Harmful Practices and De Facto Reproductive Control

Structural deprivation was compounded by entrenched practices and legal frameworks that constrained women's bodily autonomy.

Female genital mutilation (FGM) remained highly prevalent prior to its criminalization in 2020.³³ Darfur states recorded some of the highest national prevalence levels.³⁴ Infibulation (Type III) is medically associated with obstructed labour, postpartum hemorrhage, fistulas, and increased maternal mortality.³⁵ Although Sudan adopted a national criminal prohibition of FGM in July 2020, enforcement has been limited and re-infibulation remains outside the scope of the ban.³⁶

Child marriage likewise remained legally permissible under the 1991 Personal Status Law.³⁷ National survey data confirm high prevalence in rural and conflict-affected states.³⁸ In many communities, early marriage functions as a mechanism of reproductive control shaping girls'

²⁸ Babker El Shiekh & Anke van der Kwaak, "Factors influencing the utilization of maternal health care services by nomads in Sudan," *Pastoralism: Research, Policy and Practice* 5:23 (2015).

²⁹ Human Rights Watch, "No Control, No Choice": Lack of Access to Reproductive Healthcare in Sudan's Rebel-Held Southern Kordofan (22 May 2017).

³⁰ Human Rights Watch (2017).

³¹ International Covenant on Economic, Social and Cultural Rights (1966), art. 12.

³² Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), paras. 12(b), 43(a)–(f).

³³ Sudan MICS 2014.

³⁴ Sudan MICS 2014.

³⁵ Landinfo, *Sudan: Female Genital Mutilation (FGM)* (26 Aug. 2021); WHO (2020) definition of Type III.

³⁶ Redress, *Sudan Legal Amendments: Explanatory Table* (July 2020); Landinfo (2021).

³⁷ Personal Status Law for Muslims (1991).

³⁸ Sudan MICS 2014 (child marriage by age/state).

reproductive trajectories before adulthood. CEDAW General Recommendation No. 39 identifies such intersecting discrimination against Indigenous and rural girls.³⁹

When early marriage, FGM, restrictive abortion laws, and weak service access converge, the result is not merely cultural practice, it is structural reproductive control.

III.D. Limited Reform and Persistent Impunity

Prior to 2023, Sudan adopted limited reforms, including partial criminalization of FGM and a National Strategy to End Child Marriage.⁴⁰ However, core discriminatory legal provisions remained intact, and regional health inequities persisted.

The current conflict intensified this system; it did not create it.

The harms now documented, forced pregnancy, denial of emergency obstetric care, obstruction of services, were foreseeable within a legal and institutional framework that had already failed Indigenous and tribal women.

Recognition of these pre-existing structural injustices is essential to any meaningful process of reparation and reconciliation.

IV. Contemporary Forms of Injustices Against Indigenous Women and Girls' SRHR

IV.A. Collapse of Protection and Access

Although Sudanese authorities have announced investigative mechanisms regarding conflict-related sexual violence, independent reporting confirms that these measures have not resulted in effective, survivor-centred access to sexual and reproductive healthcare. The Independent International Fact-Finding Mission concluded that Sudan remains unwilling or unable to conduct genuine investigations into international crimes, including sexual violence, and documented structural barriers to accountability and selective justice.⁴¹

Since April 2023, formal guarantees of health access have become largely meaningless due to the collapse of infrastructure. WHO reports that fewer than half of health facilities in conflict-affected states remain functional, and only a minimal proportion provide emergency obstetric

³⁹ CEDAW General Recommendation No. 39 (2022), paras. 16–18, 51–52.

⁴⁰ UNICEF Sudan, *Female Genital Mutilation Fact Sheet* (2020); Redress (2020).

