Factors influencing the continuation of Female Genital Mutilation/Cutting Practice in Sudan

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Sudan

48th International Course in Health Development

September 19, 2011 - September 7, 2011

KIT (ROYAL TROPICAL INSTITUTE)

Development Policy & Practice/

Vrije Universiteit Amsterdam

It is not a matter of a day or night:

Factors influencing the continuation of Female Genital Mutilation / Cutting practice in Sudan

A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Public Health

By

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Sudan

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48th International Course in Health Development (ICHD)
September 19, 2011 – September 7, 2012
KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam
Amsterdam, The Netherlands
September 2012

Organized by:

KIT (Royal Tropical Institute), Development Policy & Practice
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam/ Free University of Amsterdam (VU)
Amsterdam, The Netherlands

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Dedication

I dedicate this work to my family,

To Mom and Dad for instilling the importance

of hard work and higher education;

To my sisters and brother;

To my cute nieces and nephews;

To my dear husband and my coming child;

To all my friends and all those who surrounded me with

their love throughout my life.

Acknowledgements

Foremost, I praise God who has given me the energy and strength throughout this year, which has enabled me to pass all the exams and gain so much knowledge.

Special thanks and gratitude go to the government of The Netherlands for giving me this great opportunity to study in one of the most prestigious educational institutions in the country, the Royal Tropical Institute.

I also extend special thanks and appreciation to the Sudanese government, which agreed to allow me to take advantage of this opportunity. My heartfelt thanks go to my advisor and to my back-stopper for their continuous encouragement and kind support to me while I was writing my thesis. Without their efforts, the completion of this work would not have been possible.

I owe my thanks and appreciation to the KIT staff, the facilitators, secretarial, library staff and the cheerful receptionists, who made it easy, smooth and enjoyable for me.

My sincere appreciation goes to my friends who are ICHD alumni - Elduma and Majid - for being there whenever I needed guidance or advice.

My great appreciation to all my family members- Dad, Mom, sisters and brother and their children , as well as to my friends who gave me the needed doses of support throughout this year that I spent abroad.

Abstract

Background: Female genital mutilation/cutting (FGM/C) is a common and traditional practice in Sudan. The prevalence is 65.5% with wide regional and ethnic disparities. The most common type is type III with lifelong complications including infertility. In spite of the continuous anti-FGM/C efforts, it still continues to be performed.

Objective: To identify the different factors that influence FGM/C practice in Sudan, describe the anti-FGM/C responses and make recommendation to better inform the health policy and practice.

Method: Literature review descriptive study.

Findings: Continuation of FGM/C is mainly influenced by traditions and cultural understanding of sexuality, gender and marriage. Religion has a less direct impact. The social pressure and accompanied set of sanctions and rewards are strong enough to maintain FGM/C. The age and level of education of mothers and attitude toward FGM/C are important individual factors influencing the continuation of FGM/C. The current anti-FGM/C efforts have achieved slight but promising change in the attitude toward FGM/C. The absence of laws prohibiting FGM/C, as well as Pro-FGM/C campaign and medicalization are challenging the precious little progress made.

Conclusion and Recommendation: Factors influencing the continuation of FGM/C are complex, interrelated and mutually reinforcing. FGM/C is mainly continues as traditional and cultural practice held in place by social influence and reciprocal expectations.

Factors influencing FGM/C need to be tackled comprehensively in order to eliminate it. The responses to combat FGM/C early are still unable to make tangible achievements.

An integrated approach is needed to change the attitude and eliminate FGM/C. Further research to better understand the factors influencing the continuation ofFGM/C is needed.**Keywords**: Female genital mutilation/Cutting, factors, traditions, culture, religion, social, Sudan.

Word count: 12940.

List of acronyms

DHS Demographic and health survey.

FGM Female Genital Mutilation.

FGC Female Genital Cutting.

FGM/C Female Genital Mutilation/ Cutting.

HTPs Harmful traditional practices.

ICPD International conference on population and development.

MICS Multiple Indicator Cluster Survey.

SHHS Sudan Household Health Survey.

SMS Safe Motherhood Survey.

UNICEF United Nations Children's Fund.

UNDP United Nations Development Programme.

UNFPA United Nations Population Fund.

WHO World Health Organization.

Note on terminology

The term used for this practice has undergone various changes. It was first referred to as 'female circumcision'. This term, however, resulted in creating confusion with the distinct practice of 'male circumcision' (UNICEF, 2005c).

From the late 1970s the expression 'female genital mutilation' gained growing attention with the word mutilation which emphasizes the severity of harm done to women. This term, more accurately refers to the violating nature of women's rights, and so it assists in promoting the efforts against the practice (WHO, 2008).

Starting in the late 1990s the terms 'female genital cutting' and 'female genital mutilation/cutting' were largely used by some agencies and in research. The negative association linked to the term 'mutilation', partly leads to the preference for this term (UNICEF, 2005c).

Late in the 1990s the 'term female genital mutilation/cutting' became the more preferred term because it is less judgmental of the practicing communities, and it also captures the significance of the term 'mutilation' at the policy level.
The expression 'female genital mutilation/cutting' is used by UNICEF and UNFPA while WHO continues to use the term 'female genital mutilation' (WHO, 2008).

Introduction

Female Genital Mutilation/cutting (FGM/C) is known as a harmful traditional practice (HTP) that causes numerous health and social consequences for both women and young girls. It involves total or partial removal of the female genitalia without any medical justification. Although FGM/C is a worldwide practice, it is more common in Africa where it is prevalent in 28 countries. The worldwide prevalence is estimated by WHO to be - between 100-140 million women and girls. In Africa, about 90 million girls and women (above nine years old) are living with the consequences of FGM/C and three million are at risk of being mutilated yearly (WHO, 2010).

This study is an endeavour to understand the issue of FGM/C by examining it from the perspectives of two groups of institutions. Firstly are the institutions which maintain and promote the practice. Secondly, are the institutions that work to combat FGM/C which includes international and national responses as well as the legal establishment.

My six years of work in the health promotion department, contributing in the planning of campaigns and designing messages for various health issues helped me to realize that the identification of the basic causes of the problem or the specific factors that influence its occurrence is of a real value in planning and designing a health promotion activity or any public health response. In addition to my professional interests, the issue attracted my attention from a point of justice and equity since it represents a severe form of discrimination against girls/women.

FGM/C is a deeply rooted and widely practiced in Sudan. The prevalence and the type vary between regions, but the overall prevalence is 65% which is far above the strategic goal of zero tolerance by the year 2018.

To support the efforts to achieve this goal, effective planning needs good understanding of the motives of those who promote and maintain the practice as well as sound information about different factors that need to be tackled before FGM/C can be eliminated.

By the end of this research, a clear picture of the factors influencing the continuation of FGM/C in Sudan and how they are interrelated will be obtained.

Chapter 1: Country profile

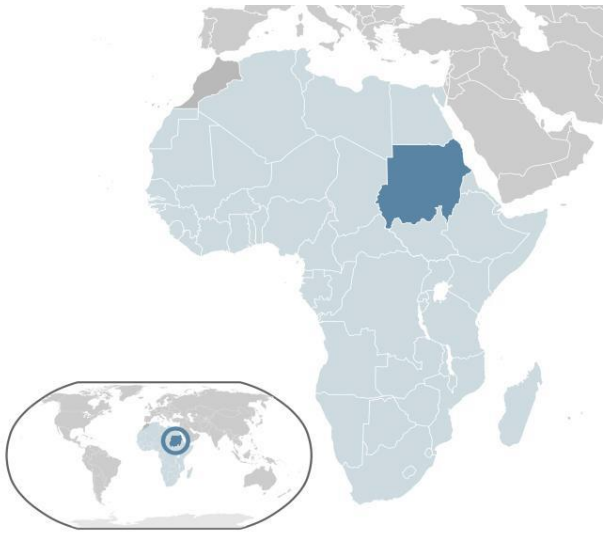
In this chapter, background information about Sudan will be presented.

1.1 Geography

Sudan is a northeast African country. It is the third largest in Africa, covers over 1.8 million km^2 and is bordered by seven countries. The land is generally flat but interspersed with some mountain ranges (UNDP, 2011). Half of Sudan is fertile and desert occupies the northern parts of the country (SNSSP, 2011).

Sudan generally has a tropical climate which is mostly dry, and the amount of rainfall increases towards the South. A number of environmental challenges are facing the country due to climate change which includes desertification, soil erosion and recurrent droughts with serious consequences on the environment (UNDP, 2011).The geography and ecology of Sudan influence the health and population situation. Coverage of health services is affected by the expansive distances and poor road network and transportation infrastructure (SNSSP, 2011).

Figure1: A map showing location of Sudan in Africa



Source: mapsof.net

1.2 Demography

Sudan's population is about 33,419,625 with an annual growth rate of 2.48% and 49% of the population are urban (UNDP, 2011). The average household size is 5–6 persons whereas the fertility rate is 3.9. The crude birth rate is 31.2

and crude death rate is 16.7 per 1,000 people (17.2 for males and for 16.3 females). The population under 15 years is about 43.2% including 15% under 5 years (SNSSP, 2011) and the dependency rate is high (WHO, 2009). The majority of Sudan's population originates from native African groups and Arabs. Arabic is the official and most widely spoken language and the Arab culture predominates. The majority (over 97%) of the population are Muslims with a small community of Christians (UNDP, 2011).

1.3 Political context

Since its independence in 1956, Sudan has had a long history of political instability and has been in an internal war for more than three-quarters of its existence (FMOH, 2003). The National Salvation Government emerged on June 30, 1989. Starting from 1991 the political system and the administrative structure of Sudan was based on the federal system and a presidential republic. The system developed through different phases until the Local Government Act (2003) was created, transferring more authority and responsibility to the localities, especially in the fields of health, education and development. Currently, there are three levels of the government system (federal, state and local government) (FMOH, 2006).

The Darfur crisis, which started in 2003, is still challenging the national government and its partners. Although the signing of Darfur Peace Agreement in Abuja (2006) brought expectations of resolution to the conflict and initiation of a recovery process, the situation is still rocky (FMOH, 2006).

1.4 Economic context

In terms of natural resources, Sudan is a rich country. It has vast areas of fertile land and millions of livestock and animal resources. Agriculture is the main source of income and employs over 80% of the population. The main cash crops are cotton and gum Arabic. In 1999, Sudan began exporting crude oil. Oil production led most of Sudan's post-2000 development. In 2010, Sudan was ranked the 17th fastest-growing economy worldwide, and despite the international sanctions, there was a rapid development in the country (UNDP, 2011). However, there are significant regional and urban/rural development disparities (MWSS, 2010). Rural communities and especially women and internally displaced people are the hardest sector hit by poverty. According to the latest poverty estimates 46.5% of the population live in poor

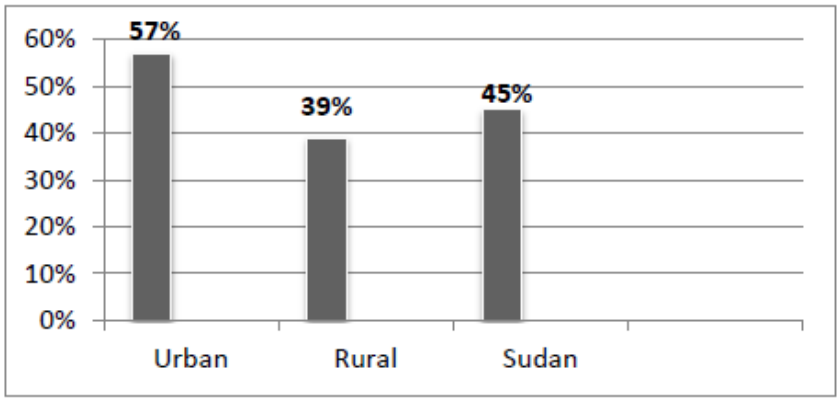
conditions, and only about 58.7% have access to improved sanitation (UNDP, 2012).

