A situational Assessment of Health Sector Role/Interventions in Female Genital Mutilation/Cutting in Khartoum state, Sudan

Final Report

2011
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Executive Summary

**Aim:** This situational analysis was carried out to examine health sector role in combating Female Genital Mutilation/Cutting (FGM/C) in Khartoum state. Data generated will be used to assist UNFPA on its country program planning cycle on FGM health related interventions and serve as an evaluation report for both National and Khartoum state Reproductive Health Programs.

**Method:** We carried out a desk review, interviews and field visits. Desk review included national and international literature either in hard print or electronic web searches. A semi structured open-ended questionnaire was developed to target policy/stakeholder and implementers. Data collected was translated, transcribed and entered into excel sheet and analyzed identifying common themes in responses.

**Results:** A total of 68 documents were reviewed and 21 interviews were carried out with program managers from governmental bodies, UN agencies and civil society organizations (CSO). Nine health facilities were visited in five localities in Khartoum state.

**FGM Situation:** Despite the decreasing trend in FGM/C, the prevalence is still high in Khartoum state (65%) with reported pockets of higher prevalence in communities living in certain localities like Jebel Awliya and Sharg Elneel. WHO FGM/C type III is still the commonest form and mostly offered (98%) by either trained or traditional. Research among midwives indicate the low knowledge of types of FGM/C or harmful consequences and attitudes supporting FGM/C practices such as re-infibulation (secondary type III FGM/C) which is carried out routinely or upon request within health facilities.

**Policy/Strategy Level:** We found FGM/C addressed vaguely within RH program policy and strategically no clear health sector goal, objective/s or approach/es defined addressing health care providers despite the almost 100% medicalization of this practice. In addition, in the strategy there were no-streamlined health interventions/activities to feed into specific outcomes. The current RH strategy (Road Map to Reduce Maternal Mortality) does not address FGM/C and as a result no activities were carried out in 2010. In comparison, the National Council for Child Welfare (many body that coordinates national program against FGM/C and Sudan National Committee for Fighting Harmful Traditional Practices have clear policies, somewhat improved strategic objectives however one was challenged with slow implementation of partners while and the other with lack of financial capacity to expand its activities.

**Program Level and Coordination:** In Khartoum state, state RH programmatic focus was mainly improving coordination, advocacy (celebrations and training of health providers
who carry out this practice (midwives mainly), development of educational material for pre-service and in service trainings and sensitization sessions for community either attending facilities or through health promotion activities. It is worth noting that the national RH program did not carry out any programmatic interventions in 2010 because the current national RH strategy focus is mainly reduction of maternal mortality. There is no mention on FGM/C in this road map.

Only two stakeholders (Sudan National Committee for fighting harmful traditional practices (SNCTP) and Ahfad University) had clear and frequent monitoring and evaluation activities that measure outcome of interventions. Even though Ahfad University carries out frequent research in this area, the literature is not systematically documented nor published in accessible outlets to all partners.

With respect to roles of partners, according to responses, the ministry of health does not play a big role with civil society. In Khartoum state, UNICEF is taking the lead role in supporting FGM/C health interventions in health facilities through Khartoum RH program while UNFPA supports National Council for Child Welfare and supports mostly advocacy within religious leaders, media. There are several coordination bodies in place, Khartoum task group, FGM/C networks but they are both challenged with funding to carry out activities.

**Health facility level outlet:** In Khartoum state, a few selected facilities (8) received FGM/C sensitization sessions and some training on FGM/C. Most of respondents in facilities thought that these sensitization sessions a UNICEF only initiated project (Saleema Campaign) and complained of lack of IEC material and weak supervision. Two thirds of health centers trained provided awareness sessions on a routine basis in ANC and Vaccination visits, while one provided counseling only for FGM/C victims and offered sessions during postpartum home visits when issue is raised. No standardized protocols and guidelines were present and misconceptions present among some health providers e.g. "**FGM/C to be useful in management of medical conditions**” and re-infibulation as a routine legal practice.

**Challenges and facilitating factors:** The most common challenges cited during interviews was the influential role of pro-FGM/C religious leaders and limited funding (Donor – UNFPA has a budget of only $200,000 per annum nationally), low absorption capacity (NCCW – has several donors to absorb the UNFPA funds allocated to them) or low capacity of NGOs to be funded. The weak role of government in hiring midwives, punitive action/mechanisms against health workers was also reported. Facilitating factors mentioned was the growing acceptance of communities to address FGM/C.
**Key recommendations:** MoH should take an active and lead role starting with revision of current health policy and re-strategizing and focusing on health providers and health promotion within schools. There should be more focus in increasing knowledge, attitude and practices among circumcisers (namely trained and traditional midwives) through pre and in-service training and advocacy role of other health care providers as advocates. Health care providers need to take active role in identifying re-infibulation cases in maternities. A nationwide knowledge, attitude and practice survey among different health care providers needs to be carried out and behavioral interventions implemented through the obstetrics and gynecology association within health facilities to address routine re-infibulation. Civil Society Organizations and midwifery associations’ capacities need to be strengthened and take lead roles in working with community. Frequent evaluations to measure FGM rates within ANC need to be carried to monitor progress instead of ten-year periods for household surveys. Research should be encouraged to examine the effect of innovative interventions and improve on current strategies to decrease FGM/C rates. Finally, all FGM/C interventions or researches need to be compiled and stored in a knowledge hub for experience sharing between all partners.
### Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AUW</td>
<td>Ahfad University for Women</td>
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<td>CAFA</td>
<td>Community Animators Friendly Association</td>
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<td>CBO</td>
<td>Community Based Organizations</td>
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<td>DG</td>
<td>Director General</td>
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<td>FGM/C</td>
<td>Female Genital Mutilation/Cutting</td>
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<td>FMoH</td>
<td>Federal Ministry of Health</td>
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<td>HCPs</td>
<td>Health Care Providers</td>
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<td>IAC</td>
<td>InterAfrican Committee</td>
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<td>INGO</td>
<td>International Non-Governmental Organization</td>
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<td>IEC</td>
<td>Information, education and communication</td>
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<td>KAP</td>
<td>Knowledge, attitude and practices</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>NRHP</td>
<td>National Reproductive Health Program</td>
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<td>NCCW</td>
<td>National Council for Child Welfare</td>
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<tr>
<td>Ob/Gyna</td>
<td>Obstetricians and Gynecologists</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>SBA</td>
<td>Skilled Birth Attendants</td>
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<td>SHHS</td>
<td>Sudan Household Survey</td>
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<td>SMOH</td>
<td>State Ministry of Health</td>
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<tr>
<td>SOP</td>
<td>Standard Operational Procedures</td>
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<td>SRH</td>
<td>Sexual Reproductive Health</td>
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<tr>
<td>STIs</td>
<td>Sexual Transmission Infections</td>
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<tr>
<td>TBAs</td>
<td>Traditional Birth Attendants</td>
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<tr>
<td>ToR</td>
<td>Terms of reference</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>WMWs</td>
<td>Village Midwives</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Acknowledgements

I would like to acknowledge the financial support and coordination from UNFPA – Gender Unit – Mrs Lamya Badri in undertaking this project. Special thanks to: Drs Mohamed Sidahmed Abdelraheem, Abdulrazig Hummaida and Majid Elamin (consultancy core assessment team) who tirelessly carried out all the delegated tasks in an efficient and timely manner. Drs. Mohamed Tawfig, Reem Mohamed and Suzan Sharief for careful data collection and entry.

Our heartfelt gratitude to Drs. Sawsan Eltahir and Lamia Khalid from the National Reproductive Program, Dr. Seham from Khartoum state reproductive program, Omdurman and Jebel Awliya Locality Health Authority Managers who facilitated this evaluation exercise and finally but not least all interviewees who shared invaluable information with our team.
Consultancy Background

Dr. Wisal Mustafa (lead consultant) of team (Drs Mohamed SidAhmed, Abdulrazig Hummaida, Majid El Amin, Suzan Sharief, Reem Mohamed and Mohamed Tawfig) was contracted to conduct an assessment exercise for health sector activities in FGM/C in Khartoum state.

The assessment exercise aims to answer the following areas:

1. The health sector involvement in FGM activities (nationnally and internationally)
2. The extent to which the health systems support FGM activities in Khartoum state

Assessment Objectives:

1. To conduct a desk review of health sector interventions in FGM/C (Sudan and Internationally)
2. To describe interventions at the health system level contributing to reduction of FGM/C rates in Sudan
3. To identify and analyze factors supporting and constraining implementation of current health interventions

These objectives were achieved through the following activities:

1. Literature review of health interventions on FGM/C focusing on policy, strategic and operational plans, surveys, federal Ministry of Health data, UN, researches
2. Development of an assessment interview tool for stakeholders from ministry of health (MoH) (Federal, Khartoum and selected locality health authority), united nations (UN) agencies, universities (Ahfad), civil society organizations (CSO) and associations working in FGM/C, health care providers (consultants, medical officers, house officers, medical assistants, midwives and health visitors) in urban and rural settings
3. Evaluation of the health interventions in FGM/C in Sudan in order to identify main focus/areas of excellence/success stories and an analysis of the factors supporting and constraining the FGM/C health interventions
4. Prepare a situational analysis report with recommendations on health programmatic interventions in FGM/C

Use of Evaluation Findings

The findings of this assessment in the form of report will be used as a basis for evidence based planning for UNFPA country program cycles and shared as an evaluation report to National and Khartoum state Reproductive Programs.

Content of Report:
This report contains an executive summary of the situational analysis then goes into details of assessment methodology, describes findings and discussion with recommendations.
**Scope and methodology**

**Assessment team**
The assessment team comprised of a coordinator (team leader) public health specialist – Dr. Wisal Mustafa – with experience in women’s health and team made up of public health specialists (3) with experience in research and evaluation of health programs – Dr. Mohamed SidAhmed, Dr. Abdulrazig Hummaida and Dr. Majid Elamin – and three data collectors – Dr. Suzan Sharief, Dr. Reem Mohamed and Dr. Mohamed Tawfig.

The evaluation exercise was divided into two phases – desk review and field phases that were carried out in a span of an eight-week period. Please refer to Figure 1 at the end of this section for the detailed implementation plan of activities.

**Desk review methodology**
Documents from MoH, UN agencies, NCCW and civil society were reviewed in this assessment focusing on several aspects of health interventions including stakeholders’ policies, strategies, annual plans and activities targeting the reduction of FGM in Khartoum state. In addition, national and international literature was reviewed for past health sector experiences in reduction of FGM, both in Sudan and countries with similar context. Online keyword searches utilizing words like FGM/C, Health, policy, strategy, Sudan legal laws, guidelines, FGM surveys, FGM/C Reports, FGM/C situation analysis, health training materials, guidelines and protocols using Google Scholar search engine and several University Electronic Libraries, such as the University of Washington Library.