⁴¹ Independent International Fact-Finding Mission for the Sudan, *Sudan: A War of Atrocities*, Report to the Human Rights Council, UN Doc. A/HRC/60/22 (5 September 2025).

care or clinical management of rape.⁴² Attacks on healthcare facilities, destruction of power infrastructure, and suspension of maternity services have severely restricted access to antenatal care, safe delivery, and post-rape treatment.⁴³

In Darfur and Kordofan, regions from which many Indigenous and tribal Arab communities originate, health system collapse has intersected with patterns of displacement and insecurity that affect women travelling from tribal-identified neighbourhoods and rural localities to urban referral hospitals.⁴⁴ For Indigenous and tribal Arab women from Darfur and Kordofan, these structural failures intersect with identity-based profiling and imputed political affiliation, compounding barriers to care.

UNFPA estimates that more than one million pregnant women lack access to essential maternal services, with Darfur and Kordofan among the most severely affected regions.⁴⁵ The Secretary-General has confirmed that insecurity and infrastructure destruction prevent survivors from reaching services within the critical 72-hour window for post-rape care.⁴⁶

IV.B. Ethnic Targeting and Obstruction of Medical Access

Testimonies from Indigenous and tribal Arab women describe checkpoint-based obstruction, ethnic profiling, assault, and denial of hospital access by SAF personnel. Women were accused of affiliation based on tribal origin and prevented from reaching emergency care. These patterns mirror the Fact-Finding Mission's documentation of identity-based targeting and indiscriminate attacks affecting civilians and medical facilities.⁴⁷

In several annexed cases, women travelling from Omdurman or Khartoum neighbourhoods associated with Darfuri or Kordofan tribal communities reported being stopped specifically because of their place of origin or tribal surname, linking ethnic identity directly to obstruction of maternal and emergency care.

⁴² World Health Organization (WHO), *Sudan Health Emergency Situation Report*, 31 October 2024; WHO, *HeRAMS Sudan Baseline Report 2025 – Sexual and Reproductive Health: A Comprehensive Mapping of Availability of Essential Services and Barriers to Their Provision*, July 2025.

⁴³ Médecins Sans Frontières (MSF), *Deadly attacks across Darfur leave nearly 100 wounded in MSF-supported facilities*, Press Release, 11 September 2025; MSF, *Sudan: MSF suspends activities at Zalingei hospital following armed attack*, Press Release, 19 August 2025; MSF, *Medical Care in the Crosshairs: The Attack on Humanity*, January 2026.

⁴⁴ See annexed testimonies.

⁴⁵ United Nations Population Fund (UNFPA), *Sudan: Rape survivors and pregnant women cut off from life-saving services as funding collapses*, Press Release, 4 June 2025.

⁴⁶ United Nations Security Council, *Conflict-related sexual violence: Report of the Secretary-General*, UN Doc. S/2025/389 (15 July 2025).

⁴⁷ Independent International Fact-Finding Mission for the Sudan, UN Doc. A/HRC/60/22 (5 September 2025).

Obstruction of medical transport and interference with access to hospitals during armed conflict engages obligations under international humanitarian law to respect and protect medical units and to allow rapid and unimpeded passage of medical care.⁴⁸

Where obstruction is carried out on discriminatory grounds, including ethnicity or imputed political affiliation, it additionally violates the prohibition on adverse distinction under international humanitarian law and engages protections against discrimination under international human rights law.⁴⁹

IV.C. Conflict-Related Sexual Violence and Forced Pregnancy

The Secretary-General's 2025 report documents widespread rape, gang rape, forced marriage, abduction, and sexual exploitation across Darfur, Kordofan, and Khartoum.⁵⁰ Survivors frequently lack access to emergency contraception, post-exposure prophylaxis, and safe abortion due to service collapse and restrictive law.

Where rape results in pregnancy and safe termination is inaccessible, women face forced continuation of pregnancy in conditions of insecurity and malnutrition. In such circumstances, denial of abortion and emergency obstetric care may amount to cruel, inhuman, or degrading treatment under international human rights law.⁵¹

For Indigenous and tribal Arab women already subject to ethnic profiling, the combined effect of insecurity, stigma, and criminal law barriers converts sexual violence into a prolonged condition of coerced pregnancy and forced motherhood.