As a result of the 2011 secession of South Sudan, where most of the oil is situated, serious economic imbalances and increasing hardship for the population resulted, in particular, for the poor. Inflation continued to increase and reached 28.6% in April 2012 (World Bank, 2012).

1.5 Education

Education in Sudan faces many challenges. Adult literacy among those 15 years and above is about 62% but ranges between 51% in the rural population to 79% among the urban population. Gender inequality is clearly noticeable with only 52% of females literate compared to 73% of males (gender gap ratio 0.71) (CBS, 2009). There is also disparity between rural and urban women's education where the women's literacy rate ranges between 39% in the rural areas to 57% among women in urban areas (SHHS, 2010). Only 53.7% of children of primary school age were attending school (SHHS, 2006). The school enrolment ratio was estimated at 71.1%, with apparent disparities between regions ranging from 93.7% in Khartoum to 36.1 in the Red Sea region (UNDP, 2011).

Figure 2:Literay rate among women (15-24 years) by areas, Sudan 2010.



Source: (SHHS, 2010).

1.6 Health system profile

The government health system has three levels; primary, secondary and tertiary. Primary health care was adopted as a strategy for the provision of health care in Sudan in the 1970s. Health services are provided through different partners including Federal and State Ministries of Health, private

sector and others. Curative services which are mainly concentrated in urban areas, gain most of the public health expenditures (WHO, 2006a).

Private health services are centred generally in urban and well-off rural areas, and are considered to provide better quality services and are mainly utilized by the well-off. The services provided in the private sector are mainly curative and secondary rather than primary health care or preventive services (WHO, 2006a). The total resources allocated to the health sector have been restricted and they have been further reduced in recent years due to austerity measures (WHO, 2009).

1.7 Socio-cultural context

The advantageous geographic location of Sudan has made it the recipient of the migrations of people of many different ethnic backgrounds, leading some scholars to name it 'Mini- Africa'. Sudan's population is one of the most diverse in Africa and it is considered a multi ethnic, multicultural and multilingual country. There are two main distinct cultures - Arab and African. Scholars have identified hundreds of tribes, languages and local dialects in Sudan. Islam played a vital role in encouraging tribal unions and creation of the so called Sudanese nation (UNIC, no date).

In Sudan the situation of women varies between regions and ethnic groups. However, the importance of the family is a common theme and the preservation of its honour and dignity is the responsibility of the family members (Berggren et al. 2006).

The age at which people marry varies between tribes and regions. In Sudan, polygamy is legal and large families tend to command more respect. The Sudanese interpretation of what constitutes a family is distinct. Traditions and customs are strongly related to the "extended family" and it is considered crucial to sustain the "good name" of the families (McLean, 2005). There are many distinctive traditional practices such as zar spirit possession, river rituals and unique brides' dances (Gruenbaum, 2006). Some of the traditions are harmful like facial scaring which has almost disappeared and female genital mutilation/cutting (FGM/C) which continues to exist and is the issue of this review. Further details about the scope, determining factors and responses to combat this practice will be presented in the following chapters.

Chapter 2: Problem Analysis, Justification and method

In this chapter the scope and magnitude of FGM/C in Sudan will be presented. The rationale and the study objectives will be articulated. This is followed by a description of the method and the framework used.

2.1 Problem analysis and Justification

FGM/C is a practice which includes: (all the procedures that involve total or partial removal of the females' external genitalia, or any injury to the females' genital organs without medical justification) (WHO, 2010). FGM/C is a deeply rooted practice in the Sudanese culture and society. It is practiced all over the country although the prevalence and the form vary between regions and ethnic groups (MICS, 2001).

The last national estimate of FGM/C prevalence was 65.5% (SHHS, 2010), this is slightly lower than the previous estimate 69.4% (SHHS 2006). Most of the available prevalence rates depend on self-reports of the respondents to surveys and many have questioned the validity of those estimations and their ability to reflect the problem (Bedri, 2012).

WHO has classified FGM/C into 4 types: I, II, III, and IV. The most common type of FGM/C practiced in Sudan is the severe one, type III, locally called pharaonic circumcision. FGM/C is always performed on girls less than 10 years old mainly by traditional birth attendants and midwives (Abdel Magied 2008b). Recently, there is a growing trend of medicalizing this practice in Sudan (UNICEF, 2005a) and some doctors are now performing it (details will follow).

FGM/C is a complex and culturally sensitive issue and the motives to perform it are diverse and vary between different communities. There is a clear knowledge gap. Experts believe that research is needed to study the factors underpinning FGM/C practice and that this could make efforts to combat it more effective (WHO 2006c).

Personally, I can clearly remember the anxiety and fear I felt when as a child I heard the heated discussions between my grandmother and mother and how my grandma was trying to convince her about FGM/C, arguing about the benefits she thought that it has, such as how cleaner and more beautiful and feminine the cut women are. Furthermore, I have also heard several sad stories from my relatives and friends about how FGM/C negatively affected

their lives. Thousands of women in the country are suffering the same and may be worse than what I have encountered among my family and friends.

Many reasons justify the efforts to eliminate FGM/C. First, it lacks any health benefits and it only results in adverse medical, psychological and social consequences ranging from immediate to long term and varying in severity between pain to haemorrhages and death (WHO, 2012).

Secondly, FGM/C is considered a human rights violation. It violates the right of women and girls to health, body integrity and in severe cases it also violates the right to life. It is nearly always carried out on minors and hence it is also a violation of the rights of children (UNICEF, 2005a).

Finally, Sudan is a developing country. With a low per capita income and worsening economy, the country might find it difficult to endure the cost implications of the health burden resulting from the complications of FGM/C and hence, there is a strong economic justification to stop this practice.

The efforts to combat FGM/C started early in Sudan during the 1940s by legislation prohibiting FGM/C and many efforts since then has been tried and continue. These include governmental and nongovernmental efforts by national and international NGOs. A national strategy to reach zero tolerance by the year 2018 was endorsed in 2008. Saleema national campaign was designed and endorsed to achieve this strategic goal (details in chapter 5). Nevertheless, the practice still continues in high rates and many Sudanese women/girls are at risk of undergoing it and many more are living with its complications. This brings the question: why FGM/C is still persistent in Sudan although there have been continuous formal and informal efforts to eliminate it?

With the objective to obtain knowledge and sound information about the factors which motivate people to continue FGM/C, this study aim at better support the proper design of the strategies and interventions needed to eliminate FGM/C.

2.2 Objectives

2.2.1 General objective

To describe the factors contributing to the continuation of FGM/C practice in Sudan, and make recommendations to inform the health system to contribute to the elimination efforts.

2.2.2 Specific objectives

1. To describe the scope of FGM/C in Sudan.

2. To study the cultural, religious and socio-economic factors influencing FGM/C in Sudan.

3. To analyse the Sudanese response including but not limited to health systems' efforts to eliminate FGM/C in Sudan, with a view to identify gaps in the current response given the factors influencing the continued practice of FGM/C.

4. To find the best practices from countries similar to Sudan and how these practices can be applied.
5. To make recommendations to inform health policy and practice.

2.3 Method

2.3.1 Study design

This is a descriptive, desktop literature review study examining the factors influencing the continuation of FGM/C practice in Sudan. Review of all available data from both qualitative and quantitative studies conducted in Sudan and countries with similar cultural background.

2.3.2 Search strategy

Published and unpublished information from Sudanese Federal Ministry of Health and other related information from other sectors in Sudan. The KIT library catalogue and VU library were used to reach published peer reviewed papers from the following sites: science direct, Google Scholar, and Pubmed, in addition to usage of Google and the Scopus database.

In addition to this, WHO, UNICEF, UNDP and UNFPA databases and websites were accessed for information on FGM/C.

2.3.3 Inclusion criteria

Literature about FGM/C in general and from FGM/C practicing countries was utilized. This include sociological, anthropological, medical and public health related materials in English and Arabic.

2.3.4 Exclusion criteria

Research literature in languages other than English and Arabic were not used. Abstracts without access to the full text were excluded due to an inability to understand their basis of inference.

2.3.5 Search terms

Female genital mutilation, Cutting, Complications, Factors, Culture, Religion, Social, Norms, Gender, Sudan.

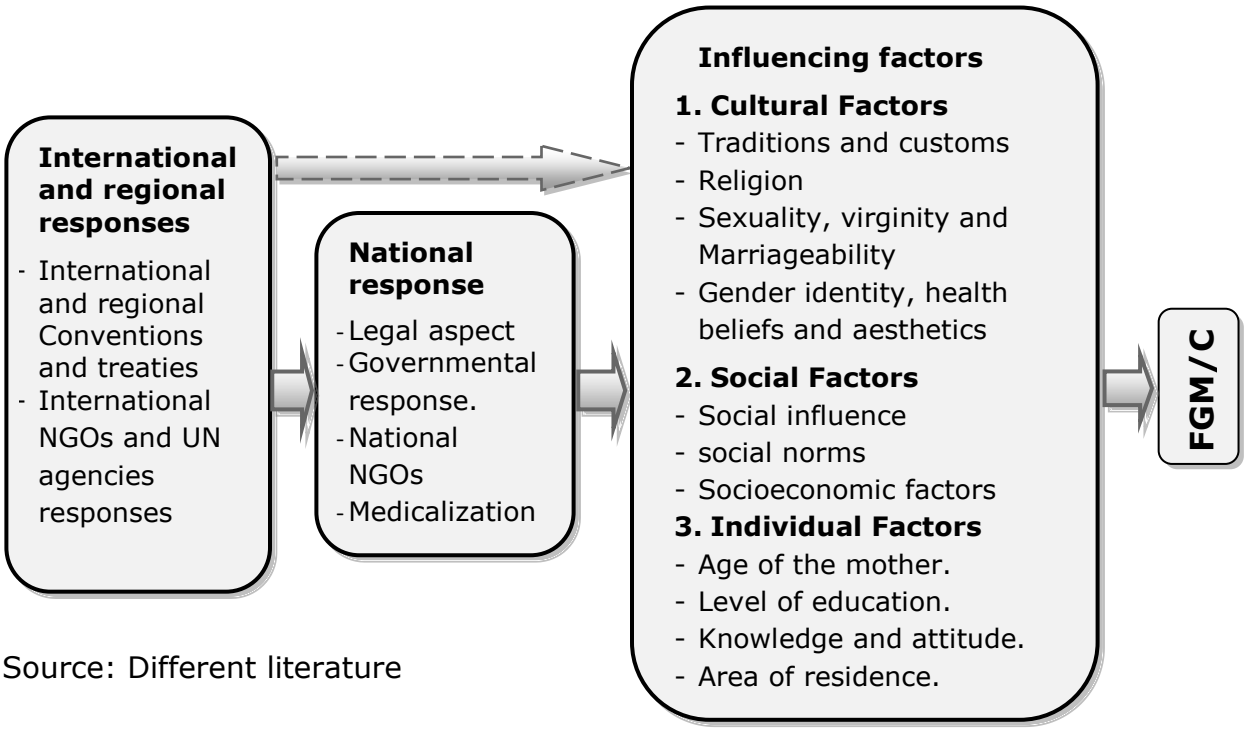
2.3.6 Limitations

This is a desk review based on available secondary data; the research objectives can be addressed better using primary data from both qualitative and quantitative research in Sudan in the future. Another limitation is that part of the information presented is about Sudan before the separation of the South due to the absence of updated information.