**Key informant Interviews methodology**
The data review of existent national and international health sector interventions in FGM was helpful in designing an assessment tool for both stakeholders/policy makers and implementers. The aim of this questionnaire was to provide qualitative insight from this population on FGM/C policies, strategies, interventions, challenges faced and sharing successful experiences and recommendations. The questionnaire tool (please see Appendix D) was piloted to test clarity of questions, redundancy etc and finalized. Thereafter the data collection exercise was started. Data compiled was transcribed, translated from Arabic to English and analyzed looking for common themes.

MoH officials at Federal and Khartoum State level guided the selection of key informants for this evaluation exercise. Core assessment team and data collectors were responsible in identifying and setting appointments with interviewees in Khartoum State.
Figure 1: Gantt Chart Of Activities

<table>
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<tr>
<th>Activities</th>
<th>Wk 1</th>
<th>Wk 2</th>
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<th>Wk 7</th>
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<tr>
<td>Desk review and summary</td>
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<td>Assessment tool development</td>
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<td>Data collectors orientation and Field work (12 stakeholders and 8 health</td>
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<td>Data compilation, translation, and analysis</td>
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<td>Report Writing</td>
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Key Findings

The results of this situational analysis are presented in two sections. The first section focuses on desk review findings on FGM/C background information while the second describes desk review, interview findings with stakeholders/policy makers and field visits to implementing sites.

Desk Review

Desk review Scope: Sixty-eight (68) documents were found, compiled and reviewed in this assessment focusing on FGM/C health related stakeholders’ policies, strategies, annual plans and interventions. Data retrieved was summarized in tabular manner (refer to Appendix D) addressing the following main themes:

- **Background Information**
  - FGM rates (with geographical focus), type of FGM practiced and willingness to practice it
  - Cultural and Religious understanding of FGM
  - Legal position on FGM
  - Donors and partners in reducing FGM in Sudan

- **Health care providers** related data was examined for type of cadre, scope of interventions (strategy and activities), achievements and constraints and health care providers preparedness to carry out FGM interventions e.g. knowledge, attitude and practices, tools, intervention model

- **Stakeholders/policy makers** from MoH (federal, state and locality level), UN (UNFPA, WHO, UNICEF), NGOs (international, national) were examined for existent policies, strategies, activities, success stories/lessons learnt, facilitating and constraining factors

Field visits and Interviews

Three teams (2-3 members per team) spent a total of 10 working days were spent in fieldwork. Twenty-one (21) interviews/meetings were carried out and nine (9) health facilities in five localities (Khartoum, Omdurman, Jebel Awliya, Sharg El Neel, Bahri) were visited in Khartoum state.

Interviewees included ten (10) stakeholders/policy makers (NRHP, KHRP, OGSSD, NCCW, SFPA, SNCTP, Ahfad University, UNFPA, Omdurman midwifery school), two (2) locality health authorities managers/staff (Omdurman, Jebel Awliya) and 21 health care providers/managers in health facilities (Please see appendix A and B). The duration of
each interview ranged between 30 – 140 minutes. The interview findings added substantive qualitative context to the literature component of our desk review findings (all elements listed in bullet forms). Data collected during the interview was entered into hard copies in both Arabic and English languages. This data was transferred/translated into English into a cross-tabulated template in excel sheet. Common themes were identified during qualitative analysis.

Challenges faced during desk review process and field visits:

- Stakeholders are usually very busy during the day to meet for more than average duration of interview (1 hr.)
- We failed to meet two targeted stakeholders (UNICEF and Population council) because FGM focal representatives were away during consultancy period
- Turnover and institutional memory weak in some interviews resulting in poor quality of data
- FGM/C was a sensitive topic and based on expectations may have respondent bias
- FGM/C research material in Sudan is mostly not published or available on line. There was no knowledge hub or directory on researches thus limiting a complete review of studies done.
A Background on Female Genital Mutilation/Cutting

Introduction

Female genital mutilation/Cutting (FGM/C) is an ancient practice in the middle belt of Africa and its exact historical origin is not known. FGM/C is believed to be common in ancient Egypt and among the ancient people of the Arab world [1]. FGM/C is deeply rooted tradition in many communities/ethnic groups, all socio-economic classes, and different regions in 28 countries in Africa and in some countries in Asia and the Middle East [2; 3].

Commonly, FGM/C is carried out on girls under the age of 15 years, more so between the ages of 3 – 8 years, by non-medical people and often without anesthesia. Sometimes, women undergo FGM/C later in life when they are about to get married, after marriage or after childbirth [2; 4].

Terminologies and Definition

Recently, new scientific terminologies have emerged in addition to older terminologies such as Pharaonic and Sunna types. These terms include excision and reduction, clitoridectomy, infibulation however World Health Organization (WHO) classification usage remain the commonest.

WHO defines FGM/C as “the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons” [2].

Figure 2: The World Health Organization classification of FGM/C

<table>
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<tr>
<th>Type</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Type I:</td>
<td>Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).</td>
</tr>
<tr>
<td>Type II:</td>
<td>Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).</td>
</tr>
<tr>
<td>Type III:</td>
<td>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 (infibulation).</td>
</tr>
<tr>
<td>Type IV:</td>
<td>All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.</td>
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</tbody>
</table>
Other local new terminologies include half (nuss), the Sandwich, the Juwaniya (English translation = “enclosed”) and Shari’a types. Also, there is what is called the intermediate type (Type II) or Masawat (English translation = “made even”) [7; 9].

Anti-FGM/C activists have rejected the local term for FGM/C as “Tahara” (English translation = “purification”) and replaced it with Khifad (English translation = Reduction) and Khitan (English translation = Circumcision) and introduced a new concept promoting “Saleama” for depicting the uncircumcised state connoting a healthy, beautiful and untouched girl [7].

**Motivation for practicing FGM/C**

Although FGM/C is an ancient practice, the current rates in many communities have attracted researchers to study the motives behind its continuation.

The 2011 WHO update describes a complex mix of interlinked socio-cultural factors, which vary from region to region, within single countries, between and even within practicing communities, as motivations for these communities to continue practicing FGM/C [2].

Sociological studies consider FGM/C as a social convention, both a social rule as well as a social norm. A social rule means that members of a community follow a behavior-based on the expectation that others have done the same and that others will follow suit. A social norm is a rule of behavior that members of a community are expected to follow and are motivated to follow through a set of rewards and sanctions. These social conventions are connected to different socio-cultural perceptions, most of which are linked to local perceptions of **gender, sexuality** and **religion**. Since family honor and social expectations enhances the continuation of FGM/C, they make it difficult for individual families to stop the practice on their own. So, no single family would choose to abandon the practice on its own as this would affect the marriageability of it’s daughters [6; 2]. In Gambia it is found that decisions about FGM/C are usually made by multiple family members in a context marked by extensive social pressure to practice FGM/C [2].

**A. Gender**

FGM/C is linked to gender related conceptions on the female body shape, physical cleanliness and the necessity to make this body different from that of males. In many communities, the girls who have undergone FGM/C are considered beautiful and physically clean [6]. Also, beauty is associated with smoothness; therefore women's bodies need to be "carved" through removing protrusions by carrying out infibulations [5; 2]. In many cultures the clitoris is seen as "male-like" organ that needs to be amputated to define the child's sex and ensure pure femininity [2; 7; 5]. In addition, some
cultures perceive the clitoris as a dangerous organ that if it touches the baby’s head during childbirth it lead to its death. Also, if the clitoris is not removed it will grow and hang between legs like a penis.

Many cultures associate the closeness of infibulation with the value of enclosure that is related to endogamy and honor necessary components in an appropriate marriage. More so, re-infibulations is perceived in Sudan as a normal thing and a necessity needed to be done for the husband's sexual satisfaction.

FGM/C is also perceived as an essential step in the transition from girlhood to womanhood and girls are considered marriageable after undergoing the procedure.

B. Sexual morality and marriageability

In communities where FGM/C is practiced, the procedure is strongly associated with sexual morality and people perceive the clitoris as the origin of sexual desire. Accordingly, the clitoris has to be removed in order to ensure chastity, premarital virginity, reduce promiscuity, marital fidelity, decent behavior and sexual modesty.

The three qualitative studies in Egypt and Senegal as well as the findings from other studies in Burkina Faso, the Gambia and Sudan, found that a desire to control women's sexuality is a strong motivation for practicing FGM/C and this practice aims to improve women's ability to comply with local sexual norms of premarital virginity, marital fidelity and sexual modesty. On the other hand, being uncut is often linked to misbehavior and is associated with low status and prostitution, while girls who are cut are considered decent, chaste, morally pure and hence suitable for marriage.

Sexual morality, virginity at the time of marriage and fidelity after marriage, are crucial factors encouraging FGM/C in many cultures. Therefore, FGM/C in these communities is not viewed as a dangerous act and a violation of rights but as an important step to raise girls “properly” and as a mechanism for ensuring that girls arrive at their marriage beds untouched.

C. Religion

Evidences show that FGM/C predates the arrival of both Christianity and Islam in Africa, but still in many communities FGM/C is often perceived a religious prescription. For example, E Herieka and J Dhar’s study among Khartoum University students found that 18.8% of the male students and 9.4% of the female students thought FGM/C was recommended by religion (Prophet Mohammed) particularly for type I (Sunna). Often valued traditions and cultural beliefs are confused with religious mandates although no religious scriptures require FGM/C. Mostly the FGM/C practicing communities indirectly link FGM/C with religion though the focus on controlling women's sexuality
and hence consider FGM/C to support the religious expectation of sexual restraint in women [2]. It is worth to note that there is no explicit call for FGM/C neither by the Bible nor the Qur’an. A study by the Population Council concluded that "FGM/C is more linked to ethnic groups than to the Islamic religion" and that lower prevalence rates of FGM/C are seen in some predominantly Muslim countries, such as Senegal, compared to countries where animism or Christianity is the leading religion, such as Burkina Faso and Cote d’Ivoire [1].

In addition, many influential lead Islamic scholars state no connection between Islam and FGM/C such as Sheikh Ali Sarraj in Sudan and also Sheikh Mohamed Sayed Tantawi in Egypt who stated "there is no text in the Shari’a, in the Qur’an, in the prophetic Sunna addressing FGM. All texts on this issue either have been called weak or could not be substantiated [7; 10]. The absence of any link between FGM/C and Islam is materialized in that many Muslim countries do not know the practice [9].

**Prevalence of FGM/C**

**FGM/C rates internationally**

Although the political and legal environment towards FGM/C is increasingly hostile towards this practice, there is still an estimated 130 - 140 million girls and women who have been subjected to this practice worldwide. In addition, there are about three million girls at risk of undergoing FGM/C every year. Most of these girls and women live in one of the 28 countries (prevalence ranges from 0.6% to 98%) in Africa and Middle East with Egypt and Ethiopia contributing half of this affected population.