IV.D. Displacement, Starvation, and Reproductive Harm

Conflict has devastated markets, pastoral routes, and access to food systems essential to women's survival. UN Women reports that millions of women and girls are acutely food insecure.⁵² The Fact-Finding Mission has documented destruction of civilian objects indispensable to survival and obstruction of humanitarian assistance.⁵³

⁴⁸ Geneva Convention IV relative to the Protection of Civilian Persons in Time of War (1949), arts. 18–20; Additional Protocol I (1977), art. 70; Additional Protocol II (1977), art. 11.

⁴⁹ Geneva Convention IV (1949), art. 27.

⁵⁰ United Nations Security Council, *Conflict-related sexual violence: Report of the Secretary-General*, UN Doc. S/2025/389 (15 July 2025).

⁵¹ Human Rights Committee, General Comment No. 36 on the right to life, UN Doc. CCPR/C/GC/36 (2018); Committee on the Elimination of Discrimination against Women (CEDAW), General Recommendation No. 35 on gender-based violence against women (2017); CEDAW, General Recommendation No. 39 on the rights of Indigenous women and girls, UN Doc. CEDAW/C/GC/39 (2022).

⁵² UN Women, *Gender Alert: Sudan*, 11 November 2025.

⁵³ Independent International Fact-Finding Mission for the Sudan, UN Doc. A/HRC/60/22 (5 September 2025).

Maternal undernutrition medically associated to miscarriage, premature birth, and neonatal mortality. Where starvation tactics and aid obstruction produce foreseeable maternal harm, reproductive injury becomes a legally relevant consequence of unlawful siege and starvation practices prohibited under international humanitarian law.⁵⁴

For tribal communities whose displacement severs access to land, livestock, and informal support networks, hunger and reproductive harm are not incidental by-products of conflict but foreseeable outcomes of deprivation of livelihood systems.

IV.E. Suppression of Local Women-Led Responses

Women-led Emergency Response Rooms and community organizations have sustained referral networks and maternal support in the absence of functioning state systems.⁵⁵ However, these actors face intimidation, bureaucratic obstruction, and direct targeting. Only a small fraction of humanitarian funding reaches women-led organizations despite their central role in maintaining SRHR access.⁵⁶

The targeting or obstruction of community-based responders further compounds the barriers faced by Indigenous and tribal Arab women, who often rely on these networks rather than formal state institutions for confidential referrals and post-rape care.

The cumulative effect of infrastructure destruction, ethnic profiling, legal restriction, starvation tactics, and suppression of local responders has created a coercive environment in which Indigenous and tribal women cannot exercise meaningful reproductive autonomy.

IV.F. Monitoring, Documentation, and Data Gaps

Documentation of reproductive healthcare abuses remains severely constrained. Survivors often do not report violations due to stigma, fear of retaliation, and lack of confidential referral pathways.⁵⁷

Despite widespread documentation of attacks on healthcare in Sudan, accountability remains limited.⁵⁸ This pattern of impunity reinforces underreporting and contributes to normalization of violations affecting reproductive healthcare in conflict settings.

⁵⁴ Additional Protocol I to the Geneva Conventions (1977), art. 54; Rome Statute of the International Criminal Court, art. 8(2)(b)(xxv).

⁵⁵ Gender in Humanitarian Action Working Group (GiHA WG), *Women and Girls in Sudan – Escalation of Hostilities*, 29 October 2025.

⁵⁶ Gender in Humanitarian Action Working Group (GiHA WG), *Women and Girls in Sudan – Escalation of Hostilities*, 29 October 2025.

⁵⁷ Legal Action Worldwide, reporting on sexual violence and access barriers in Sudan, 2025; UN Security Council, *Conflict-related sexual violence: Report of the Secretary-General (S/2025/389)*, 2025.

⁵⁸ Médecins Sans Frontières (MSF), *Medical Care in the Crosshairs: The Attack on Humanity*, January 2026.