2.4 Conceptual Framework

The framework was developed and built based on the literature. I was inspired by Lalonde's determinants of health model (Lalonde, 1974) which is generally related but it has a group of determinants that are not appropriate to FGM/C since it is not a biological health problem. Factors which emerged from the different studies I have examined were used e.g. (UNICEF, 2010), (Gruenbaum, 2006), and others. Based on all these factors, this model was developed to study the factors influencing the continuation of FGM/C in spite of the continuous efforts to combat it in Sudan.

Figure 3: Factors influencing the continuation of FGM/C.



Source: Different literature

Culture and traditions are a big umbrella under which different components and elements fall. Religion as a component of culture (AFY, 1994) is known as a motive for FGM/C among the followers of different religious backgrounds (Moges, 2003). FGM/C is also influenced by a set of cultural beliefs, values and misconceptions related to virginity, sexuality, gender, beauty and health of females (Gruenbaum, 2006).

Another important group of factors that have a strong influence on FGM/C practice is the social factors. These include the social pressure by others on

both parents and daughters to undergo FGM/C. This is a manifestation of the assumption that FGM/C is now continuing as a social convention among the practicing communities. Another factor is the social norms which are enforced by a set of sanctions and rewards for those who break or conform to the practice (UNICEF, 2010). Economically, FGM/C tends to be linked to the socioeconomic status of the family, and it has been observed to be more prevalent among the poor (Almorth, 2005). Moreover, the circumcisers, as long as they are being paid, have their own interest to maintain the practice.

Demographic variables found to have an influence on the decision to cut a daughter include: the parents' level of education; age of the mother; her knowledge and attitude toward FGM/C (Ouedraogo, 2009). Other demographic factors include: area of residence and having a cut mother (Rasheed *et al.* 2011).

Efforts to combat FGM/C started early in the last century and it has resulted in many international and regional conventions and treaties that consider FGM/C as human rights violation for children and women. Additionally, different relative UN agencies and international NGOs have policies and strategies against the practice and have many interventions going on in coordination with the national governments to stop FGM/C (details in chapter 4). (details in chapter 4).

National governments of most FGM/C practicing countries have enacted laws and legislations against the practice (UNICEF, 2005a). The response by the health systems of these countries can be seen in the policies, strategies and interventions to stop this harmful practice.

This framework assumes that FGM/C continuation is maintained by the influence of culture and traditions, social and individual factors. The national responses are directly working to counteract the effect of these factors while the international responses directly influence the national efforts. For instance through the conventions and consequently indirectly influence the encouraging factors.

Generally the factors in this framework are linked and interact with each other. FGM/C exists as a product of this interaction.

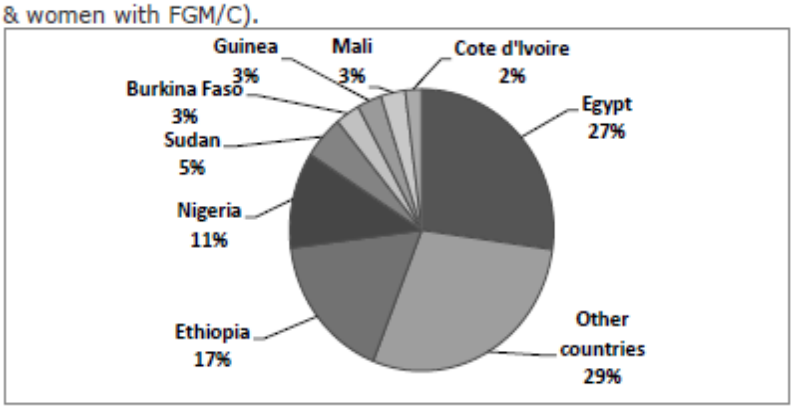
Chapter 3: Scope and distribution of FGM/C

This chapter discusses the scope of FGM/C by giving a description of the global picture, the origin and prevalence of FGM/C and the different types in Sudan. A description of the procedure and its complications will be given. Finally, light will be shed on the decision making process.

3.1 Global Overview

FGM/C is a global practice. It is largely practiced in Africa, the Middle East and also among immigrants throughout the world. Moreover, recent data shows that it is now practiced on a larger scale. FGM/C continues to be one of the most continuous and extensive human rights violations (UNICEF, 2005c). According to WHO, about 130-140 millions girls/women globally are presently living with the negative consequences of FGM/C. In Africa, it is practiced in about 28 countries with an estimated 92 million girls, 10 years old and above have undergone it (WHO, 2011).

Figure 4: Where girls and women with FGM/C live (% of the 92 million girls & women with FGM/C).



Source: WHO 2011

Global prevalence rates show large geographic and regional variations. In north-eastern Africa, prevalence varies from 97% in Egypt to 80% in Ethiopia. In western Africa, 99% of women in Guinea versus 5% in Niger were cut, while in south-eastern Africa, the prevalence rates are relatively lower with 32% in Kenya and 18% in Tanzania. The regional variation may reflect the presence of diverse ethnic communities (UNICEF, 2005a).

3.2 FGM/C classification

FGM/C is classified according to WHO into 4 types: type I (clitoridectomy), type II (excision), type III (infibulation) and type IV which includes all other forms of FGM/C (WHO, 2011). For more details see the table below.

Table 1 WHO classification of FGM/C.

Type	Description	Subtypes
Type I (Clitoridectomy)	Partial or total removal of the clitoris and/or the prepuce.	Type 1 a: removal of the clitoral hood or prepuce only
		Type 1 b: removal of the clitoris with the prepuce
Type II (Excision).	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora	Type IIa, removal of the labia minora only. Type IIb, partial or total removal of the clitoris and the labia minora; Type IIc, partial or total removal of the clitoris, the labia minora and the labia majora.
Type III (Infibulation).	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris	Type IIIa, removal and apposition of the labia minora. Type IIIb, removal and apposition of the labia majora.
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.	

Source: (WHO, 2011).

3.3 History of FGM/C

FGM/C has been found in different cultures and throughout history. Nevertheless, there is no proof documenting the definite origin and the same finding could be true for its origin in Sudan.

There are different theories explaining its origin and dissemination. One claim is that FGM/C was brought to Sudan by the Arab traders after it started in the Arabian Peninsula before Islam. Another claim states that FGM/C was first started in Egypt by the pharaohs on their wives to ensure their fidelity. This can justify the name 'pharaonic circumcision' which is given to infibulation. Herodotus referred to FGM/C in Egypt 500 BC and claims that it was practiced among the Phoenicians and Ethiopians; an area, which might include some parts of modern Sudan (Lightfoot-Klein, 1991). According to these two theories an assumption can be drawn that in the northern parts of Sudan FGM/C might have spread from Egypt while the east of Sudan acquired it from the Arabs through the Red sea and later it spread to the whole country. Along the similar line, until the 1960s American

gynaecologists practiced clitoridectomies as a treatment to erotomania, hysteria, lesbianism, and clitoral enlargement (Nour, 2008).

3.4 Types of FGM/C in Sudan

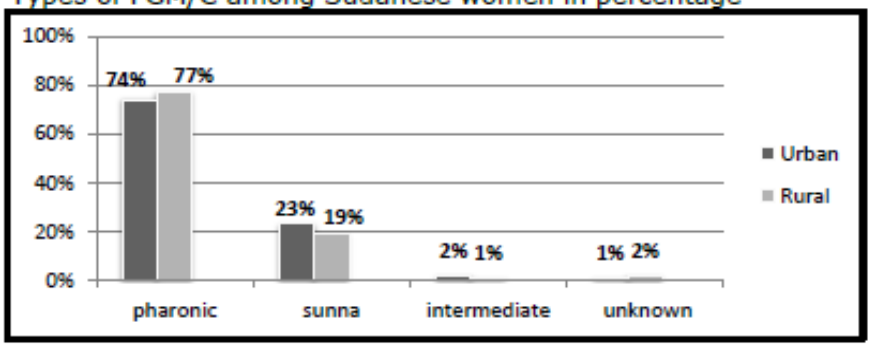
FGM/C is a common practice in Sudan. Khifad is the name given to FGM/C in classical Arabic which means reduction. In Sudanese popular Arabic it is called Tahur (literally means purity and cleanliness) (DHS, 1991).

In Sudan, however, three main types of FGM/C can be distinguished, first the "*pharaonic circumcsion*" or infibulation (WHO Type III), which consists of complete removal of the clitoris and both the labia minora and majora followed by stitching of the wound's two sides. In fact, this type implies narrowing the vagina leaving only a tiny orifice for urine and menstrual blood (DHS, 1991). The method of infibulation varies by area of residence and ethnicity (UNICEF, 2005a). Pharaonic circumcision is the favoured type in Sudan with prevalence of 74% in urban and 77% in rural areas (MICS, 2001). There are obvious regional variations where the Pharaonic type is more common in most of the north but it is less practiced in Darfur (UNICEF, 2005a).

The second type is the "*sunna*" or clitoridectomic type which is the mildest form and ranges from removal of the prepuce to complete excision of the clitoris. It is the second most preferred type of FGM/C with 23% prevalence in urban and 19% in rural areas. The proportion of the sunna type varies greatly between 3% in Northern state to 71% in West Darfur (MICS, 2001).

Matwasat (literally means intermediate) is the third form of FGM/C, which lies between the sunna and pharaonic with regard to the amount of the excised tissues and severity. Matwasat generally involves removal of the clitoris, the anterior part or all of the labia minora, and all or a portion of the labia majora and stitching of the wound but without narrowing the opening. Matwasat appeared after legislation prohibiting *pharaonic circumcision* in 1946 (DHS, 1991) and it is the least prevalent form of FGM/C in Sudan.

Figure 5: Types of FGM/C among Sudanese women in percentage



Source: (MICS, 2001).

Different studies in Sudan showed that there is a shift in the practice from pharaonic to clitoridectomy, apparently among young educated families (Almoth, 2005).

Reinfibulation (literally means improving and putting right) is a unique form of FGM/C and has been defined as the re-stitching (following delivery) of the scar tissue resulting from infibulation, but it could also be performed as an additional tightening simulating the narrow opening of a virgin (Berggren *et al.* 2006).

3.5 Prevalence of FGM/C in Sudan

The changes in FGM/C prevalence along a period of approximately three decades (1979-2010) will be presented in the following section.

The World Fertility Survey in 1979 reported FGM/C total prevalence to be 96% (DHS, 1991). Five years later, a national survey in Sudan conducted in 1983 by Rashwan and El Dareer estimated the overall FGM/C prevalence at 96.5% (Abdel Magied, 2008a).