Most of FGM/C is practiced in Africa with 91.5 million girls and women aged 10 years and above have undergone FGM/C [2]. FGM/C prevalence in Africa ranges from 5% in the Democratic Republic of Congo and Uganda to more than 90% in Egypt, Somalia, Eritrea, Mali and Sudan [3]. High prevalence rates have also been reported in certain populations in Kenya and Senegal [6].

Figure 3 below shows the data on FGM/C from seven countries in Africa with an encouraging decline as seen in the prevalence rates among 15 – 19 compared to the 45 – 49 age categories [2].
Figure 3: Prevalence of FGM/C among 15-19 and 45-49 age groups from selected 7 African countries surveys carried out in 2005 – 2008


FGM/C rates in Sudan

FGM/C is widely practiced in Sudan and often in its most severe form (Type III). Usually girls are cut when they are 5 to 11 years old \[11; 6\]. Overall, the trend over time shows gradual decline in the rates and types of FGM/C practiced. For instance, a 7% (96% down to 99%) decline in the decade between the Sudan Fertility Survey of 1979 and Sudan DHS of 1990 with a 10% shift in practice from more severe form (infibulation) to lesser severe forms (clitoridectomy) \[12\]. However, between 1990 and 1999 (the Safe Motherhood Survey - SMS), the FGM/C rates remained the same with slight increase from 89% to 90% for the women aged 15 - 49 years \[13\]. Subsequently, the 2000 Multiple Indicator Cluster Survey (MICS) reported a 90% prevalence of FGM/C among “ever married” women category in North Sudan \[14\] while the 2006 Sudan Household Survey (SHHS) showed a promising further 21% reduction (down from 90% to 69%) (Please see Figure 4) \[15; 5\]. Finally, in the latest 2010 SHHS, the overall prevalence of all types of FGM/C in Sudan reduced further from 69% to 65.5% (See Figure 5).

The prevalence of FGM/C is different geographically among ethnic groups for instance in 1999 SMS showed rates of over 99% in the Northern State compared to 52% in Western Darfur State, while the 2006 SHHS found 39.8% prevalence in Western Darfur compared to 83.9% in River Nile State and finally in 2010 SHHS, prevalence rates lower than 50% in
West Darfur (46%) and Blue Nile (48.7%) states compared to rates higher than 80% in River Nile (83.4%) and Northern (83.8%) states.

In addition, FGM/C prevalence rates vary slightly among age groups indicating a slow shift of this practice within generation. This could be explained by the persistent pro FGM/C attitude among women in childbearing age (please refer to the following section on attitudes of women towards FGM/C). In 2010 SHHS, FGM/C rates remains higher than 89% among women older than 34 years with only a slight decrease in the prevalence of FGM/C in 15 – 19 years compared to 45 – 49 years age categories. The survey findings indicate that most of the girls and women undergo FGM/C when they are 5 – 14 years old (See Figure 6).

**Figure 4: FGM/C prevalence rates from 2006 SHHS**

![FGM/C prevalence rates from 2006 SHHS](image)

**Attitude towards FGM/C practice in Sudan**

There is improvement in the anti-FGM/C attitudes among both women and men in Sudan. For example the SHHS - 2006 found that 51% of 15-49 years old women thought the practice should continue compared to 79% in 1989 – 1990 SMS. Also, 54% of ever-married women in 2006 intended to have their daughters cut compared to 82% in 1989-1990 [6]. In another survey, it was found that 80% of the women and 79% of the men indicated that FGM should be stopped. In addition, 77% of the females and 73% of the males indicated they will not cut their daughters [5]. Furthermore, in a study among the university student of Khartoum, it was found that 78.8% of the males and 88.1% of females thought FGM/C should be abolished [4]. Moreover, 65% of married males
preferred to be married to uncircumcised women and the same was indicated by 74.8% of the male respondents in the Khartoum University study [5; 4].

The SHHS-2010 showed variation in the attitude of women aged 15 – 49 years towards the continuation of FGM/C. Almost three-quarters (74%) of this age category in Khartoum state thought this practice should be discontinued compared to two-thirds (66%) in Kassala state (Please see Table 1).

**Table 1: Attitude of women aged 15-49 years towards whether the practice of FGM/C should be continued or discontinued, Sudan, 2010 [SHHS -2010]**

<table>
<thead>
<tr>
<th>State</th>
<th>Continued</th>
<th>Depends</th>
<th>Do not Know</th>
<th>Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>38.7</td>
<td>1.2</td>
<td>3.1</td>
<td>56.7</td>
</tr>
<tr>
<td>River Nile</td>
<td>46.3</td>
<td>.5</td>
<td>4.2</td>
<td>48.8</td>
</tr>
<tr>
<td>Red Sea</td>
<td>59.9</td>
<td>.0</td>
<td>2.8</td>
<td>36.9</td>
</tr>
<tr>
<td>Kassala</td>
<td>66.0</td>
<td>1.6</td>
<td>3.3</td>
<td>29.0</td>
</tr>
<tr>
<td>Gadarif</td>
<td>27.7</td>
<td>5.4</td>
<td>1.1</td>
<td>65.6</td>
</tr>
<tr>
<td><strong>Khartoum</strong></td>
<td><strong>22.2</strong></td>
<td><strong>1.3</strong></td>
<td><strong>2.2</strong></td>
<td><strong>74.0</strong></td>
</tr>
<tr>
<td>Gezira</td>
<td>28.2</td>
<td>.6</td>
<td>1.9</td>
<td>69.1</td>
</tr>
<tr>
<td>White Nile</td>
<td>45.8</td>
<td>1.3</td>
<td>1.5</td>
<td>49.8</td>
</tr>
<tr>
<td>Sinnar</td>
<td>44.8</td>
<td>3.7</td>
<td>1.6</td>
<td>49.7</td>
</tr>
<tr>
<td>Blue Nile</td>
<td>40.6</td>
<td>5.0</td>
<td>1.1</td>
<td>53.0</td>
</tr>
<tr>
<td>North Kordofan</td>
<td>44.9</td>
<td>2.5</td>
<td>3.3</td>
<td>49.2</td>
</tr>
<tr>
<td>South Kordofan</td>
<td>48.7</td>
<td>7.9</td>
<td>2.6</td>
<td>40.7</td>
</tr>
<tr>
<td>North Darfur</td>
<td>53.2</td>
<td>2.8</td>
<td>3.1</td>
<td>40.8</td>
</tr>
<tr>
<td>West Darfur</td>
<td>53.0</td>
<td>.8</td>
<td>4.9</td>
<td>41.1</td>
</tr>
<tr>
<td>South Darfur</td>
<td>66.5</td>
<td>1.7</td>
<td>1.3</td>
<td>30.1</td>
</tr>
</tbody>
</table>

Similarly, we found that more than two thirds (69%) of the ever married women in Khartoum state thought the practice should be discontinued, while three-quarters (75.5%) of the same category of women in Kassala state though FGM/C should be continued (Please see Table 2).
Table (2): Attitude of ever married women aged 15-49 years towards whether the practice of FGM/C should be continued or discontinued, Sudan, 2010 [SHHS -2010]

<table>
<thead>
<tr>
<th>State</th>
<th>Continued</th>
<th>Depends</th>
<th>Do not Know</th>
<th>Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>42.9</td>
<td>2.0</td>
<td>2.8</td>
<td>52.1</td>
</tr>
<tr>
<td>River Nile</td>
<td>53.9</td>
<td>.5</td>
<td>3.2</td>
<td>42.2</td>
</tr>
<tr>
<td>Red Sea</td>
<td>68.1</td>
<td>.0</td>
<td>2.2</td>
<td>29.7</td>
</tr>
<tr>
<td>Kassala</td>
<td>75.2</td>
<td>1.3</td>
<td>1.8</td>
<td>21.7</td>
</tr>
<tr>
<td>Gadarif</td>
<td>28.9</td>
<td>6.8</td>
<td>1.0</td>
<td>63.3</td>
</tr>
<tr>
<td>Khartoum</td>
<td><strong>25.8</strong></td>
<td><strong>2.0</strong></td>
<td><strong>2.6</strong></td>
<td><strong>69.3</strong></td>
</tr>
<tr>
<td>Gezira</td>
<td>32.2</td>
<td>.8</td>
<td>.8</td>
<td>66.1</td>
</tr>
<tr>
<td>White Nile</td>
<td>51.3</td>
<td>2.0</td>
<td>2.0</td>
<td>43.6</td>
</tr>
<tr>
<td>Sinnar</td>
<td>51.2</td>
<td>4.8</td>
<td>1.0</td>
<td>42.8</td>
</tr>
<tr>
<td>Blue Nile</td>
<td>42.7</td>
<td>5.9</td>
<td>.8</td>
<td>50.5</td>
</tr>
<tr>
<td>North Kordofan</td>
<td>49.3</td>
<td>2.6</td>
<td>2.6</td>
<td>45.5</td>
</tr>
<tr>
<td>South Kordofan</td>
<td>53.1</td>
<td>9.2</td>
<td>2.6</td>
<td>35.1</td>
</tr>
<tr>
<td>North Darfur</td>
<td>56.4</td>
<td>3.2</td>
<td>3.6</td>
<td>36.7</td>
</tr>
<tr>
<td>West Darfur</td>
<td>56.9</td>
<td>.7</td>
<td>4.4</td>
<td>37.9</td>
</tr>
<tr>
<td>South Darfur</td>
<td>72.1</td>
<td>2.1</td>
<td>1.8</td>
<td>23.8</td>
</tr>
</tbody>
</table>

Men in comparison to women had higher anti-FGM/C attitudes, for instance, 50% of men thought FGM/C should discontinued in all the states apart from Kassala where only about one third (34.5%) of the men thought it should be discontinued (Please see Table 3).

Table 3: Attitude of men aged 15-49 years towards whether the practice of FGM/C should be continued or discontinued, Sudan, 2010 [SHHS -2010]

<table>
<thead>
<tr>
<th>State</th>
<th>Continued</th>
<th>Depends</th>
<th>DK</th>
<th>Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>34.9</td>
<td>5.0</td>
<td>7.2</td>
<td>52.9</td>
</tr>
<tr>
<td>River Nile</td>
<td>30.0</td>
<td>8.8</td>
<td>6.1</td>
<td>55.2</td>
</tr>
<tr>
<td>Red Sea</td>
<td>39.6</td>
<td>.8</td>
<td>5.7</td>
<td>53.2</td>
</tr>
<tr>
<td>Kassala</td>
<td>60.0</td>
<td>4.1</td>
<td>1.3</td>
<td>34.5</td>
</tr>
<tr>
<td>Gadarif</td>
<td>14.8</td>
<td>2.3</td>
<td>8.0</td>
<td>73.8</td>
</tr>
<tr>
<td>Khartoum</td>
<td><strong>22.4</strong></td>
<td><strong>1.8</strong></td>
<td><strong>3.7</strong></td>
<td><strong>72.1</strong></td>
</tr>
<tr>
<td>Gezira</td>
<td>10.9</td>
<td>6.9</td>
<td>6.7</td>
<td>75.3</td>
</tr>
</tbody>
</table>
As shown in table [4] below, the lowest percentages of ever married women who intend to cut their daughters were seen in Khartoum (27.4%), Gezira (28.3%) and Gadarif (32.1%) states while the highest rates were observed in South Darfur (71.3%), Kassala (68.3%), North Darfur (62%) and North Kordofan (61.4%) states.