Monitoring is further impeded by communication blackouts and insecurity, limiting access for UN agencies and civil society actors.⁵⁹

Sudan does not systematically collect or publish disaggregated data on Indigenous or tribal women's access to reproductive healthcare. The UN Women 2021 National Gender Statistics Assessment confirms significant gaps in gender-sensitive data production and institutionalization.⁶⁰ Maternal mortality, miscarriage, and pregnancy loss are not recorded by ethnicity or tribal affiliation. This statistical erasure obscures patterns of ethnically mediated reproductive harm and undermines accountability.

V. Recommendations

(Anchored in UNDRIP, CEDAW, ICESCR, ICCPR, CRC, Maputo Protocol, Rome Statute, IHL, UNSCR 1325, and the Pinheiro Principles)

The Special Rapporteur is respectfully encouraged to recommend that the Government of Sudan and relevant international actors:

V.A. Recognition and Non-Discrimination

- **Formally recognize** Arab tribal communities, including Baggara, Rezeigat, Missiriya, Beni Halba, Awlad Rashid, and related groups, as Indigenous and tribal peoples within the meaning of international law and entitled to protection under UNDRIP.
- **Publicly acknowledge** that Indigenous and tribal women have experienced distinct and cumulative violations of sexual and reproductive health and rights, including sexual violence, denial of maternal and post-rape care, forced pregnancy, ethnic profiling in access to services, and dispossession from land and housing.
- **Affirm** that access to reproductive healthcare is a core human rights obligation that may not be restricted on the basis of conflict, insecurity, ethnicity, or religious justification.

V.B. Immediate Protection of Sexual and Reproductive Health

- **Guarantee** immediate, safe, and non-discriminatory access to comprehensive sexual and reproductive healthcare, including emergency obstetric and neonatal care, clinical management of rape (including emergency contraception and HIV post-exposure prophylaxis), contraception, post-abortion care, and access to safe abortion consistent with international human rights standards.
- **Demilitarize** health facilities and prohibit armed or intelligence presence in maternity wards and reproductive health settings in accordance with international humanitarian law.

⁵⁹ UN Security Council, *Conflict-related sexual violence: Report of the Secretary-General (S/2025/389)*, 2025; Gender in Humanitarian Action Working Group (GiHA WG), *Women and Girls in Sudan – Escalation of Hostilities*, 29 October 2025.

⁶⁰ UN Women, *Sudan National Gender Statistics Assessment*, 2021.

- Ensure safe passage** to medical care by prohibiting ethnic profiling, arbitrary detention, and obstruction at checkpoints, particularly for pregnant women and survivors of sexual violence.
- Ensure mobile** and culturally appropriate SRHR services for nomadic and pastoral communities to meet Sudan's obligation to guarantee physically accessible, non-discriminatory maternal healthcare.

V.C. Structural Legal Reform

- Amend** the Personal Status Law (1991) to eliminate discriminatory provisions, including male guardianship requirements, unequal divorce rights, polygamy without consent, and legal obedience norms.
- Criminalize** marital rape and **adopt** comprehensive domestic violence legislation consistent with international standards.
- Reform** abortion laws to remove procedural and evidentiary barriers, **eliminate** police documentation requirements, and **ensure** access at minimum in cases of rape, incest, severe fetal impairment, and risk to physical or mental health.
- Repeal** zina and related public morality provisions that criminalize survivors and deter reporting of sexual violence.
- Fully criminalize** female genital mutilation nationwide and **ensure** effective enforcement, including prohibition of medicalized FGM, and survivor-centered protection measures.
- Establish** eighteen as the absolute minimum age of marriage without exception and prohibit judicial authorization of child marriage.

V.D. Land, Housing, and Resource Restitution

- Recognize** that Indigenous and tribal women's reproductive health is inseparable from secure access to ancestral land, housing, pastoral routes, markets, and water sources.
- Implement** restitution and compensation mechanisms for homes unlawfully occupied or seized, destruction of agricultural assets and livestock, and loss of livelihood.
- Reform** land tenure systems to guarantee equal land registration rights for women and eliminate discriminatory customary barriers to land ownership and financing.