Table 2: Shows FGM/C Prevalence in Sudan (1979-2010)

%	Year	Source
96%	1979	(DHS, 1991)
96.5%	1983	(Abdel Magied, 2008a)
89.2%	1990	(DHS, 1991)
90%	1999	(Abdel Magid, 2008a)
90%	2000	(Abdel Magid, 2008a)
69.4%	2006	(SHHS, 2006)
65.5%	2010	(SHHS, 2010)

Sudan Demographic and Health Survey (DHS) reported FGM/C prevalence of 89.2% (DHS, 1991). In the period between the Fertility Survey and the

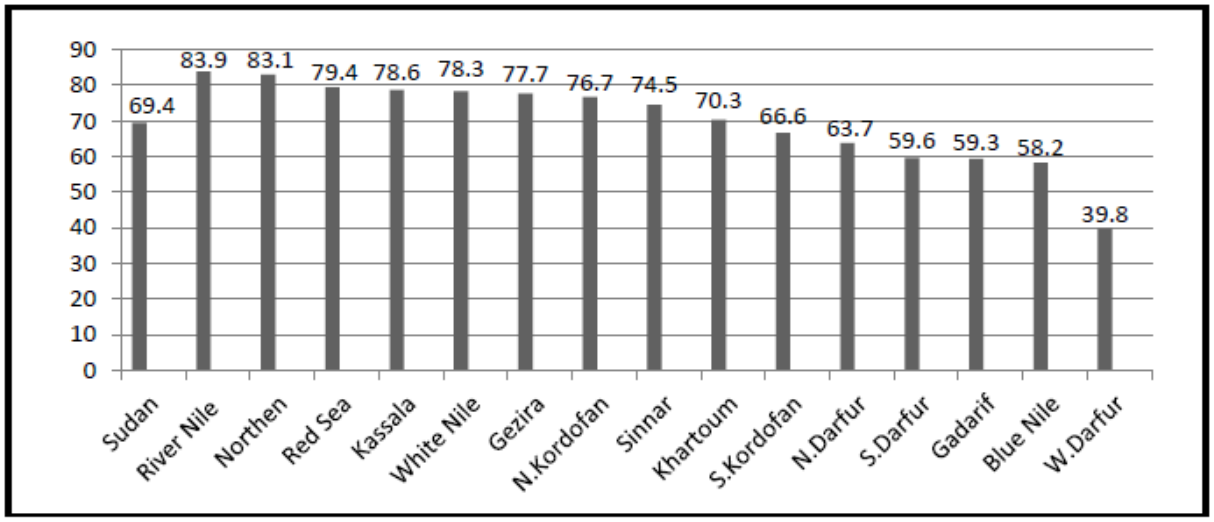
DHS, there was a slight decrease in the total prevalence from 96% to 89.2% and 10% shift in practice from infibulation to clitoridectomy (Toubia and Sharief 2003).

The Safe Motherhood Survey (SMS) conducted in 1999, recorded 90% prevalence. Successively, the Multiple Indicator Cluster Survey (MICS) in 2000 estimated the overall prevalence at 90% (Abdel Magid, 2008a).

Accordingly, FGM/C prevalence had almost remained constant for about two decades (1979-2000), obviously unaffected by the efforts to raise awareness about FGM/C complications (Berggren *et al*. 2006 and Almroth 2005).

The Sudan Household Health Survey (SHHS, 2006) reported a sharp decrease of the total FGM/C prevalence of 69.4%. The alleged abrupt drop in prevalence (20.6%) seems unrealistic within a period of six years because achieving this reduction would involve a change in the attitude toward the practice through appropriate intervention efforts, a situation which is not achievable within such relatively short time (Abdel Magied, 2008a). So, this estimation should be taken with caution.

Figure 6: Prevalence of FGM/C among women (15-49) years who have had any form of FGM/C by states, Sudan, 2006



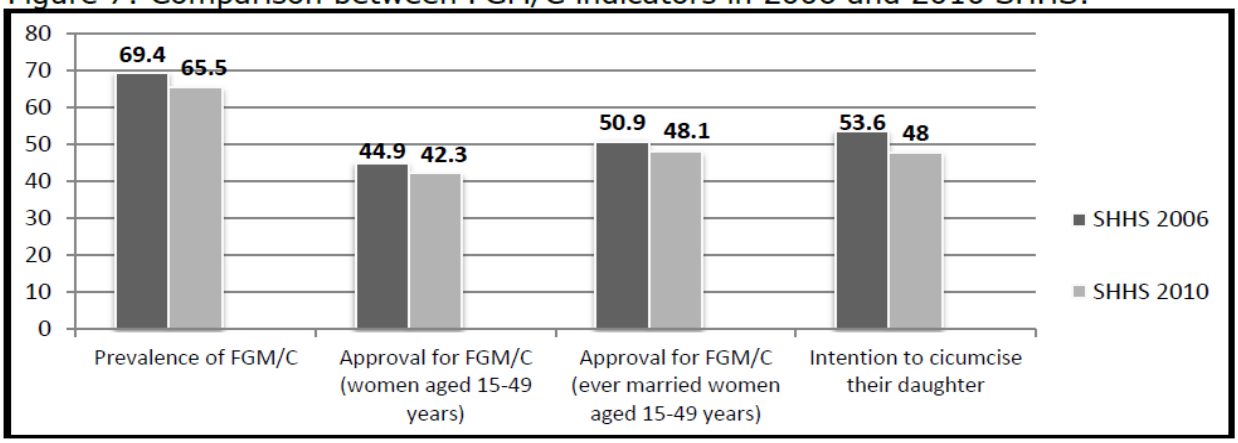
Source: (SHHS, 2006).

FGM/C prevalence estimated in 2006 varies between different parts of Sudan; higher rates were recorded in the north and central parts of Sudan where the prevalence ranges between around 84% in River Nile to 70% in Khartoum and the least prevalence was recorded in West Darfur which was about 39.8% (SHHS 2006). This observed variation may be due to variations in tribes and ethnic groups in different regions indicating that FGM/C is not

universal among Sudan's different ethnic groups. The proportion of women who had been mutilated was higher (90.6%) among women between (35-39) years and slightly lower (86.6%) among girls between (15-19) years (SHHS, 2006). This may indicate a slight decrease in the trend.

FGM/C prevalence is currently high; the last national estimate by SHHS (2010) was 65.5% with only 3.9 drop from the last estimate in 2006. A comparison between FGM/C indicators 2006 and 2010 in (figure 7).

Figure 7: Comparison between FGM/C indicators in 2006 and 2010 SHHS.



Source: SHHS 2006 and 2010.

3.6 The procedure

The procedure of FGM/C in Sudan has the following characteristics:

FGM/C is performed on the victimized girls without their mature consent generally less than 10 years old. However, there are regional and ethnic variations where for example it is performed during the first week after birth among Beni Amir and Bija tribes, east of Sudan (Abdel Magied, 2008b). Generally, the practice is performed during the school holidays, between April and July (SOAT, 1999 cited by Landinfo, 2008) hence, this can be a suitable period to intervene against FGM/C.

According to UNICEF, more than 60% of those who perform FGM/C in Sudan are traditional birth attendants (TBAs traditionally called dayas) (2005b), and approximately 32% are midwives (UNICEF, 2005a). Trained midwives are more likely to perform the milder form of FGM/C than TBAs. 65% of the severe form was performed by TBAs and only 34% was performed by midwives (UNICEF, 2005b). Recently there is a trend of medicalization where FGM/C is performed by medical professionals using anaesthetics and surgical instruments (UNICEF, 2005a).

UNICEF reported that razors and knives are the most common instruments used in the cutting of girls (UNICEF, 2005b). Currently, in urban areas, modern instruments are used and the operation is done using anaesthesia. However, in some rural areas in Sudan, primitive instruments are still used and the operation is done without anaesthetic (Bedaux and Schuiling 2005).

The operation takes usually 10-20 minutes, depending on the type. During the operation, the girl is held down by some women. Afterward the wound is treated by a topical application of local herbs or other traditional materials. In the case of infibulation, the legs of the girl are bound together to control mobility till the wound heals (UNHCR, 1995).

The operation is mostly accompanied by celebrations and the child receives gifts (Almorth, 2005). A study in east Sudan reported that it is less common to celebrate FGM/C now. This might indicate changes of the attitude towards the practice (Ansorge, 2008).

3.7 Decision making process

The pattern of FGM/C decision making process is intricate (Almorth, 2005). The decision-making process where FGM/C is common is an interdependent process which not only relies on individuals' preferences but, it depends on reciprocal expectations (UNICEF, 2010).

In a study in Khartoum, the younger women claimed that the older ones have the power of decision and they always insist on performing FGM/C, preferably the pharaonic (Berggren *et al*. 2006). Almorth's study showed that currently men are also involved especially when the decision is not to perform FGM/C or reinfibulation (Almorth, 2005).

In the case of reinfibulation, mothers, female relatives and the midwives have influence in the decision, always with the husband's support (Berggren et al. 2006).

3.8 FGM/C Complications

FGM/C involves removing and distorting healthy and normal tissues interfering with the natural functions of female's bodies. It has considerably severe and always irreversible lifelong complications (UNICEF, 2008). Both types of FGM/C commonly practiced in Sudan (sunna and pharaonic type)

have health complications, however those resulting from the pharaonic type are generally more frequent, severe and long-lasting (Toubia, 1995).

In-addition to its medical complications, FGM/C may lead to psychological complications and adverse effects on the social life of women and the family (eg. divorce). Complications of FGM/C depend mainly on: the type performed; circumciser's skill; girl's age; instrument used; general conditions and use of antiseptics (Reyners, 2004).

3.8.1 Immediate complications

FGM/C operation is usually followed by a range of immediate medical and psychological complications including pain, bleeding, urinary tract infections and trauma of the surrounding organs (WHO, 2012). Immediate psychological complications include disturbances in sleeping, eating, mood, and cognition, beside feelings of fear, inhibition, rage and bitterness."(Rahman and Toubia, 2000)

3.8.2 Long term complications

Psychological, Psycho-sexual and social complications:

FGM/C causes psychological (conscious and unconscious) dysfunctions since it is a bloody and highly traumatic procedure. FGM/C is considered child abuse (Reyners, 2004).

A study in Egypt revealed different psychosexual complications (table 3). Divorce as a social complication was reported higher among cut women (Reyners, 2004). Moreover, a significant reduction in the sexual satisfaction among cut women was reported in Nigeria (Mukoro, 2004).

Table 3: showing Psycho-sexual complications in a study in Egypt (2004)

Percentage	Complication
60%	have low scores for sex frequency
56%	has never experienced orgasm
50%	experience pain during intercourse or reaction with vaginismus
30%	have less libido, are more passive, repulsive
25%	does not feel any arousal during intercourse
10%	feel to be less female because of the lack of a typical organ
5%	suffered from depression; mostly caused by relationship issues
6%	divorced compared to 1% of the not circumcised women

Source: (Reyners, 2004).

Obstetric complications and infertility: It is has been proven that cut women are at a high risk of complications during delivery including increased probability of being complicated by caesarean section, postpartum haemorrhage, episiotomy, extended hospitalization and perinatal death of the infant (WHO, 2006b).

Moreover, a study in Sudan reported a strong association between severe types of FGM/C, and primary infertility among women. Women's concerns about fertility impairment are undeniable in Sudan where motherhood is an essential source of status, support and security (Almroth *et al.* 2005).

Male complications: Male also are facing some complication due to having a mutilated (mainly infibulated) wife. Male complications include difficulties in penetration, wounds and infections on the penis, and psychological problems (Almorth *et al.* 2001).

Chapter 4: Factors influencing the continuation of FGM/C in Sudan

In this chapter, the factors that have an influence on the continuation of FGM/C will be reviewed, presented and analysed in an attempt to answer the question "why FGM/C continues?".

4.1 Traditions and Culture

Traditions and cultural practices reflect beliefs and values held by the community members often for long periods. Each social group has its specific set of these practices. While some of them are beneficial; others are harmful mainly to disadvantaged groups, such as women (UNHCR, 1995). FGM/C is one of those (HTPs) that it is deeply rooted in Sudanese local culture.

According to DHS report, FGM/C is mainly based on tradition, rather than religion (DHS, 1991). In the same context, in a study in Khartoum, women mentioned tradition as a main reason for practicing FGM/C and reinfibulation as the proposed men sexual pleasure, for which women have to sacrifice. The older women in the same study stressed that FGM/C is an important tradition. The unequal power in the maternalistic[1] relations between daughters and mothers might assist in maintaining the tradition of FGM/C (Berggren *et al.* 2006). Tradition was also the main reason given by the grandmothers in Almorth's study (2005). Similarly a survey carried out in Darfur documented that tradition was also the major reason cited for the justification (36.4%) forFGM/C (Rahma, 2009). Consistent with this, UNICEF reported that in Sudan, Côte d'Ivoire and Eritrea, around 70% of women find traditions and customs the most influential cause justifying the continuation of the FGM/C (UNICEF, 2005a).