Table 4: Percentage of ever married women aged 15-49 years who intend or not intend to FGM/C their daughters, Sudan, 2010 [SHHS -2010]

<table>
<thead>
<tr>
<th>State</th>
<th>Yes</th>
<th>DK</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>52.5</td>
<td>7.4</td>
<td>34.7</td>
</tr>
<tr>
<td>River Nile</td>
<td>57.0</td>
<td>4.3</td>
<td>28.7</td>
</tr>
<tr>
<td>Red Sea</td>
<td>56.3</td>
<td>6.9</td>
<td>19.0</td>
</tr>
<tr>
<td>Kassala</td>
<td>68.3</td>
<td>3.6</td>
<td>14.9</td>
</tr>
<tr>
<td>Gadarif</td>
<td>32.1</td>
<td>2.2</td>
<td>49.0</td>
</tr>
<tr>
<td><strong>Khartoum</strong></td>
<td><strong>27.4</strong></td>
<td><strong>2.8</strong></td>
<td><strong>50.5</strong></td>
</tr>
<tr>
<td>Gezira</td>
<td>28.3</td>
<td>2.1</td>
<td>48.8</td>
</tr>
<tr>
<td>White Nile</td>
<td>52.7</td>
<td>2.8</td>
<td>31.5</td>
</tr>
<tr>
<td>Sinnar</td>
<td>51.9</td>
<td>2.3</td>
<td>32.0</td>
</tr>
<tr>
<td>Blue Nile</td>
<td>41.2</td>
<td>2.6</td>
<td>48.5</td>
</tr>
<tr>
<td>North Kordofan</td>
<td>52.3</td>
<td>4.8</td>
<td>28.7</td>
</tr>
<tr>
<td>South Kordofan</td>
<td>61.4</td>
<td>3.6</td>
<td>28.5</td>
</tr>
<tr>
<td>North Darfur</td>
<td>62.0</td>
<td>3.3</td>
<td>21.2</td>
</tr>
<tr>
<td>West Darfur</td>
<td>47.6</td>
<td>2.9</td>
<td>30.1</td>
</tr>
<tr>
<td>South Darfur</td>
<td>71.3</td>
<td>2.2</td>
<td>12.7</td>
</tr>
</tbody>
</table>
Findings in table (4) and (5) are alarming, since previous studies indicated that mothers are influential in the decision-making and taking for cutting their daughters. For example, in the study of Khartoum University students, 65% of the circumcised females claimed their mothers were responsible in taking the decision, while the grandmothers and fathers were responsible in 52% and 21% of cases, respectively\(^4\).

**Figure 5: Prevalence of types of FGM/C in Sudan**

![Prevalence of all type of FGM/C among women of all ages in Sudan - 2010](image)

*Source: Federal Ministry of Health, Sudan Household Survey (SHHS) – 2010*

**Types of FGM/C**

Types of FGM/C vary in regions across the African continent. Using WHO classification as reference, type I is the most common form of FGM/C in Ethiopia, Eritrea and Nigeria, while type II in Sierra Leone, Gambia and Guinea. Type III (infibulation) is the commonest form of FGM/C in Sudan and Somalia\(^3\).

In Sudan only two basic types of FGM/C in Sudan were described in 1970, Pharaonic (type III) and Sunna (types I/II). More recently, three were described (using WHO classification) in 1990 Sudan Demographic and Health Survey indicating 85% prevalence of type III and 15% of type I or II in the northern, eastern and western provinces of the country\(^7; 5\).

Although the overall prevalence of FGM/C has dropped slightly, there is promising shift in the reduction of more severe types for instance the prevalence of type III dropped from 85% to 60% during 1995 - 1999\(^13\). Please see Figure 6 below.
FGM/C Type III is the commonest form in Sudan

According to household surveys, type III still remains the most common type of FGM/C in Sudan usually performed to young girls of about five to six years old. The operation include removal of the prepuce, clitoris, labia minora, and most of the labia majora, followed by infibulation, or stitching closed, of the labia across the urethral and vaginal openings, leaving a single tiny opening for urination and future menstrual flow. Once healed, the vulva becomes a smooth surface of skin and scar tissue [7; 8]. Susan Elmusharaf et al argue that WHO classification (involves suturing regardless of whether the labia minora or majora have been cut) and does not describe the extent of the mutilation that has been done which is related to frequency and severity of complications [9]. On the other hand, a smaller but growing proportion of the Sudanese women are undergoing the less severe form (Type I) which includes removal of the prepuce and all or part of the clitoris [7].

In addition, research on types of FGM/C practiced indicates over reporting of Sunna type or type I [9]. Two studies found that at least half of the women who self-reported to have undergone types I and II, upon examination were found to have type III. Similarly, midwives who were asked to describe type I provided operative details of types II and III [5].

Secondary FGM/C in Sudan

An additional form of cutting or circumcision is carried out after primary FGM/C. This secondary form is called re-infibulation and is usually performed to previously infibulated women by re-stitching together the scar tissue after childbirth and is called
locally "El Adel". Re-infibulation is described as a desirable and necessary procedure to be performed after childbirth to mimic the narrow vulva of a virgin so as to increase the sexual pleasure of the husband. In 1982, El Dareer estimated that over 50% of the Sudanese women underwent re-infibulation. Also, Ahmed et al in 2000 stated that most infibulated Sudanese women had re-infibulation after childbirth. Usually, the re-infibulation is performed by midwives to the women between 2 hours and 40 days after childbirth. In fact, there are two types of re-infibulation; Khiata (English translation = “suturing”) and Adel (English translation = “repair”). Midwives consider Khiata to be medically necessary since they reconstruct the vaginal orifice to the size before childbirth. On the other hand, El Adel is an extensive operation to regain the size of primary infibulation.

Complications of FGM/C

Short-term complications

The immediate or short-term consequences/complications of FGM/C include severe pain, edema/swelling and infections including tetanus. Other complications include genital ulcers, hemorrhage, shock caused by the severe pain and/or hemorrhage, septic shock, difficulty in passing urine and feces, urine retention and death as result of hemorrhage or infections.

Long-term complications

The most common complications are dermoid cysts and abscesses. Also, chronic pelvic infection can cause chronic back and pelvic pain and frequent urinary tract infections. FGM/C can also lead to negative psychological complications such as posttraumatic stress disorder, anxiety, depression, and other psycho-sexual problems. Studies show that women who have undergone FGM/C are more likely to experience psychiatric diagnosis, suffer from somatization, phobia and low self-esteem. Also, sexual problems are common among these women. They are 1.5 times more likely to experience pain during sexual intercourse, less sexual satisfaction and they are twice likely to report they did not experience sexual desire. For many women sexual intercourse is painful during the first weeks after sexual initiation and also the male partner can experience pain and complications. Some of the urino-genital complications of FGM/C include dysmenorrhea, urinary incontinence, anatomical damages and vaginal stenosis as well as chronic urinary and reproductive tract infections and pelvic inflammatory disease. FGM/C also increases the risk for complications for both mother and child during childbirth. The rates of caesarean section increase by 29% for type II and 31% for type III FGM/C as well as the risk of postpartum hemorrhage increase by 21% for type II and 69% for type III FGM/C. Moreover, there was an increased probability of tearing and
recourse to episiotomies. Also, these women usually experience difficulties in childbirth. In addition, the birth complications increase with the extension of FGM/C [2]. The risks for the infant include significantly higher death rates including stillbirths by 15% for type I FGM, 32% for type II FGM and 55% for type III FGM compared to women with no FGM/C. Women with type III FGM/C need to undergo de-infibulation and in some countries this is followed by re-infibulation [2; 4].

Concerning obstetric outcomes, a large scale multi-country study in 2006 in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan showed that women with FGM/C are significantly more likely to develop adverse obstetric outcomes compared to those with no FGM/C. Deliveries to women with FGM/C are most likely be complicated by caesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant and inpatient perinatal death than those with no FGM/C. These risks are greater with more extensive grades of types of FGM/C [2]. In another multicenter case-control study in Sierra Leone showed an association between FGM/C and obstetric fistulae due to the higher risk of obstructed labor. Also, vulvular keloid formation due to FGM/C has been shown to be common leading to failure of dilatation during contractions which leads to prolonged and painful labor increasing the risk of obstructed labor and hence increases the chances of the baby to undergo severe asphyxia that may lead to brain damage and death [2; 1].

Many studies investigated the relationship between increased risk to sexually transmitted infections and FGM/C. It seems that the damage to the genital tissue caused by FGM increase the risk of vaginal infections [16]. FGM/C increases the risk of pelvic inflammatory diseases (PID) and that risk increases in relation to the extent of the FGM/C operation as it has been documented in Sudan that incidence of PID in women with type III was more than three times higher than in type I FGM/C [3]. In addition, women who have undergone FGM/C have significantly higher prevalence of bacterial vaginosis (BV) and higher prevalence of herpes simplex virus 2 (HSV2) than those with no FGM/C [1]. Moreover, a study in Nigeria showed that women with FGM were more likely to have experienced repeated symptoms of reproductive tract infections [3]. Accordingly, FGM/C does not seem to be protective against acquiring STIs.

The association between FGM/C and fertility has been studied and documented by many studies. Also, FGM/C has been shown to increase the risk of primary infertility in Sudan [3]. A recent study in Sudan showed an association between infertility and the anatomical extent of FGM/C, the risk increased three times in women with infibulation compared to women who had undergone clitoridectomy [9; 16].
FGM/C Interventions Targeting/by Health Care Providers

Shabban et al. stated that the most effective approach to eradicating FGM – like all efforts to change broad social norms – seems to be multifaceted, intervening at many strategic points throughout society promoting a different norm publicly through stakeholders, health professionals, and policymakers [20]. However, and according to the WHO, in most countries where FGM is practiced, the health sector has had limited involvement with the prevention of FGM in girls and women. Systematic cooperation between the key players at national, grassroots level and the health sector is insufficient [43].

Our review findings showed the involvement of HCPs in the reduction of FGM/C in the following categories:

1. Understanding Knowledge, Attitudes and Practices (KAP) of HCPs towards the practice of FGM
2. Medicalization of FGM practice
3. Training of Health Care Providers (HCPs)
4. Human Rights and Illegalizing FGM practice

These categories are described in detail in subsequent subsections.