V.E. Accountability

- Investigate** and **prosecute** attacks on maternity wards, health facilities, and reproductive health infrastructure as potential war crimes.
- Investigate** patterns of sexual violence, forced pregnancy, and systematic denial of maternal care as potential crimes against humanity where threshold elements are met.
- Remove** immunity provisions shielding state-affiliated perpetrators and ensure accountability under principles of command responsibility.
- Investigate** and **prosecute** conflict-related forced marriages as potential war crimes or crimes against humanity.

V.F. Reparations for SRHR-Related Harm

- Establish** a gender-responsive **reparations** framework addressing sexual violence, forced pregnancy and forced motherhood, early and forced marriage, preventable maternal and neonatal deaths, miscarriage and reproductive injury caused by assault or denial of care, psychological trauma, and loss of housing and land affecting reproductive survival.
- Provide** long-term reproductive **healthcare**, psychosocial rehabilitation, livelihood restoration, income support, education access for affected women and girls, and community-level anti-stigma initiatives.
- Ensure** access to reconstructive and obstetric care for survivors of FGM, sexual violence, or obstetric violence or harm, including fistula treatment.
- Support** culturally grounded FGM and Early Marriage prevention initiatives led by Indigenous and tribal women.

V.G. Protection and Resourcing of Women-Led Organizations

- Provide** direct, flexible, and multi-year funding to women-led Emergency Response Rooms and Indigenous women's organizations delivering SRHR and protection services.
- Protect** women human rights defenders and SRHR providers through security guarantees, relocation mechanisms, and digital protection measures.
- Recognize** attacks on women-led clinics and community responders as violations of international humanitarian law.

V.H. Data and Monitoring

- Establish** mandatory disaggregated data collection systems capturing SRHR outcomes by sex, age, ethnicity or tribal affiliation (where safe and consent-based), region, and displacement status.
- Integrate** Indigenous and gender indicators into national health and statistical systems in line with treaty reporting obligations.

V.I. Participation in Peace and Governance

- Guarantee** meaningful participation of Indigenous and tribal women in peace negotiations, transitional justice processes, health system reform, and land and governance mechanisms, consistent with UNDRIP and Security Council Resolution 1325.

V.J. Responsibilities of the International Community

- Ensure** unimpeded humanitarian access, including cross-line and cross-border assistance to conflict-affected Indigenous regions.
- Increase** funding for SRHR and gender-based violence services and prioritize direct support to local women-led actors.

-Condition international engagement on measurable reforms addressing discrimination in family law, abortion law, land rights, and equitable access to reproductive healthcare.

VI. Conclusion

The violations documented in this submission demonstrate that Indigenous and tribal Arab women in Sudan have been subjected to cumulative and intersecting harms that impair their sexual and reproductive health and rights in both structural and conflict-driven ways. These harms are not incidental consequences of armed conflict. They arise from the convergence of discriminatory family and criminal laws, ethnic profiling and identity-based targeting, militarization of civilian infrastructure, obstruction of humanitarian assistance, and the collapse of reproductive healthcare systems.

For Indigenous and tribal women—whether living in rural pastoral areas, displaced settings, or urban centres—reproductive autonomy has been constrained by both legal control and conflict violence. The denial of maternal care, obstruction of post-rape treatment, forced pregnancy, displacement from homes, and destruction of livelihood systems constitute violations not only of bodily integrity but of equality, dignity, and collective rights protected under international law.

Taken together, these patterns engage Sudan’s obligations under international humanitarian law, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and the United Nations Declaration on the Rights of Indigenous Peoples. They also reflect the intersecting discrimination identified in CEDAW General Recommendation No. 39.

Recognition, reparation, and reconciliation will remain incomplete unless the reproductive harms suffered by Indigenous and tribal women—including those belonging to Arab tribal communities—are explicitly acknowledged, independently investigated, and addressed within accountability mechanisms, peace processes, and institutional reform.