Traditions are always enforced by myths and cultural beliefs. For instance Beja tribes (a large ethnic group in eastern Sudan) believe that an uncut female is vulnerable to 'evil spirits' and accordingly they perform the Pharaonic circumcision within the first week after delivery to protect the girls (Sahl *et al.* 2004).

1 'It is a female version of paternalism, meaning some form of interference with another person's preference regarding their own good with the aim of benefiting her' (Berggren et al 2006).

To conclude, tradition is reported as the main motive for FGM/C continuation. And according to Moges (2003) it is the justification given to cover many reasons behind FGM/C as all other norms of our life. Tradition is often twisted and enforced by the cultural understanding of sexuality, marriage, gender, and family (UNICEF, 2010).

4.2 Sexuality, virginity and marriageability.

Sexuality, virginity and marriageability are related concepts and they are considered determinants of FGM/C in different studies.

Gruenbaum in her studies (1970s, 1989 and 1992) in Sudan, identified sexuality and marriageability as highly influential factors of FGM/C (Gruenbaum, 2001). Uncut girls/women are perceived as hypersexual, without an ability to control their sexuality and this is considered undesirable for marriage and may bring social shame to the family (Berggren *et al.* 2006). In a study in the east of Sudan, women claimed that FGM/C increases male pleasure during sex, and consequently increases the marriage prospects (Ansorge, 2008). Some women added that reinfibulation makes the husband satisfied and prevented him from divorcing (Berggren *et al*. 2006). In Sudan both men and women perceived infibulation significant for male sexual pleasure, a belief that consequently encourages its continuation (Gruenbaum, 2006).z

Virginity is vital for most of the Muslim population. A non-virgin bride risks immediate divorce and brings great disgrace on her family. The value of virginity is gained from Islam which prohibits extramarital sexual relations (Gruenbaum, 2001). Mackie, 1996 in his study concluded that FGM/C is a symbol of honour (Ouedraogo, 2009). The link between virginity and FGM/C lies in the belief that FGM/C is a key mechanism to ensure virginity and consequently secures the family honour. The main types of FGM/C practiced in Sudan are considered as a means to ensure virginity. In the Pharaonic type the infibulated vagina serves as a 'natural' barrier to sex while the sunna type which involves removal of the sensitive clitoris is believed to reduce the girl's sexual desires, and minimizing the chance of sexual experience before marriage. After marriage both types of FGM/C are held as causes for greater marital fidelity (Gruenbaum, 2001). In consistence with this finding a study in Egypt reported a belief that women's sexual desire resided in the clitoris and it would be decreased by cutting so, FGM/C is a useful measure to preserve virginity and marital faithfulness (WHO, 2010).

A study in Sudan reported increase marriageability and tradition as the main motive for FGM/C (Berggren et al. 2006). In Sudan, female virginity is considered as a condition for marriage, and generally it is beleived that virginity and sexual chastity can be ensured by FGM/C (Gruenbaum, 2006). Chesnokova and Vaithianathan conceptualized FGM/C as pre-marital investment where marriage market competition can lead to inefficiently high levels of FGM/C in equilibrium. In this case, regulation can be useful because the cost of FGM/C to females is higher than the benefit to men (Coyne and Mathers, 2009).

4.3 Gender

Different aspects of gender bear upon the relationship between FGM/C and gender. Gender identity and aesthetics and related health beliefs will be discussed in the following.

FGM/C is performing in a context of a patriarchal system with clear unequal gender relations that result in emphasizing male honour and pleasure at the expense of female right and dignity (Berggren *et al.* 2006) and hence, FGM/C is considered a form of gender inequality. It has a discriminatory nature against girls/women (UNICEF, 2010), denying their right to sexual full enjoyment. FGM/C can also be considered as a mean of 'controlling women' or 'suppressing female sexuality' (UNICEF, 2005a). In Sudan many women, mainly rural, prioritize men's sexual satisfaction at the expense of their own satisfaction, and some also claimed that they feel happy to satisfy their spouses; hence they enjoy sex vicariously (Gruenbaum, 2006).

FGM/C is considered by its practitioners a significant part of girls'/women's culturally known gender identity (UNICEF, 2005c). It is widely believed that the clitoris is a "male part" on girls and it should be removed since it produces gender ambiguity, and hence FGM/C is performed to complete the natural sexual identity of girls (Gruenbaum, 2006). In communities practicing FGM/C the removal of the clitoris is perceived to make a woman feminine (Moges, 2003).

Beauty and sexual desirability are interpreted variously in different cultures. Individual adherence to traditional body forms is supported by traditional aesthetic values (Gruenbaum, 2006). Regarding FGM/C, in Sudan, it is believed that female genitalia are ugly and if they are not cut they will grow to become bulky therefore, FGM/C is considered beautification, and related

to cleanliness (Berggren et al. 2004). Different health related misconceptions are influencing FGM/C practice. An uncut woman is seen as unclean and must be purified (Ouedraogo, 2009). These misconceptions are built on the false belief that secretions from the glands in the clitoris and labias have an unpleasant smell (AWO, 2003).

In some communities like in Nigeria FGM/C is practiced as a "fertility rite" just before marriage (Kolawole and Kwaak 2010).

4.4 Religion

FGM/C antedates both Christianity and Islam and is practiced by the followers of both religions in addition to followers of some traditional beliefs and animists (Moges, 2003). In the following, religion will be presented as a motive for FGM/C with special focus on Islam since Sudan is an Islamic country. The Holy Qur'an does not mention FGM/C but the practice might be justified on the basis of Hadith[2]. FGM/C has acquired a religious dimension because it is extensively practiced among Muslims in FGM/C practicing countries (Moges, 2003). Furthermore some religious terms are used to describe it.

For instance the popular term to describe FGM/C is Tohara (in Sudan it is Tahour), which means in Islam (ritual cleanliness). There is a deep-rooted belief that uncut women cannot reach this state of cleanliness because the clitoris will grow forming skin folds, which stash dirt that cannot be easily removed. Another example is the term 'sunna circumcision' that used to describe (clitoridectomy) which contains the Islamic word 'Sunna'[3] (Asmani and Abdi 2008).

Although there is no formal religious doctrine, different surveys in Sudan reported religion as a motive for FGM/C (Almroth 2005). However, Ansorge (2008) in her study in eastern Sudan and Almroth (2005) in his community-based study (also in Sudan) found that religion seems to have less impact on FGM/C than tradition and social influences.

A study in Sudan found that men commonly mention religion as arguments both for and against FGM/C (Berggren *et al.* 2006) and similarly, Almorth

2 Saying of the prophet Muhammed (PBUH) (Asmani and Abdi 2008a).

3 (Sunna means any saying or act attributed to or approved by the Prophet Mohammad) (Asmani and Abdi 2008a).

(2005) reported that fewer women than men believed that FGM/C is part of the religion (33% & 56% respectively) and the degree to which people believe in the relationship between Islam and FGM/C is not influenced by their level of education.

A considerable proportion of women, in high prevalence rate countries, stated that they believe religion requires FGM/C. This idea is supported by research in which 70% of women in Mali, 57 % in Mauritania, 33% in Yemen and 31% of Egyptian women believe that FGM/C is a religious requirement. The commonly held view that Muslim women are more likely to cut their daughters was refuted in Ethiopia, Kenya, and Tanzania where the prevalence of FGM/C is lower among daughters of Muslim women than among daughters of Christian women (UNICEF, 2005a).

To conclude, the religious dimension of FGM/C is complicated due to cultural and social reasons and the influence it has as a determinant for FGM/C varies between countries.

4.5 Social influence

Humans are basically social beings and they need to feel part of their society, to do so, they have to conform to the social rules (Fehr and Fischbacher 2004). The social influence that FGM/C has on people to maintain its existence originated from it is being performed as a social convention and a social norm altering the decision-making to interdependence rather than individual process (UNICEF, 2010).

A study in Sudan showed that many parents do not want to perform FGM/C on their daughters but they think it is socially unacceptable and hence the social importance determines their decisions. The same study found that social pressures on the parents from outside the family, has a strong influence on the decision to perform FGM/C and the daughters may ask to be cut as a response to peer pressure (Almorth, 2005). Another survey in Darfur (west of Sudan) concluded that the second most frequent reason for FGM/C practice is the social pressure (tradition was the first reason), according to 33.3% of the respondents (Rahma, 2009). There are also some families who do FGM/C ritual celebration but pretend to cut. They seem afraid to stand out, and choose to show plausible conformation to the community norms (Ansorge, 2008). This clearly shows how a choice of a family is influenced by and influences the choices made by other families in

the community. Social convention theory explains that in the areas where FGM/C is common, an equilibrium state is created and no family has an impetus to swerve from the social expectation (UNICEF, 2010).

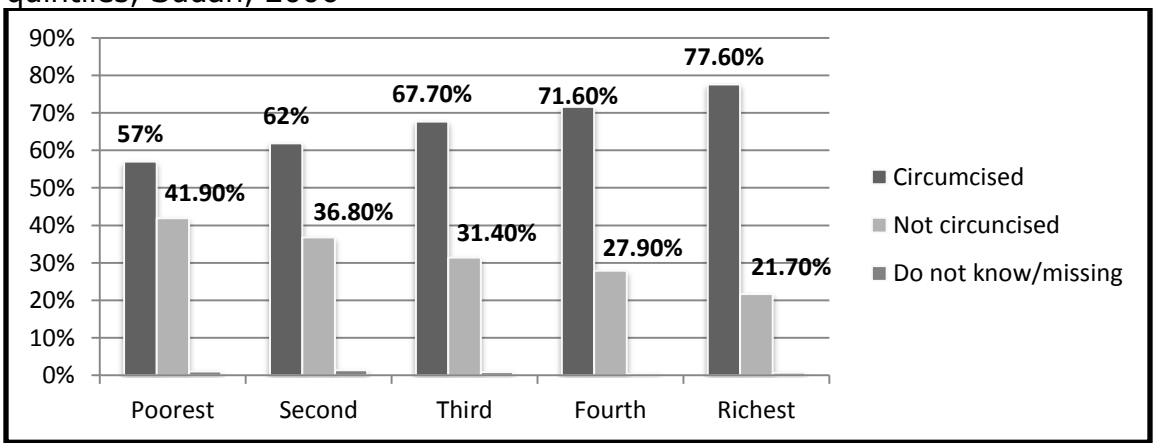
The role of social norms in maintaining FGM/C in a given community could be seen in the social approval or disapproval which is manifested as community and peer pressure. Conformity is encouraged by expectations of rewards for adherence which is important to maintain an individual's social status and acceptance in the community and also to safeguard the status of the family and non-adherence is followed by sanctions which include social isolation and ostracism (UNICEF, 2010). Sanctions also include the risk of stigmatization and uncut girls may be described as being hypersexual. They may also be exposed to violence and insult, for example by the expression "Ghalfa", meaning that the girl is perceived as smelling nasty (Berggren et al. 2006). Traditional beliefs as FGM/C protect girls from sexual assault, influence and enforce the social factor (Almroth, 2005).

4.6 Socioeconomic factors

The prevalence of FGM/C tends to be linked to the household economic level. The parental socio-economic level is a significant factor determining FGM/C practice in Sudan (Almorth, 2005). A study among adolescents (13-19 years) in Khartoum found a strong association between the economic status of the parents and the state of FGM/C of the daughters. Most of the girls with parents of high socio-economic status were not cut while the majority (91%) of those with parents of lower socio-economic status were cut (Abdel Magied *et al.* 2003). Similarly, in Burkina Faso, the probability a daughter will be cut is lower among richer families than among poor families (Ouedraogo, 2009).