Health Care Providers’ Knowledge, Attitude and Practices towards FGM/C

Health Care Providers (HCPs) can play an effective role in reducing FGM/C as shown in a study in Nigeria. According to this study, in a campaign to reduce FGM/C the most common contact point between women and health care providers was during antenatal sessions and depended on how strongly the doctors or nurses felt about this subject. Two-fifths (40%) of all mothers of non-circumcised daughters said that the chief influence in their decision was a doctor or nurse in contrast to 2% who were influenced by a religious leader [25]. It is therefore important to assess the knowledge, attitude and practices of health care providers towards FGM/C as a base to direct interventions towards them so that they effectively take the leadership role in reducing this practice.

Knowledge

A study in North Eastern Province and in Nairobi, Kenya assessing health provider knowledge on clinical management of Somali women immigrants found that the health system is ill-equipped to serve women who have been cut, in particular infibulated women who are pregnant and delivering [44].
In Sudan, midwives have low knowledge of types of FGM/C, when asked to describe type I they provided operative details of types II and III. No studies have been carried out to assess the knowledge of other health providers.

**Attitudes**

A study among Kenyan health providers felt that the parents would perform the circumcision elsewhere, and that they (HCP) should best perform it themselves despite the HCPs’ personal opinion of opposing the practice. Moreover, an Egyptian study revealed that 52% of a sample of 5th year medical students at Alexandria University supported the continuation of FGM and 73.2% were in favor of its medicalization as a strategy for reducing the risk associated with it.

While in Sudan, a study examining midwives perception/attitude on re-infibulation in two hospitals in Khartoum state, found a lucrative gain plus meeting socio-cultural demands as principal motives and a perception that they were assisting in increasing women’s value by this procedure that will maintain her marriage as well as body beautification. The same study showed that midwives carry out different types of FGM/C performed 2hrs to 40 days after delivery.

**Practice or medicalization of FGM/C**

It is important to underscore the wide practice of FGM/C among midwives (traditional or trained) and in Sudan – please refer to the following section that provides more details.

**Medicalization of FGM/C**

Based on the WHO’s definition, “Medicalization of FGM refers to situations in which FGM is practiced by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of re-infibulation at any point in time in a woman’s life.”

The recent years have witnessed increasing rates of medicalization of FGM/C. Globally, it is estimated that 18% of all women with FGM/C was performed by health care providers. This increasing rate ranges between 9% and 74% in six countries. Despite this increment of medicalization of FGM/C, the practice is still performed by "traditional female excisors". In Sudan however, the most recent data on FGM/C in Sudan show that almost all the FGM/C is carried out by health care providers who are always either traditional and nurse midwives i.e. almost all the circumcisers are health care providers. This means that FGM/C is fully medicalized in Sudan. It is worth noting that the contribution of doctors in this practice is negligible in almost all the states apart from Khartoum where doctors performed 1.2% of all the FGM/C (Please see Table 5).
In Khartoum state specifically, almost all (98.2%) FGM/C is performed by midwives whether traditional or nurse (nurse category had higher rates than all states) usually for financial gains [8]. Medical doctors perform less than 2% of the FGM/C. Usually these medical doctors are supported by some religious groups who still advocating for a milder form of FGM/C (clitoridectomy) [8; 6].

Table 5: Person who performed the FGM/C by state – 2010 [SHHS 2010]

<table>
<thead>
<tr>
<th>State</th>
<th>Traditional midwives</th>
<th>Nurse or midwife</th>
<th>Doctor</th>
<th>Other health professionals</th>
<th>Others</th>
<th>DK or Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>36.4</td>
<td>62.8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.8</td>
</tr>
<tr>
<td>River Nile</td>
<td>51.4</td>
<td>44.9</td>
<td>0.1</td>
<td>0</td>
<td>2.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Red Sea</td>
<td>79.3</td>
<td>17.6</td>
<td>0.2</td>
<td>0</td>
<td>0</td>
<td>2.7</td>
</tr>
<tr>
<td>Kassala</td>
<td>76.0</td>
<td>22.9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.1</td>
</tr>
<tr>
<td>Gadarif</td>
<td>67.0</td>
<td>27.5</td>
<td>0</td>
<td>0.1</td>
<td>0.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Khartoum</td>
<td>42.3</td>
<td>55.9</td>
<td>1.2</td>
<td>0.2</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Gezira</td>
<td>66.1</td>
<td>31.7</td>
<td>0.2</td>
<td>0</td>
<td>0</td>
<td>2.0</td>
</tr>
<tr>
<td>White Nile</td>
<td>36.5</td>
<td>62.3</td>
<td>0.2</td>
<td>0</td>
<td>0</td>
<td>1.0</td>
</tr>
<tr>
<td>Sinnar</td>
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<td>32.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.4</td>
</tr>
<tr>
<td>Blue Nile</td>
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<td>28.7</td>
<td>0</td>
<td>0.1</td>
<td>0</td>
<td>0.3</td>
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<tr>
<td>North Kordofan</td>
<td>59.1</td>
<td>35.8</td>
<td>0.3</td>
<td>0.2</td>
<td>0.2</td>
<td>4.4</td>
</tr>
<tr>
<td>South Kordofan</td>
<td>67.5</td>
<td>30.6</td>
<td>0</td>
<td>0</td>
<td>0.3</td>
<td>1.5</td>
</tr>
<tr>
<td>North Darfur</td>
<td>52.4</td>
<td>41.6</td>
<td>0.4</td>
<td>0.9</td>
<td>0.9</td>
<td>3.9</td>
</tr>
<tr>
<td>West Darfur</td>
<td>62.4</td>
<td>34.9</td>
<td>0</td>
<td>1.9</td>
<td>0.1</td>
<td>0.7</td>
</tr>
<tr>
<td>South Darfur</td>
<td>60.5</td>
<td>37.6</td>
<td>0</td>
<td>0</td>
<td>1.2</td>
<td>0.8</td>
</tr>
</tbody>
</table>

According to Shell-Duncan, medicalization of FGM could be considered as an “interim solution” for reducing the harm of FGM/C, since complete abandonment of the practice by the community is not an achievable target. However, among the challenges to this approach are the possibilities that this may encourage communities to continue to perform the procedure, the slow process of changing attitudes of supporters of FGM/C, and encourage others to adopt the practice or overburden healthcare systems by adding another service to the package [21]. It has been shown that medicalization of FGM/C to be aN easy lucrative service for underpaid health workers in Egypt and Nigeria [25]. In addition, the FGM/C rate trends in Sudan is falling but at a slow rate with only 6% reduction the past 10 years. This could be explained by the addition of medical
legitimacy to FGM/C practice and institutionalization \[1; 2\] further contributing to the persistence of this practice.

In addition, a report from Kunnskapssenteret in Sweden stated that while FGM that is performed by medical personnel in hospitals and health clinics may reduce some short-term complications regularly seen when it is performed by traditional practitioners, it is not necessarily less severe or done in sanitary conditions. Moreover, there is no evidence that medicalization reduces obstetric or other long-term complications associated with FGM \[27\].

In summary, medicalization of FGM/C requires further research, sensitization and training programs to nurses, midwives, and other health professionals and more so understanding Health Care Providers’ Knowledge Attitude and Practices towards FGM/C.

Training Health Care Providers

One of the interventions that targeted Health Care Providers (HCPs) was the provision of training regarding complications of FGM. A number of medical organizations have published guidelines and position papers on the issue of FGM. These include Royal College of Nursing, the Royal College of Midwives, Royal College of General Practitioners and the British Medical Association. These papers and guidelines were issued to emphasize the need for HCPs to know about the health and legal issues surrounding FGM. Moreover, these guidelines and position papers were also intended to disseminate information; not only to HCPs, but also to the communities they serve. Additionally, they played a part in highlighting that FGM was unacceptable and that the respective organization had a part to play in its prevention.

Several examples of this approach were seen during the review. For instance, through a predesigned training curriculum a Kenyan project team helped the providers reflect on how this was conflicting with their roles as parents, community leaders and providers of care \[19\]. Following this training package, some providers made a personal decision not to perform the procedure, while others took a stronger position by publicly opposing FGM when performed by other colleagues. The participants in the training even helped in the designing of posters and messages targeting the community that show health workers refusing to perform the procedure \[19\]. Similarly, Population Council conducted a project in Somalia in collaboration with the Ministry of Health targeting 145 health workers from North Eastern Province in managing FGM related complications generally, and specifically during and immediately following pregnancy and delivery. Kelly and Hillard in 2005 explained that the understanding of female genital mutilation will allow the clinician to address the emotional and physical needs of the children, girls, and
women who have undergone this practice or who are at risk for undergoing this practice. This, according to them, will allow the practitioner to individualize the history and physical examination, and to provide appropriate management with recognition and treatment of complications. Increased knowledge of the laws against female genital mutilation will allow the healthcare provider to educate and advise at-risk girls and women as well as their parents [26]. In 2005, Shabban et al stated the same principle in their review, where they suggested that medical providers can play an important role in advocating against female genital mutilation and treating women who have had the procedure [20]. Shabban also referred to the work by Jones et al in Burkina Faso and Mali that showed an important role for training medical providers to identify the increased health problems caused by female genital mutilation, including bleeding, internal scarring, vaginal narrowing, and complications during childbirth [20].

Results from other experience however, do not provide convincing evidence that training health personnel is likely to have an effect on knowledge or belief/attitudes regarding FGM/C mainly due to the time span provided for training (usually short, three sessions over two months). Results from one study that evaluated the effects of an intervention program for medical and health personnel suggested that after the intervention, few health personnel from Mali wished to play a role in educating others about the practice. Sense of advocacy among health personnel appeared to be low and since this is a group that could play a role in halting the prevalence of FGM/C, it would be important to encourage advocacy in an effort to gain their active contribution.

Because medical personnel are important caretakers of girls and women who have been subjected to FGM/C and experience complications, and because such personnel are actors of power and authority in many communities, it is vital that their knowledge and skills about FGM/C are superior. However, according to Diop, the training seemed to fail to significantly improve health personnel's knowledge level and beliefs about FGM/C. Their knowledge level remained low, particularly with regard to complications of FGM/C. For example, only 56% of them could name immediate complications that can result from FGM/C, and 39% believed that uncut women have "loose morals". Diop believes that this finding, coupled with health personnel’s misperception that FGM is safe if performed in a hygienic environment, speaks to the importance of counteracting negative attitudes and convictions about FGM among medical and health care personnel [22].

**Human Rights and Illegalization of FGM/C**

**International Level**
FGM/C is considered as a violation of the human rights of girls and women through violating their right to health, security and physical integrity; the right to be free from torture and inhuman or degrading treatment; and the right to life when the procedure results in death. The practice is discriminatory and assigns girls and women an inferior position in the family and community [6].

The set of international legal instruments and consensus documents that supports FGM/C abandonment efforts include:

- A specific focus on female genital mutilation/cutting is found in UN General Assembly Resolution 56/128 on Traditional or Customary Practices Affecting the Health of Women and Girls (2001).
- The Beijing Declaration and Platform for Action
- The Programme of Action of the International Conference on Population and Development (ICPD) calls on governments “to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices” (paragraph 4.22).
- The Inter-Africa Committee on Traditional Practices adopted a Common Agenda for Action on Zero Tolerance for FGM/C by the year 2010 and declared February 6 as the International Day of Zero Tolerance against FGM/C.