Surprisingly, in Sudan SHHS results showed that the percentage of women (aged 15-49 years) who had any form of FGM/C among those from the poorest households was 57% while it was 77.6% among those from the richest households (SHHS 2006). This may be due to confounding by ethnicity or regions. A study carried out in Egypt found that the socioeconomic level of the parents has no influence on the incidence of FGM/C (Rasheed *et al.* 2011). This may be due to the high prevalence of FGM/C in Egypt.

Figure 8: Percentage of females who have had any form of FGM/C by Wealth index quintiles, Sudan, 2006



Source: (SHHS, 2006)

Women and girls are normally less educated than men, and have limited job opportunities, especially outside urban centres, hence they have no or few options and would find it difficult to survive without the approval of their community (Landinfo, 2008). According to Nwakeze, women's sexuality is influenced by their limited decision-making power, and the decision making power is a function of their economic independence (Nwakeze, 2001). Along the same line, uncut daughters are not eligible for marriage where FGM/C is a common practice in the community. They may be seen as an extra burden on their parents and to avoid this, parents prefer to cut their daughters (Moges, 2003). This may explain how the economic status of women influences their decision.

On the other side, the circumcisers also play a considerable role in promoting and maintaining FGM/C practice especially in rural areas. Their business provides them with a social status and a regular income in the community (Moges 2003). For instance, in the cases of reinfiulation, some women in Sudan claimed that the midwives are the major decision maker since they are being paid, and a few women stated that the midwife had automatically reinfibulated them after delivery (Berggren *et al.* 2006). In Egypt, a study among practitioners who perform FGM/C revealed that 30% of them perform it only for profit (Refaat, 2009).

4.7 Age of the women and FGM/C experience

Younger women are less likely to approve FGM/C than older women. Among women aged 15-19, 41.9% approved the continuation of FGM/C, while

48.4% of women between the ages of 35-39 did. Shockingly, it is also found that the approval of mutilating daughters was stronger than the approval of FGM/C in general among ever married women groups, since about 53.2% intended to cut their daughters among the age group 35-39 years while only 50.3% among the same group approved the continuation of FGM/C (SHHS, 2006). A study in Egypt concluded that having a cut mother is a significant factor determining the likelihood of a daughter being cut (Rasheed *et al*. 2011).

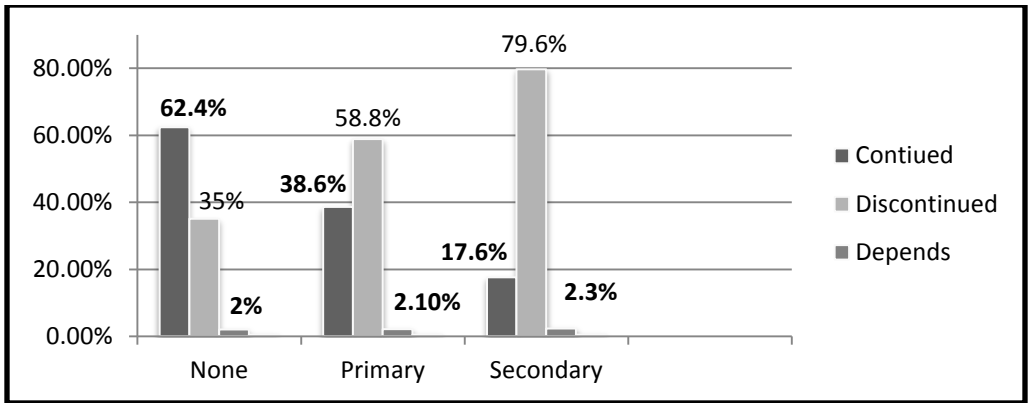
In Burkina Faso and Nigeria younger women are less likely to cut their daughters. This could mean that the practice is reducing over time (Karmaker *et al*. 2011 and Kandala *et al*. 2009). Generally, many countries showed less prevalence among the younger groups. However, very little change can be found in Sudan indicating that FGM/C has been roughly constant over the last period (UNICEF, 2005a).

4.8 Level of education

Parental level of education is considered in many studies as a factor influencing the decision of FGM/C.

Almorth (2005) found that parental level of education is an important determinant for practicing FGM/C in Sudan. Another study in Khartoum also reported that the parents who had spent significantly fewer years in the school system had either cut or intended to cut their daughters (Satti *et al.* 2006). The data of SHHS (2006) showed that the educational level of the women has a clear effect on the attitude toward FGM/C where the approval to its continuation is inversely proportionate with the level of education of the women.

Figure 9: Attitude of women aged 15-49 years towards whether FGM/C should be continued or discontinued by level of education, Sudan, 2006



Source: SHHS, 2006

In Kenya, a study showed an inverse proportion between education and both the attitude of a woman toward the continuation FGM/C and the probability of a woman being cut (Hayford, 2005). Similar results were also seen in Egypt, East and West African countries with high and low FGM/C prevalence levels (Hayford and Trinitapoli 2009)

Contradictorily, in Nigeria, FGM/C prevalence is higher where the level of education is higher in southern areas. This finding may indicate that FGM/C is deeply rooted in culture, which has been difficult to change (Kandala *et al.* 2009).

4.9 Knowledge and attitude toward FGM/C

In Sudan, the curricula, in all levels of education, almost completely lacks any topics of reproductive health and sex education. The subject of FGM/C is mostly discussed among women because they are the main victims of it (Abdel Magied and Makki 2004). This may have an implication on the level of knowledge and attitude toward FGM/C among the community. A study in Egypt concluded that the women who are aware of the health complications of FGM/C are more likely to disapprove its continuation (Dalal *et al.* 2010).

The SHHS (2006) data indicated that 44.9% of women aged 15-49 years in Sudan approved the continuation of FGM/C but, there are regional variations where the least was in Khartoum (26.9%) and the highest (62.9%) was in North Darfur. The low level of FGM/C approval in Khartoum might be attributed to the presence of more educated women (DHS, 1991). The data of SHHS (2010) reported a slight decrease in the attitude toward FGM/C where 42.3% of women aged 15-49 years approved its continuation.

A study among university students showed that the majority were aware of the complications caused by FGM/C (91.4% males and 94.2% females). This awareness, however, didn't translate into disapproval of FGM/C where 17.3% of the males and 15.7% of the females still either approved FGM/C or were not sure about it. This could mean that the pressure from cultural, social and religious beliefs is stronger than any perception of danger caused by FGM/C (Herieka and Dhar 2003).

Results of another study among religious groups showed that about 5-15% denied any harmful effects of FGM/C. The majority of them (55% of Sufists -75% of imams) prefer not to mutilate their daughters (Abdel Magied *et al.* 2005). This result should be taken seriously since the religious leaders are important stakeholders in any response against FGM/C.

A study in Egypt showed that although more than half of the parents (57.4%) were aware about the risks associated with FGM/C. None believed that it is actually dangerous in any way, although the majority of the parents whose daughters did not undergo FGM/C (78.1%) had received information about the risks associated with FGM/C. Only 6.4% of them believed that it is dangerous, (Rasheed *et al*. 2011) this may reflect how deeply rooted FGM/C is in the community.

To conclude, knowledge about FGM/C harms has an influence on the attitude towards FGM/C but it works in combination with other factors for the elimination.

4.10 Rural/ urban effect

Urban development has been considered as a factor that might influence FGM/C prevalence in most of the FGM/C practicing countries the prevalence tends to be higher in rural areas (UNICEF, 2005c). In 1990, the proportion of Sudanese women who approved the continuation of FGM/C was lower (72%) in urban areas than in rural areas (82%) (DHS, 1991). However, UNICEF recently found that in Sudan the prevalence in urban areas is higher than in rural areas. This may be due to the confounding effect of ethnicity (UNICEF, 2005c) or poverty since most of the urban residents (e.g. in Khartoum) are poor (Almorth, 2005). The assumption of a confounding effect can be supported by the finding in Egypt (which is also a high prevalence country) Where in contrast to Sudan rural residence was

reported as one of the socio-demographic factors most associated with higher rates of FGM/C (Rasheed *et al.* 2011).

Chapter 5: Responses to eliminate FGM/C and Challenges

This chapter focuses on the responses and efforts to abandon FGM/C practice, as well as the challenges facing these efforts with an emphasis on its "medicalization".

5.1 Responses against FGM/C

The responses at different levels, to combat FGM/C practice will be presented.

5.1.1 International level

Over the last several decades FGM/C has gained increasing international attention. It was considered a human rights violation at Vienna Conference on Human Rights in 1993. Successively, at the ICPD in Cairo (1994) FGM/C was mentioned specifically as a women's reproductive health violation, for the first time in an international document. Following that, in 1995, this was emphasized in Beijing at the 5th world conference on women. Related UN agencies (WHO, UNICEF, UNFPA) have policies against FGM/C (Toubia and Sharief 2003). There are also many international conventions and treaties which call for an end to HTPs. These include: the convention on the elimination of all forms of discrimination against women; the convention on the rights of the child; and the African charter on the rights and welfare of the Child (UNICEF, 2005a). In 2008, the World Health Assembly endorsed a decision on the elimination of FGM/C, in which all the states agreed to work towards the abandonment of FGM/C and that the procedure should not be performed by health professionals (WHO, 2010). The Millennium Development Goals (MDGs) set some targets of development which are related to ending FGM/C, namely: to decrease child mortality, to empower women and promote gender equality and to improve maternal health (Bennett, 2010).

5.1.2 Legal aspect

Making bodily harm to a person, even with his consent, is considered a crime with the exception of medical surgeries and since FGM/C lacks any religious, hygienic or medical justification it should be considered a crime and the parental consent might not be lawful (Cook *et al.* 2002).

In Africa, Sudan was the first country to legislate against FGM/C in 1946. The infibulation was prohibited but the less severe forms were allowed (Landinfo, 2008). Due to the lack of community support, the implementation of this law failed. As Sudan gained its independence, the law was upheld in 1957, and the penalty for the practitioners of infibulations was to be fined and/or imprisonment up to seven years (Bedri, 2012). When Sharia law was introduced in 1983, the article on FGM/C was dropped from the penal code (Ahmed *et al*. 2009). Currently the penal code does not criminalize FGM/C, although its articles on "physical injury" might cover the practice (Landinfo, 2008).

The most frustrating setback in the battle against FGM/C was the removal of Article 13, which prohibits FGM/C, from the 2009 Child Bill contradicting the country's constitution and the declared strategy to eliminate FGM/C in all its forms. This decision followed a fatwa[4] from the Islamic Jurisprudence Council which asked for a distinction between the various forms of FGM/C to be made; meaning that type 1 (sunna) must not be banned (Bedri, 2012). In the event that this distinction is granted, it will lead to the creation of a serious loophole which together with strong messages on the health risks of FGM/C, might contribute to the rapid medicalization of FGM/C as the case in Egypt (UNICEF, 2005c).

Fortunately, at the states level, two states- South Kordofan and Gadaref - have ratified the Child Bill with the article banning FGM/C in 2008 and 2009 respectively (Bedri, 2012).

In Africa and the Middle East, many countries have introduced specific legislation against FGM/C. These include to name but a few: Ghana, Djibouti, Burkina Faso, Egypt, Tanzania and Senegal. Ethiopia took a further step and prohibited FGM/C in its constitution. National legislation, although important, it has its limitations and is most effective when accompanied or preceded by a range of policy measures involving awareness raising (UNICEF, 2005c)

The Sudan Medical Council issued a decree in 2003 prohibiting doctors from practicing FGM/C and reinfibulation. However, it is difficult to bring matters

4 "Is a religious opinion on Islamic law issued by an Islamic scholar" (Shaukat, 2009).

to the courts because there is a lack of statutory prohibition (Landinfo, 2008).