The banning experience from Egypt included community monitoring of implementation of this ministerial decree to report on doctors who continued to perform FGM and the Ministry of Health started penalizing those doctors by way of penalty, fine and imprisonment.” [23] However, and according to Mohamud et al, when efforts were made to denounce the procedure and state that anyone who performs it would face serious consequences, the results were very negative. The public felt that this was an attack on
their culture, began to perform the procedure in secret, or sought out healthcare providers whom they knew and trusted. They also began performing the procedure at an earlier age because they were afraid it could be banned all together in the future. \[19\]

**National Level**

In Sudan, several FGM laws exist:

1. **Medical Council law Number 366**, which states that “based on the Islamic Fundamental Principle of ‘no harm and no damage’ the Medical Council has issued the following recommendation: ‘Doctors are not allowed to practice any work that would harm the human being or which might have any similarity of harm, including all forms of FGM/C’.”

In addition, the current legal situation considers midwives who perform primary infibulation and hospitals as illegal acts punishable by law \[8\].

2. **The Criminal Law**

All forms of FGM/C with exception of Sunna Type I have been considered a criminal offence since 1946/1947 till the latest revision in criminal code 1991 under Article 138: wounds and their types \[7\].

The existing national laws criminalize the performance of all types of FGM/C except type I (Sunna). For example the law of the Sudan (volume 9, 1974 - 1975) clause 284A reads: “Whoever voluntarily causes hurt to the external genital organs of a woman is said, save as hereinafter expected, to commit unlawful circumcision. Whoever commits unlawful circumcision shall be punished with imprisonment for a term not exceeding five years or with fine, or with both.” It is important to note that the law exempts those who merely remove the free and projecting part of the clitoris \[4\].

Nationally, there have been several attempts to criminalize all forms of FGM/C. Perhaps the strongest initiative was the national FGM/C that was drafted in 2007 by a government-led committee. However, the law has not yet been submitted to Cabinet for consideration \[6\]. Another attempt was section 145 of the Proposed Amendment of the Criminal Code of 1991 (2008) that reads as follows:

“\(1\) There shall be deemed to have committed female circumcision any professional or practitioner using any or all methods that lead to the deformation or partial or total removal of the external sexual organs of the female.

\(2\) Whoever commits female circumcision shall be punished with: (a) Ten years imprisonment and compensation if the act resulted in the death of the victim; (b) Imprisonment for a term not exceeding three years with compensation if the crime is committed for the first time; (c) Life imprisonment in case of repetition.
At state level, more encouraging results have been achieved legislatively outside Khartoum state. For instance, South Kordofan was the first state (November 2008) to pass a legislation to ban FGM/C completely. The law consists of two separate state laws: the Child Law, which contains an article criminalizing FGM/C; and the Female Genital Mutilation/Cutting Law, which makes both the practice and its promotion illegal. Thereafter, in July 2009, Gadarif state too passed a law banning FGM/C.

3. The Child Law 2004

Setbacks in the fight against FGM in Sudan

Firstly, the most serious setback in the fight against FGM/C was the removal of Article 13 which used to prohibit FGM/C as a harmful practice and tradition affecting the health of children from the 2009 Child Bill. The removal of Article 13 violates several laws and policies such as Article 32 of the Constitution (“the state shall fight harmful habits and traditions which weaken the dignity and position of women”), the 2007 National Policy for Empowerment of Women (signed by the President) which considers the elimination of FGM/C as one of its main objectives, and also violates the Medical Council resolutions and contradicts the resolution of the National Assembly No. 29 (“impose necessary legislations that prevent FGM and the need to fight all harmful habits and mobilize all related bodies to support these efforts”) [15]. This decision of the Cabinet followed a fatwa of the Islamic Jurisprudence Council, which called for a distinction to be made between the various forms of FGM and not to ban the practice known as Sunna (cutting of the clitoris and/or the prepuce). The Council of Ministers is reportedly planning to define the types of FGM other than Sunna that should be made subject to criminal sanctions [10].

In addition, the removal of Article 13 is considered as a violation to many regional references such as the African Children’s Charter; the 2005 Dakar Declaration on the elimination of female circumcision; the Rabat Declaration on children’s affairs in the Muslim world issued by the Conference of Ministers; and the Declaration of Khartoum issued by the 2nd Conference of Ministers held in February, 2009. It is worth noting that paragraph 25 of this declaration clearly states, “Necessary procedures shall be implemented to eliminate all forms of discrimination against girls, including harmful traditional practices such as the wedding of children and FGM” and was approved and signed by Sudanese officials [15].

Furthermore, the removal of this article acts against the World Health Assembly resolution (WHA 61.16) that has been passed by all WHO Member States in 2008. All the
countries agreed and committed themselves to increase their efforts to support the elimination of FGM through concerted action in all sectors \(^2\).

Secondly, another setback was the removal of the sections banning FGM/C by the Parliament from the criminal law (2008) and the National Public Health Law (2007) \(^6\).

**Initiatives to abolish FGM/C**

In Sudan, there are many initiatives including laws, policies, strategies and declarations for abolishing FGM/C including:

- Sudan Declaration on Safe Motherhood, 1999;
- Comprehensive Peace Agreement (CPA), 2005;
- Article 32 (1) of the Bill of Rights in the Interim Constitution of the Republic of Sudan, 2005, which states: *The State shall combat harmful customs and traditions which undermine the dignity and the status of women*;
- The Directives of the Quarter-Century Strategy 2007-2031;
- The National policy for Population as per Resolution No.48 of the Sudan Council Of Ministers 2002, which reads: *The studies available on the practice of harmful customs reaffirmed the association between FGM and the pregnancy and childbirth complications. In spite of the efforts exerted to eliminate FGM, the practice is still very common; more than % 80 of females undergo FGM practice in Sudan*;
- The Strategy and Work Plan to Eliminate FGM in Sudan, Federal Ministry of Health 2001, signed by the Minister of Health;
- National Policy for the Empowerment of Women, Ministry of Social Welfare and Women Affairs, March 2007, signed by the President of the Republic of Sudan. It identified the widely practiced FGM as one of the most critical challenges that empowerment of women faces, and aimed at uprooting FGM practice;
- Resolution No.366 of the Sudan Medical Council, which reads: "Based on the fundamental principle rule that there should be neither harm nor malice". The Sudan Medical Council issued the following recommendation: "doctors are not allowed to practice any deed that causes harm, or of suspicion of harm to any human being, including Female Genital Mutilation, in its all forms";
- Resolution No. 29 of the National Assembly, dated 20/06/2007 to enact legislations necessary to prohibit FGM, highlighting the necessity of fighting all harmful customs, and calling the relevant institutions to support these efforts.
- The NCCW and partners have prepared a law that criminalizes and prohibits FGM, which was approved by a number of relevant ministries and is ready for endorsement. Also, educational programs and projects were designed to
introduce the issue of FGM in the syllabus of both primary and high schools and to train teachers.

- The National Strategy for the Abandonment of FGM/C in One Generation (2008-2018) was incorporated into the Government’s Five Year National Strategic Plan for Childhood for the period 2007-2011. The strategy expands the time frame for the national plan beyond 2011, places FGM/C in a human rights context and identifies key sectors and partners to undertake activities for the abandonment of FGM/C. It also established various structures within the ministries of social welfare, education, health and justice to coordinate initiatives.

- RH POLICY STATEMENTS: The RH policy also calls on the government to take necessary steps, and for that FMOH shall work with SMOH that traditional practices that are harmful for reproductive and sexual health particularly female genital mutilation, early marriage, and GBVs are prevented.

- RH Policy Guiding values and principles: Right based: This policy emphasizes the free reproductive health care is the right of every citizen, as laid down in the constitution of Sudan, and assures optimum response to needs and rights of the clients [17; 15; 6; 18].

Desk Review and Interview Findings among Stakeholders

Background

We found historically, the MoH (no dates available) coordinated all FGM related interventions. However, in 2004, a national FGM program was established within the National Council for Child Welfare (NCCW) with support from UNFPA and UNICEF.

The current program vision/goal is to abolish FGM/C within a generation and has a ten-year FGM strategy (2008 -2018). The national program management structure however, is still under development, with six staff members representing 6 units that have no clear terms of reference and an incomplete financial management unit to manage donor funds. The program is also challenged by donor – state specific funding e.g. UNFPA – five states of focus that do not include Khartoum state.

Main FGM Partners/scope of work

Several partners were identified in FGM/C programming and/or implementation in Khartoum state. Please refer to Table 6 that summarizes roles of each partner.
Table 6: Summary of partner roles in FGM/C control activities in Khartoum state

<table>
<thead>
<tr>
<th>#</th>
<th>Type of partner (grey shaded rows) and Name</th>
<th>Role in FGM/C reduction related activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Governmental bodies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. National Council for Child Welfare (NCCW)</td>
<td>Coordinates and monitors national FGM/C Program and implements some activities on advocacy, training and development of Information Education and Communication (IEC) material</td>
<td></td>
</tr>
<tr>
<td>ii. Ministry of Health (MoH) through Reproductive Health (RH) Programs</td>
<td>Coordinates and monitors FGM activities within health sector and directly implements some activities in advocacy, training and development of IEC material</td>
<td></td>
</tr>
<tr>
<td>iii. Ministry of Religious affairs and endowment through:</td>
<td>Advocacy by religious leaders targeting religious leaders (imams), religious schools (Khalawi) and Sufi groups</td>
<td></td>
</tr>
<tr>
<td>a) The center of social studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Forum for religious revision (Muntada el Murajaat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Select active religious leaders advocates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv. Women parliamentarian group</td>
<td>Advocacy for legislations against FGM/C</td>
<td></td>
</tr>
<tr>
<td>2. UN agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. UNFPA (Gender, Y-Peer)</td>
<td>Provides support (technical and financial) to national FGM program in NCCW and several implementers for example the ministry of health, Tayba Press, select universities (Ahfad, Kassala, Gedaref), advocacy</td>
<td></td>
</tr>
<tr>
<td>ii. UNICEF (Child Protection)</td>
<td>Provides support mainly to children (technical and financial) to national FGM program and implementers e.g. Khartoum RH program and facilities (e.g. Saleema Campaign)</td>
<td></td>
</tr>
<tr>
<td>3. National Organizations/Associations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Sudan National Committee for fighting traditional harmful practices (SNCTP)</td>
<td>Member of InterAfrican Committee (IAC) based in Addis Ababa. Has activities mainly sensitization through debates, discussions, coffee meetings and IEC material at community level through its office branches in 13 states (not present in Red Sea, North and West Darfur).</td>
<td></td>
</tr>
</tbody>
</table>
ii. Babikir Bedri Association
Service arm of Ahfad University with focus on educational activities to community in UNFPA focus states

iii. Community Development Association formerly called Community Animators Friendly Association (CAFA)
Service arm of Ahfad University, initiated by community following Ahfad FGM/C related activities

5. Universities:
   a) Ahfad University for women (AUW)
   b) Omdurman Islamic University (very recently)
Research, policy making, advocacy among faculty, university students and community (AUW), social study units have established networks with women associations and communities that are targeted in educational/sensitization activities (Omdurman Islamic University)

6. Teeba Press
Training center for journalists and trains on FGM material

7. International Network to Analyze, Communicate and Transform the Campaign against FGM/C (INTACT) managed through Population Council
Is an international group of researchers, scholars, and activists committed to bringing scientific evidence to bear on the campaign to end FGM/C. INTACT helps communicate lessons learned, disseminate research, and promotes the utilization of research findings to assist in the campaign against FGM/C

**Stakeholder/Policy makers Analysis**

**Policy**

According to the desk review of Stakeholder’s policies (MOH, UN Agencies and NGOs), all entities have addressed FGM/C prevention or abandonment within their policies. For example, and according to the National Reproductive Health Policy, Female Genital Mutilation should be prevented [31]. In addition, the WHO and UNICEF issued a joint statement and signed an interagency agreement aiming towards the abandonment of the practice of FGM [39].

The majority of stakeholders interviewed (e.g. NCCW, OGSSD, AUW, and Omdurman Midwifery School) had no specific written FGM/C program policy but expressed that in principle that they are against all forms of FGM/C. Those that reported an existent policy included MoH, SFPA and SNCTP.
Governmental bodies

A surprising find however was that NCCW (national coordinating body) did not have a policy. NCCW: “There is no policy but there is strategy”

In addition, it is worth noting that the MoH policy is vague in content and does not clearly address MoH position, approach or focus and merely calls upon involvement of government in this area. In addition, was not possible to determine the extent/effectiveness of technical roles of UNFPA (no institutional memory to support this) and UNICEF (focal person was not present for interview consultancy period) during national health policy and strategy development process to support governmental bodies (MoH, NCCW respectively).

Associations and Civil Society

It seems that CSO had clearer polices on FGM than governmental institutions. SNCTP follows their headquarters’ (IAC) policy which addresses two pronged approach the negative and positive aspects of FGM/C on health and human rights approached. Only recently has Sudan Family Planning Association (SFPA) introduced a new approach (All in one) into, policy of the gender based violence and women and child welfare that clearly states FGM/C being a cross cutting issue in all activities. OGSSD reported no written policy but against all forms of FGM/C: “No written policy but society is against all forms of FGM”.

Academic institutions

While academic institutions such as AUW and Omdurman midwifery school understandably do not have a specific policy or follow national RG policy, FGM/C issue is embedded/core component within their educational curriculum.

AUW: “No policy needed as Ahfad University integrated FGM as core component of its academic strategy and has Babiker Bedri Association established since 1979 to focus and implement FGM activities, our focus is advocacy and policy making in FGM”

Omdurman Midwifery School: “No policy, but we follow SRH policy and integrated into the national curriculum for midwifery schools”

Strategy

Governmental bodies

With regards to strategy of fighting female genital mutilation, different stakeholders had different strategies. They either had a human right or positive approach in FGM interventions. For instance, the strategic approach by RH program in FmoH is composed of multifaceted interventions with no strategic objectives, outcomes and impact of
specific health interventions or clear M&E framework. The overall impact indicator identified was 2011 target was to of reducing FGM/C rates down to 30%.

The strategic interventions include formulating committees and involving professional bodies (e.g. Obstetricians and Gynecologists’ society, Pediatric society, Midwifery groups) to formulate plans and support the elimination of FGM \[^{[30]}\]. It also enlists the support of the community (e.g. women and youth groups), together with political and religious leaders as an important factor for elimination of FGM. Moreover, the strategy includes the introduction of pre-service and in-service training of reproductive health service providers, IEC material development and research \[^{[30]}\].

In contrast, the RH strategy at Khartoum level has more focus strategically with emphasis on addressing FGM/C through health promotion aspect. We found that FGM/C activities fall under promotion of health behaviors and behavior change objectives.

There was a stakeholder concern regarding the existent MoH national strategy content not being effective: “FGM rates are reducing but at a slow rate and there is a need to re-examine the strategy and think of effective interventions that reduce FGM rates at a faster rate”

The NCCW reported that the national FGM/C program strategy was developed with involvement of all partners, women's association and journalists associations. The strategy has several approaches e.g. Positive approach (Saleema Campaign) and Rights based approach (SNCTP).

**UN Agencies’ Strategy:**

UNFPA recognizes the human-right’s based approach to accelerate the abandonment of FGM \[^{[38]}\] through the empowerment of communities, having effective media campaigns and the engagement of traditional and religious leaders as agents of change in the fight against FGM. Similarly, other UN agencies such as the WHO and UNICEF adopt the same approach \[^{[42]}\]. All agencies however, oppose the medicalization of FGM as an intervention and are in line with NGOs in the global strategy against the medicalization of FGM \[^{[38; 42]}\].

In 2007, UNFPA and UNICEF developed a joint program that includes annual joint plans at country officers with ten key outputs. The program/strategy is to work in synergy with governments, civil society, religious leaders, communities and key stakeholders to reduce FGM/C by 40% among infants and girls up to age of 15 by 2012.
Civil Society Organizations/Associations

We found that OGSSD worked along the national strategy on FGM/C however some agencies had their own organizational strategies. For instance, the SNCTP has a five-year strategy (2008-2012) addressing mainly awareness raising among different community segments such as religious leaders, politicians, housewives, youth, school children, health workers and community leaders/influential players such as community committee (Lijan Sha’abiya). Similarly, SFPA has a five year strategy (2011-2015) addressing five main areas (Youth and Adolescent, HIV, Abortion, and Advocacy) having crosscutting FGM interventions.

Coordination and Annual Health related Activities

National, State RH program and UN agencies

The national reproductive program works with eight bodies (religious, media, community, education, NCCW, community, education, health and legal) with support from UNFPA in implementing its activities.

NCCW: “All the partners have plans except the ministry of education...The ministry of health has a plan for anti-FGM/C under the RH program but the implementation is weak due to funding issues”

The national RH program did not carry out any FGM related activities for 2010 and focused primarily on implementing the “Road map to reduce maternal mortality strategy which does not have any FGM/C related component. However, in the past year or so, their activities were mainly in UNFPA focus states. This included trainings (e.g. 130 midwives in 2009), surveys and mostly IEC activities. The FmoH survey on midwives showed that there was a money incentive to drive them to do FGM. Based on this finding, in 2001, policy was made to employ all midwives. However, localities were made the responsible for hiring and because of lack of funds this policy was not effective in many states. In addition, it also made midwives shift from their own localities to richer localities that were able to hire. Gedaref state was successful in hiring all midwives, while some states like Sennar, North Darfur and South Darfur have also initiated employing them.

IEC activities include booklet development entitled "Wrong Conceptions on FGM/C", film cartoon involving men having a conversation, educational posters and pamphlets for midwives, production of a film (Adel) with AUW and WHO. The film content is mostly an Ob/Gyn consultant talking about practice and counseling a mother.

In contrast, Khartoum RH program is more active in FGM/C activities. Their main activities, include development of action plans with partners, meetings with KRT task
force, participation in world child and FGM day, discussion sessions within hospital and health centers, training of midwives and health promoters, supervisions, distribution of mother presents (Saleema Campaign), pamphlets and posters, radio messages, quarterly releases, production of drama material and implement punitive action to providers who practice FGM/C.

The main partner for Khartoum RH program is UNICEF. Khartoum RH also is a member of Khartoum task force (working group composed of NCCW, Women's Union, and civil society) but was reported to be not effective as it lacks the financial capacity. UNICEF has been instrumental in implementing “Saleema Initiative” targeting three hospitals (El Saudi, Elturkey, Elbanjadeed) and will expand to four (Un Daw Baan) and nearby health centers in three localities namely Jebel Awliya, Umdurman, Sharg Elneel in Khartoum state. The choice of these states was based on the prevalence of FGM rates. The FGM interventions in Saleema Campaign, includes group discussion during pregnancy and individual counseling. Mother signs an oath not to practice FGM/C to their daughters, receive vaccination card with stamp indicating that she will not practice FGM/C and receives an incentive (bag). They plan to expand services to include home visits to follow up health facility interventions.

UNFPA and UNICEF have been following the same joint strategy since 2007. The main activities carried out in 2010 were mostly non health related interventions that include community education and empowerment through open discussion on FGM, provision of financial and technical support to government ministries to translate the texts of laws against FGM/C into local languages, print copies and disseminate them [39].

NCCW on UNFPA role: “UNFPA targets eight institutions/areas - Religious leaders, Teeba press (Mohd Lateef)-2008-2010, Social studies - UoK -2008 that carried out a social and psychological study of FGM effects in Khartoum state, Gedaref university - women associations, Kassala University - community development college, Ministry of Religious affairs and endowment, Ahfad university, Parliamentarian association in three states and focused on brainstorming session to build on consensus, and newly added Umdurman Islamic University that has activated 60 out of 150 centers that provide counseling on FGM”

Regarding roles of UN agencies and government as funders, NCCW interview findings summarizes it well: “UNICEF funds awareness raising activities and FGM/C councils while UNFPA supports activities targeting Religious and community leaders including M&E activities. The government provides only the building and the officers. UNICEF supporting the work in the 15 states (since 2011) while UNFPA supports 5 states.”
However, some organizations reported not receiving funds from UNFPA e.g. “UNFPA is not a donor to us, other donors are Belgium, Norway, Holland, Spain, African Development bank.”

NCCW’s annual plan includes developing guidelines and distributing them to states, training on the manual guide on abolishment of FGM/C, training of anti-FGM/C partners, workshops for the women union, participation with other bodies in the child protection law, World Day Celebration by involving health cadre especially the Midwives and the students in midwifery schools, production of drama in collaboration with band from North Kurdoferan and media campaign by broadcasting more than 12 Radio and TV programs.

**CSO, Academia and Associations**

**Coordination**

One organization reported good coordination in the past but not recently:

“Coordination with other partners working on fighting FGM such as NCCW is weak in coordination), ministry of health and education coordination was good in the past”

There are reported networks e.g. SNTCP is networking with more than ten organizations that includes: Ahfad University, Babikir Badri Association, Salam Alizza, Abrar Organization, The Sudanese Organization for Reconstruction, Women and AIDS Association, Child's right institute, Sisterhood Organization and Pancare. The network however, faces difficulties in funds and scope of activities is limited.

Most of CSO activities aim to raise awareness of the community through several outlets such as health centers, schools and mosques either through focus group discussions, debates through home visits, coffee meetings and distribution of IEC material. Some reported training of health staff and small-scale research.