5.1.3 Governmental efforts

The Ministry of Health endorsed the National Plan of Action on FGM/C in 2001. In addition, the Reproductive Health Strategy by the Federal Ministry of Health also includes a chapter on FGM/C. Both the strategy and the plan have provided a favourable environment for advocacy groups (Bedri, 2012). The plan of action has promoted establishment of mechanisms at various levels, federal, state and the community level. Involvement of different stakeholders and media campaigns are also promoted (UNICEF, 2005c).

In 2008, a strategy to eliminate FGM/C across the country within a generation (2008-2018) was endorsed by Sudan's National Council on Child Welfare (NCCW) (UNFPA, 2011a). Following the strategy a national campaign was launched with a focus on promoting debate to trigger collective behavioural change in the communities by replacing the negative ideas and words such as "Ghalfa" with a new social norm ; one that values and celebrates girls who are (Saleema) an Arabic word that means intact and healthy (UNICEF, 2010).

In 2011, 13 Sudanese states introduced programs to eliminate FGM/C, up from five states in 2008. In an innovative lesson on the effect of education in changing old traditions, a course in community development was provided to illiterate rural women by three universities. After graduation, 700 of those women were convinced of the harmful effects of FGM/C and started advocacy groups against it (UNFPA, 2011b).

In Sudan, 10% of the health facilities provide FGM/C counselling about prevention in their services. FGM/C is also included in the medical training curricula of staff members of the Ministry of Health. Similar training is also provided in midwifery and nursing schools of Sudan (UNFPA, 2011b).

5.1.4 National Non-Governmental Organisations

NGOs have typically been vital players in designing and implementing successful programs to combat FGM/C (UNICEF, 2005c). Although the Sudanese legal efforts started in the early 1940s, community awareness efforts had not been started until the 1970s by few NGOs (Bedri, 2012).

Many national NGOs are now working against FGM/C in Sudan. For example 'Babiker Bedri Association for Women Studies (BBAWS)' which started in 1979. Its pattern of activities in the first period was a trial and error exercise. Recently, it has developed interventions based on a new strategy. Another example is the 'Sudan National Committee for Traditional Practices (SNCTP)' which was established in 1998 with a major objective to combat HTPs, mainly FGM/C. In fact little has been achieved by the national NGOs with the tendency being more toward the direction of regional efforts rather than local coordination (Bedaux and Schuiling 2005).

5.1.5 Efforts of International NGOs

Different international NGOs have been working in Sudan with an objective to advocate against FGM/C. Among those is ACORD, which has a strategy for FGM/C within a package of community development. It has developed a special approach to address FGM/C through surveys and analysis to identify the stem causes and design effective interventions (Sahl *et al.* 2004).

Another example is GOAL which works in eastern Sudan. FGM/C is a small part of the organization's gender related issues strategy (Bedaux and Schuiling 2005).

5.1.6 Efforts of United Nations (UN) Agencies

In 1997 WHO, UNICEF, and UNFPA issued a joint statement on FGM/C and they declared their support for its abandonment (WHO, 1997). The document emphasized the importance of the major role of these three UN agencies when advocating jointly against FGM/C.

5.1.6.1 WHO

The input of WHO in the fight against FGM/C is generally technical through funding consultants and training of trainers (Bedaux and Schuiling 2005). The issue of FGM/C is not a priority issue within the WHO cooperation plans in Sudan (Abdel Magied, 2007).

5.1.6.2 UNFPA

UNFPA advocates against FGM/C through three programs: reproductive health, family planning, and population policy development (Bedaux and Schuiling 2005). It has also supported some national NGOs efforts for instance, in 2008, (Tuti Free of FGM/C), an initiative was launched as a

partnership between UNFPA and (Seema Centre for Women and Child Protection) to fight FGM/C in Tuti-Island. The focus was on raising the awareness especially among grandmothers. As a result of the project activities the prevalence rate in Tuti decreased by 50% within two years (UNFPA, 2010).

5.1.6.2 UNICEF

UNICEF is an important player in anti-FGM/C activities in Sudan. In addition to its well-established global strategy and plan of action it has specific country projects. It supports activities on: advocacy, community mobilisation, policy development, training and legal reform. It does not implement interventions but assists the government, NGOs and other partners in implementing interventions that address the FGM/C national strategy (Bedaux and Schuiling 2005).

5.1.7 Challenges to anti-FGM/C responses

There are many challenges facing the efforts to eliminate FGM/C. These include pro-FGM/C campaign with considerable political support who accuse the anti-FGM/C activists of anti-Islamic behaviour and having foreign agendas. Accordingly activists and NGOs working to stop FGM/C are subjected to pressure and difficulties (LANDINFO, 2008). Other challenges include: the inability to address the misconceptions and linking of FGM/C to Islam; and lack of coordinated efforts between sectors; information exchange; the monitoring and evaluation of the impact of campaigns and the operationalization of laws in the states are crucial elements for the success of the efforts (Bedri, 2012).

Experience over the past decades has gained some success. A definite achievement of these efforts is that FGM/C is no longer considered as a taboo and now it can be discussed in public (Bedaux and Schuiling 2005). Nevertheless, the effect of the previous efforts, seem less than the expected probably due to the contra-campaigning for FGM/C based on religious and medical basis (Almorth, 2005). However, it is clear that in order to obtain effective results and achieve a change in FGM/C practice, there is a need for sustainable interventions that are evidence based to target and involve different groups in the community (Bedri, 2012).

5.2 Medicalization

Medicalization[5] of FGM/C is a serious challenge to the health system's efforts to combat FGM/C.

Recent estimates revealed that more than 18% of the mutilated girls/women were cut by health-care providers including physicians, medical assistants, clinical officers, nurses, midwives and trained TBAs (WHO, 2010). The growing trend of medicalization could be attributed to the early efforts against FGM/C which emphasized its health complications and have now led to a misconception that medicalization decreases the negative health consequences (UNICEF, 2005a).

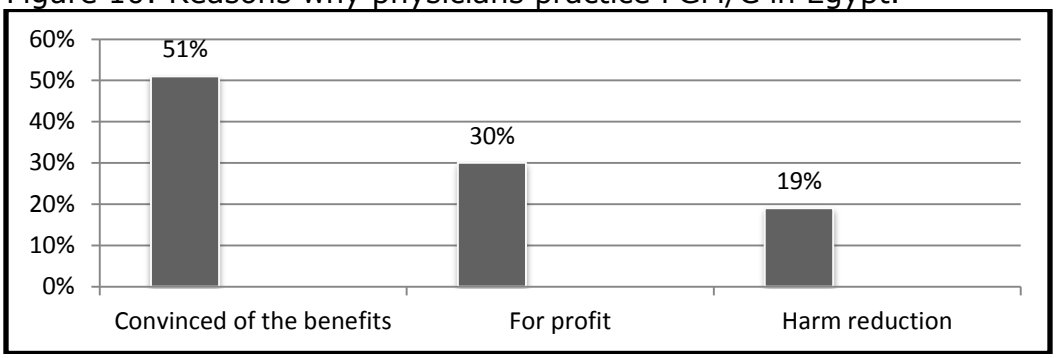
Medicalization implies serious risks like legitimizing FGM/C as being medically sound. It can further institutionalize FGM/C as medical personnel often hold authority, power and respect in the community (Budiharsana, 2004). Moreover, medicalization is considered by some medical professionals as a harm-reduction strategy with the argument that it reduces the immediate risks (Shell-Duncan, 2001) and could be a useful movement towards total abandonment, but there is no documented evidence to support this (WHO, 2010).

In Sudan, FGM/C is mainly performed by TBAs followed by nurses with small contributions by doctors (UNFPA, 2011a). However, the trend of medicalization is growing (UNICEF, 2005a). The doctors who started to perform FGM/C are supported by some religious groups that promote a milder form of FGM/C as a religious requirement. An example of this is Dr. Sit-albanat Khalid who has registered an organization to promote what she calls "religious female circumcision''. On the website of her organization, she attempts to disseminate religious evidence supporting FGM/C and seeks legal protection for FGM/C practitioners (UMATIA, 2012). According to SHHS (2010) the proportion of nurses/midwives who are performing FGM/C varies between 62.8% in the Northern state to only 17.6% in the Red Sea while the percentage for doctors range between 0% in many states to 2% in Khartoum and 4% in North Kordofan (UNFPA, 2011a).

5 Medicalization is defined as " a situation in which FGM/C is practiced by any category of health-care provider, whether in a public or private clinic, at home or elsewhere. It is also includes the procedure of reinfibulation at any point in time in a woman's life" (WHO 2010).

A study in Egypt showed that about 19% of physicians perform FGM/C, the majority (81%) of whom, were influenced by their personal beliefs (Refaat, 2009). Figure 9 shows the different reasons given in the study.

Figure 10: Reasons why physicians practice FGM/C in Egypt.



Source: (Refaat, 2009).

Chapter 6: Best practices

The factors that contribute to maintain FGM/C will continue to do so unless proper measures are taken to stop this. Different interventions to eliminate FGM/C have been reviewed and two best practices[6] which are implemented in Ethiopia and Senegal were chosen. The selection was based on the impact, community involvement and the sustainability of the program. Context similarity was also considered.

6.1 Tostan: The Community Empowerment Program (CEP)

Box (1): Tostan (CEP) objective and organization description

Objective: Empower African communities.

Number of staff: 59 paid staff and 500+ community facilitators

Budget range: annually US $3,000 - $5,000 in each direct implementation community

Funding sources: private contributors, government partners, foundations, and multilateral organizations, UNICEF and USAID

Working languages: different local languages.

Audience: rural women all ages.

Duration of the intervention: 2-3 years

Source: (Wilcher *et al.* 2006)

Background: Tostan is worldwide known programme for its impact on FGM/C although its elimination is not a stated objective. FGM/C in Senegal was estimated at 28.2% according to DHS in 2005 however, it is about 90% in many regions where Tostan works. FGM/C is continuing as a social convention in Senegal (Wilcher *et al*. 2006).

Method: Tostan used a human rights approach that is culturally sensitive. The method is based on community ownership and holistic approaches. The communities contributed to programme introduction and implementation (Diop *et al.* 2008). Tostan method is based on 200 sessions, 2-3 hours each. To disseminate the knowledge, Tostan uses an "organized diffusion process"

6 Best practices "are those that have a demonstrable and tangible impact, are socially, culturally, and economically sustainable, and have the potential for replication" (USAID 2006a).

and an "adopt a learner" strategy. Public declaration is another method to influence change by shifting the convention although it does not always lead to immediate complete FGM/C abandonment (Wilcher *et al*. 2006).

Evaluation: by FRONTIERS' (2000-2003) showed that Tostan program has achieved significant success. Knowledge of FGM/C has increased, approval ofFGM/C has decreased and the prevalence of cut girls (below 10) has also decreased. Another evaluation by the government showed that about 83% of the 24 communities visited had abandoned FGM/C (Wilcher *et al*. 2006). A third evaluation reported that Tostan knowledge rising programme had resulted in perception shift and motivated the individuals to stop FGM/C (Diop *et al*. 2008).

Lessons learned: Public declaration leads to a "tipping point" in which a convention shift stated and FGM/C stops. Mapping of the communities is necessary before implementation to yield important information about the networks (Wilcher *et al.* 2006).

Policy Implications: The Tostan approach can result in a significant reduction in FGM/C in the targeted communities. Both education and public declarations are significant. It is necessary to establish follow-up mechanisms to ensure the sustainability of changes. The community empowerment approach it has pioneered and its emphasis on cultural change rather than behavior change.

The limitation is that the program is not applicable in deprived areas lacking infrastructure where people are focusing on the daily survival (FIRH, 2008). Another limitation is that the programme duration is lengthy and might lead to the drop out of some participants

6.2 Five-Dimensional Approach for the Eradication of FGM/C in Ethiopia

It is considered a successful project due to the wide range of activities and the multidimensional approaches used.

Box (2) Objective & Organization Description

Partners: The National Committee on Traditional Practices of Ethiopia (NCTPE) and IntraHealth
Objective: To encourage FGM/C abandonment by closing knowledge gaps, strengthening communication among policymakers and different groups, and empowering women to change their attitudes and behavior toward FGM/C.
Number of staff: 2.5
Budget range: US$ 80,000 per year
Funding sources: USAID
Working languages: Local languages and English
Audience: All, with tailored interventions for specific groups

Source: (Wilcher *et al*. 2006)

Background and method: The estimated national prevalence of FGM/C is 80%. The motives for the practice were religious, gender inequality, lack of knowledge and false beliefs (Kebede, 2008). The aim of the project is to abandon FGM/C through awareness rising in the areas of health, gender, religion, human rights/law, and information, enforcing communication among policymakers and other community groups, and empowering women to change their attitudes and consequently their behaviour toward FGM/C. The communities' perceived benefits of FGM/C were considered as "obstacles" which need to be overcome to achieve success. The negative consequences identified, such as health problems, became opportunities for the project to gain support for FGM/C abandonment (Wilcher *et al*. 2006).

Interventions: A systematic approach was designed to focus on communication channels, cultural and religious values, and the social roles of men and women in the community. Interventions included national and regional workshops, community leaders training, training of trainers, community mobilization, religious leaders' forum, public declarations and media programs. The activities included generating dialogue, empowering women to advocate against FGM/C and involving political and religious leaders (Kebede, 2008).

Implementation: Since it was basically a team initiative to build the capacity of the local NGOs, the IntraHealth led some of the activities while the others led by the NCTPE (Wilcher et al. 2006).

Evaluation and project results: It was evaluated by IntraHealth in 2005 through qualitative methods and documentation of the impact of the community mobilization interventions. The main successes of the project

were: the enacting of a penal code; 83 religious leaders banned FGM/C publicly; 4,200 community members gained FGM/C knowledge through different project means; and there were public commitments made by well-known circumcisers to stop the practice (Wilcher *et al*. 2006).

Lesson learned and sustainability: The crucial key components to the project success were: focus on stopping the demand for FMG/C; providing knowledge through a multi-dimensional perspective to bridge information gaps; respecting socio-cultural values and settings during implementation; community involvement; and ownership transfer (Kebede, 2008).

Many organizations in Ethiopia are now applying the lessons learnt from this project (Wilcher *et al.* 2006).

Applicability: This project is considered highly successful; its application in Sudan might also lead to achievements against FGM/C. The people in Sudan and Ethiopia are similar due to the continuous migrations. The project was implemented in Islamic areas and the FGM/C rational is similar. The vertical approach used to create networks of anti-FGM/C groups from the national to the community level helped to engage the whole community in the battle including the religious leaders. This may particularly help in the case of Sudan where there is a pro-FGM/C campaign supported by religious groups. Furthermore it may also help to influence the policy makers to enact a law criminalizing FGM/C.

To conclude, FGM/C programmes, even if they are successful, cannot be copied from one setting to another but they must be adjusted to the local characteristics and needs of each community. Sudan can learn from the success achieved by these programmes (WHO, 2012).

Chapter 7: Discussion

With the objective of presenting a better understanding of FGM/C, this study attempts to identify the factors that maintain the practice.

FGM/C is mainly a cultural and traditional practice in Sudan. Different cultural values and components -relating to sexuality, virginity, gender and religion- are redefined traditionally or being twisted and used to influence the continuation of FGM/C.

Traditional beliefs related to sexuality serve as strong motivation for performing FGM/C. It is believed by some that infibulation and reinfibulation increase the husband's sexual pleasure and satisfaction. Although some men particularly of the younger generation have complained about complications related to FGM/C, many women still continue the practice based on this belief.

Virginity is also a significant value in the practicing communities due to its cultural and religious implications. It is closely tied to the family honour since having sex before marriage is a cultural and religious taboo. FGM/C gains its importance in this regard since it is seen as a mechanism to preserve virginity and consequently the family honour. The belief is that by removing the sensitive clitoris or forming a mechanical barrier by narrowing the vaginal opening in the case of infibulation, makes it less likely that girls/women will engage in pre-marital sex due the difficulty of penetration. Virginity is also seen as prerequisite for marriage and an uncut woman may find it difficult to find a husband in settings where FGM/C is widely practiced. FGM/C is practiced in a patriarchal system context which intensifies the importance of virginity before marriage and fidelity in the interest of conserving male honour.

Ignorance of sexuality issues, marriage concerns and morality by the awareness-raising efforts made these areas remain as obstacles to change the convention about FGM/C (Gruenbaum, 2006) Fortunately, however, this has started to change, particularly among urban young men where a considerable proportion of them prefer uncut women.

Women, especially in rural areas, are less educated than men. They tend to be dependent on men and marriage for economic security as well as for social status. Illiteracy and economic dependency limit their decision making

power in issues that affect their lives, making them powerless to challenge harmful practices. Women and girls are expected to follow defined gender roles within the family and the community; and they may even contribute to endorsing the discriminatory and harmful norms that are intended to control them.

As presented earlier, FGM/C represents a form of gender inequality that is deeply embedded in the socio-economic structures of the community. Central to its existence is the need to control female sexuality. It adversely affects women and assigns an inferior position to them in the family and society. Although FGM/C is often intended to protect girls/women and ensure them better marriage prospects, in reality it subjugates them with different degrees of harm being done to them (UNICEF, 2010).

Nevertheless, women play a significant role in ensuring that FGM/C continues since mothers and grandmothers are responsible for the majority of the decisions. This is difficult to explain, taking into consideration that women are the main ones who bear the adverse consequences of FGM/C (Herieka and Dhar 2005). Women's empowerment could bring about a difference since the majority of the educated university students do not approve the continuation of this practice.

Culture, tradition and religion are interlinked and mutually reinforcing. Accordingly, cultural beliefs and valued traditions are sometimes mistakenly considered to be required by religion. FGM/C, as a harmful practice and a form of violence against girls/women has been influenced by traditions and culture (UNICEF, 2010) for centuries; it has been co-opted and legitimized as a religious ritual. Another face of the traditional influence is the aesthetic value FGM/C is given which is culturally defined and thereby encourages] the practice of FGM/C since female genitalia is seen as grotesque and in need of reshaping. This mutilated shape implies a sense of decency and morality (Gruenbaum 2006). This understanding reflects how violence against girls/women persists and is tolerated in different contexts.

According to the findings, women are facing strong social pressure to continue this tradition. This pressure originates mostly from the female hierarchy guided by the elder women. This specific social pressure upon females can be understood as a form of maternalism in which women intend to do what they think is better for other women. The function of maternalism in FGM/C practice in Sudan can be seen in relation to the patriarchal context

and the subordination between younger and older women and between daughters and mothers. This unequal power relation rooted in the maternalistic relations could contribute to maintaining the practice of FGM/C since the older women might promote the old attitudes trying to conserve the tradition and oppose any attempt for change (Berggren *et al*. 2006).

As mentioned earlier the attitude toward FGM/C seems to be influenced by the educational level. The more educated a woman is the less likely she is to approve FGM/C continuation. Different surveys and studies reported changes in the attitude among the practitioners towards FGM/C practice. Although this might not lead to significant effect on the practice now, due to the effect of other influential factors, it at least reflects an increase in the public awareness that may gradually lead to the desired change.

The governmental responses to combat FGM/C are still confined to setting plans and strategies. However, at the level of interventions its role is restricted mainly in coordination with other players in implementation. This may be due to the shortages in the budget that the governmental sector is facing. The strategy endorsed in 2008 by (NCCW) with the goal of having Sudan free of all forms of FGM/C within a generation, could be considered as the strongest response which led to launch of the national Saleema campaign attempting to modify the social norm of stigmatising un-cut girls by promoting the norm of intact and healthy girls (Saleema). If it continues, in combination with other efforts, it will probably lead to a tangible change in the attitude and the practice of FGM/C in Sudan.

Appropriate legislation prohibiting FGM/C can accelerate the change effectively by creating an enabling environment to support the abandonment efforts (UNICEF 2005c). Sudan lacks this, since FGM/C falls under "physical injury" in the penal code without mentioning it specifically, thereby weakening the ongoing elimination efforts. For instance the medical council decree prohibiting the practice by doctors cannot be enforced since FGM/C is not a crime by law. Another serious challenge to the elimination efforts is the pro-FGM activities by some religious groups who have political support. Both the lack of explicit law and the pro-FGM activities encourages to the medicalization of FGM/C and weakening the on-going abandonment efforts by different players.

The Sudanese efforts can learn from the comprehensive human rights approach used in Senegal to empower women by giving them knowledge,

thereby enabling them to stand for their rights. Sudan can also learn from the Ethiopian experience particularly, the vertical approach of engaging different key groups in the efforts against FGM/C as mentioned earlier.

Chapter 8: Conclusion and recommendation

8.1 Conclusion

This study examined the factors influencing the continuation of FGM/C. These factors are complex, interrelated and mutually reinforcing. It is found that FGM/C is mainly influenced by culture and traditions. Under this umbrella, a wide variety of factors fall, including sexuality, gender, religion, cultural beliefs and misconceptions.

Sexuality is an important motive for the continuation of FGM/C. It acts as a fetter pulling back the people from the elimination of FGM/C, especially due to the belief that the body of an uncut female, lacks beauty and tightness and is unpleasing to the future husband.

Gender inequalities and the imbalanced relation between men and women have led women to continue FGM/C at the expense of their rights in spite of all its adverse effects on them. Empowerment through education and human rights awareness is likely to change attitude and curtail FGM/C.

Religion is found to have less of a direct impact on the continuation of FGM/C. However, it does have an indirect influence through enforcing other values related to sexuality, virginity and honour since it prohibits sexual activity before marriage so as to preserve virginity. People have mistakenly perceived FGM/C as a mean to do that.

Various beliefs continue to reinforce the tradition of FGM/C. For instance those related to aesthetics and health which originated from misconceptions and lack of knowledge. These can be addressed through education and awareness raising.

FGM/C is maintained by a strong social pressure enforced by reciprocal expectations. The system of sanctions and rewards is strong enough to lead the continuation of FGM/C. Interventions targeting change in the social norms (e.g. Saleema campgain) may effectively lead to change.

The efforts to combat FGM/C have gained little success. Furthermore, it is challenged by the absence of a national law prohibiting FGM/C, which adversely affects efforts against it. It allows for the emergence of a pro-FGM/C campaign and encourages the medicalization of the practice. There is a strong need for expanding and intensifying efforts to eliminate FGM/C

including activities within the community and advocacy programme among both the religious and political leaders, using the vertical networking approach to overcome these obstacles and achieve better results.

8.2 Recommendations

Based on this study, I propose a number of recommendations:

1 Adoption of integrated multidimensional approach by all the partners, considering the interrelated perspectives of the practice (cultural, social, religious, socio-economic, health, legal) to dissolve the convention nature of FGM/C and consequently lead to its elimination.

2 The stakeholders including religious leaders, should be effectively involved in the different phases of intervention against FGM/C because they hold respect and influence thus, they are the most capable people to dissolve the link between FGM/C and Islam and to educate the people about its harms.

3 Extensive advocacy activities targeting the policy makers and the parliamentarians to push for a law criminalizing FGM/C practice.

4 Strategies to eliminate FGM/C should be accompanied by comprehensive, community-based education and awareness-raising to empower women and make them in charge of their own body and health.

5 The Generation of FGM/C prevalence maps can be an effective tool for designing policy, monitoring, and targeted intervention to eliminate FGM/C.

6 Further qualitative and quantitative researches to examine the factors influencing the continuation of FGM/C is recommended.

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