**Geographical Coverage of activities**

In addition, we found that organizations had activities outside Khartoum state e.g. Goal Ireland focuses on FGM training to RH staff including midwives and TBAs as well community health promoters to raise awareness of in Kutum (North Darfur) and Kassala states. Khartoum state had minimal support from CSO. Interestingly, OGSSD activities were mainly in Khartoum mostly in advocacy (involving some active members), and in conferences however, it was noted that their activities were infrequent and symposium sub-offices in other states are not active in this area.
Type of FGM/C interventions

OGSSD: Society reported some activities through mostly personal initiatives (e.g. Dr. Ashmaik, Dr. Nasr) attended several meetings debating with religious leaders (such as Prof Abu Asha, Sheikh AbdelHai who promote FGM/C- Elkarim and Elkoda are understanding) who promote FGM. It was also noted by the evaluation team that society members do not routinely integrate FGM/C issues into their practice such as routine service such as counseling to expectant mothers.

SFPA: Activities include counseling and awareness raising in all SFPA’s centers targeting youth e.g. video, production of IEC and drama on abolition of FGM and outreach activities that target men, women, girls, and boys.

SNCTP: Methodology of interventions include training of trainers, debates that involves both genders, home visits, peer interventions for example school children trained and they in turn talk with their peers and report the number they talked to and recorded in a register, tea meetings to discuss FGM, school drama, television, pamphlets, brochures, shirts and annual magazine production.

AUW: We found that it launched a campaign against FGM with numerous activities such as outreach, service provision, researches, curricula and training. According to Dr. Nafisa Badri, the AUW is currently implementing a UNV Program & UNFPA project on combating FGM through the use of community volunteers, children & leaders. Interview findings indicated active role AUW in advocating FGM/C issue among faculty staff and students in all fields (e.g. curriculum, outreach activities) and regular events. In addition measuring the pre-enrollment and post enrollment knowledge and attitude and following up their activities in this area after graduation. Health related interventions included training of health workers and health managers.

“FGM is integrated in different curriculum, addressed in field trips, students are encouraged to carry out field trips and address gender inequities. PhD programs have 2-3 FGM topics”

In contrast, midwifery school curriculum is not as rigorous as AUW’s. It is addressed as a topic in the curriculum and revised every 2-3 years.

Achievements

According to desk review (FMOH report in 2011) and interview findings, important achievements in the fight against FGM can be summarized in the following:

Policy/Strategy

- Formulation of National RH policy and strategic plan (2006-2010) in both documents elimination of FGM was addressed as a key target
• In 2007 RH directorate participated in formulation of the national strategy of the National Council for Child Welfare to eliminate FGM
• The Presidency of the Republic issued a resolution to create jobs for midwives in the civil service and link them with the health system, which will enable supervision and provision of fixed source of income [32]

**Pre-service and In-service Training**

• Development of FGM/C related educational materials
• Development, printing and distribution of training manual for midwives on elimination of FGM
• Integration of a chapter on how to fight FGM within the basic curriculum of midwifery schools
• Conduction of TOT training on abolition of FGM/C
• In-service training on abolition of FGM (150 midwives) in 5 states
• AUW developed a training package targeting journalists to show them how to deal with FGM and carry out discussions on FGM material.
• Two trainings for journalists on abolition of FGM at (15) states
• Training of researchers on the manual guide
• Training of participants from women's union (Ansam network)
• Training on the child's rights and law
• Training for midwives and focus group discussion for teacher from high secondary schools

**Legislations**

• Medical Council issued professionally resolution at the meeting 366 on 08/27/2003 prevent the practice of FGM by health professionals.
• A draft of the Public Health Act in 2007 included clause prohibiting health staff to make the process of FGM
• The covenant of honor for midwives not to conduct FGM in all its forms was prepared, and it was circulated at graduation

**Research**

• Al Saudi hospital, Dr. Atif Fazari has published a study on the psychological and health effects of FGM/C which included 650 study subjects
• Prof. Ahmed AbdelMajid from Ahfad University carried out research to understand root causes of FGM
• Research was done to examine the students attitudes towards FGM
• Study on the social and psychological effects of FGM (conducted by the Social Studies Center - Khartoum state)

Advocacy
• OGSSD carried out and led a walk against FGM with White Ribbon Alliance, Population council, Ahfad University in 2010 in spite of security repercussions
• Debates with religious leaders have led to understanding that FGM/C is a makrama and not compulsory

FGM/C services
• Omdurman Islamic University activated 60 out 150 social service centers
• Ministry of Guidance and Endowments Sudan conducted awareness raising session for religious leaders and Khalwa's students on abolishment of FGM

Community
• Both UNFPA and UNICEF successfully conducted 71,245 community education sessions in the 12 target Countries globally, reaching 6,400 families, resulting in 52 communities in Sudan who abandoned the practice in 2010 [39].
• UNFPA also supported Ahfad University for Women in a campaign that used community-based interventions for data collection, the training of volunteers, and advocacy campaigns.

Constraints
The most reported constraint to the implementation of activities and interventions to reduce FGM was the opposition of religious, community and political leaders.

Religious:
“Religious leaders who support sunna FGM and say "do you want our girls to smell"
“In a discussion with them, we were almost beaten and were verbally abused”
“They say to us (civil society) and other anti-FGM/C religious leaders "they bought you with dollars"
“Fifteen religious leaders walked out on a presentation by doctor explaining the use of different parts of female genitalia and refused to even eat our meeting food saying that it was "kafir's" (English translation=non believer) food”

Community
“FGM/C promotes “iffa” (English translation = Abstinence from unlawful sex)
“Midwives with less academic background are more resistant to change behavior and communities in outskirts of KRT state are closed and hold to their cultural norms and follow religious leaders”
“War in Darfur and community movement have introduced FGM rates in this area and increased FGM rates”

“Community protects midwives who carry out this practice, they are the ones who bring their children to midwives and hide these cases”

“Behavior change is difficult and takes time”

Pro-FGM advocacy:

“Dr. Sit elbanat (Obs/Gyn) developed a video to teach health cadres to safely practice FGM”

“Amal Ahmed Bashir (sister to Khartoum ex-Minister of health) supports medicalization and claimed in a newspaper that it is a safe and cheap alternative”

“Dr. Sit Albanat [Obs & Gyn consultant] trained 5 doctors on performing type I [Sunna/ Sharei] FGM/C and intending to open 5 centers for FGM/C as well as she introduced the Sharei FGM/C in the curriculum of one college, Dr. Sit Elbanat trained 5 doctors and new centers are offering FGM services. Dr. Sit elbanat has good connections with religious leaders and protected and is supported and can expand centers that offer FGM services”

Other reported repeated themes in constraints include:

- Monetary incentives
- Ineffective punitive action/mechanisms
  - “Medical council does not have prohibit FGM clearly”
  - “Even though FGM/C is forbidden to be practiced by health care providers, punitive measures are taken ONLY if patient complains to Sudan Medical Council on complications. That is why Drs like Sit Elbanat and Wife (doctor) of religious leader (Sheikh Abdelhai Yousif) can continue to carry out FGM/C”
  - “The public health act does not address FGM, The RH policy is not endorsed because of FGM”
  - “Withdrawal of act 13 of child protection”
  - “Legal regulation does not work because it is deeply rooted in our community. For instance, case of girl who died of FGM recently in Khartoum, the community protected her saying " the girl who died is one of ours and the one who did it is also one of ours, this is our business and we will deal with it”

- Absence of FGM in all educational curriculum “you will find a university graduate not aware of FGM facing difficulties living a normal life with husband and does not know the reason why”

- Limited coverage by UNFPA as it targets 5 states

- Non active role of Government
  - “Midwives carry out 80% of deliveries at home and a further 10% in health facilities, they are not a big number in Sudan and can be employed”
There is a lack of governmental support to NGOs and dependence on external donation... The government gives millions to the Women Union and nothing to NGOs’

“The President is instigated to antiFGM/C activists by his religious advisors who think if FGM/C is eliminated and targeted, it will provide room to oppose and fight male circumcision... as a western influence”

“There is no criminalizing law against FGM unlike Iran”

- Lack of documentation that results in duplication of researches and in doing so wasting time and money resources
- Weak coordination and sharing of information between MoH RH program, ministry of social welfare
- Capacity of CSO “Working with weak partners such as national NGOs and CBOs is problematic because we cannot confidently expand implementation because of weaknesses in planning, reporting and scale up of implementation”

Facilitating Factors

Reported facilitating factors included:

- “Existent national FGM strategy, interest of donors, presence of documentation among UN and other agencies (e.g. population council) for exchanging and learning experiences, community is beginning to accept FGM interventions compared to 20 years ago”
- “Midwives covenant or oath to Allah upon graduation that cannot be broken with three days’ fasting”
- Training/Academia have a positive impact
  - “Training has changed some of midwives perceptions
  - “Midwifery school is strict about it and teaches them and prohibits them from practicing it”

- Growing support from community, religious leaders and politically
  - “The strategy is fully supported by first lady”
  - “Religious leaders are both facilitating and constraining factors”
  - “Communities are much open and cooperative and they come and ask for awareness services and support”
  - “There are less negative discourses from government e.g. the president against anti-FGM interventions”

- Active coordination and clarity of roles among some partners
  “The National Council of childhood has an active role and existence of division of labor between UNICEF and UNFPA facilitates work”
Lessons learnt and experiences

At community level, sensitization and education of leaders in community has resulted in villages declaring 0 FGM rates. The approach of talking to community about benefits (positive) of not practicing is better than negative consequences of FGM/C. Targeting elderly populations has shown to be effective e.g. Grandmother association in Tuti Island.

Coordination and involvement of partners using their strengths e.g. media or journalists and community in planning and budget development leads to increased ownership. In addition it seems that “NGOs do a better job in bringing together different ministries because they are neutral bodies”. Meetings are always successful and bring in all representatives from different governmental bodies in a neutral ground with successful outcomes.

Students who carry out FGM researches, become very active advocates and integrate FGM related activities in their work and community.

Sensitized communities can become very active and advocate through successful CBOs e.g. CAFA in Umbadda (Khartoum) competing now with Babiker Bedri Association, Manas in Abu Seid (Khartoum state), Asdaa in Gezira Aba, in White Nile state.

Finally, the midwifery school has learnt that educational curricula content need not be standardized and should be culturally sensitive and modified according to the target population in different settings.

Recommendations

More evidence/knowledge sharing needed:

- Carry out assessments/questionnaires/studies while implementing pilot interventions
- Documentation of process and impact of interventions for purposes of leaning and replication e.g. Saleema Campaign
- Publication of FGM research on website (frequent updating and contribution of partners in oabdandon-fgm.net website)
- Development a resource center for FGM as a unified institutional memory for all related FGM/C material
- More social researches on FGM/C on psychosocial impact is needed

Scope/coverage of activities:

- “Effect of training is like a drop in an ocean”. Training of midwives has been weak, with funding available to train a few from all states. Recommend that a few select states (2-5) identified for training to ensure more numbers trained.
• Educational
  o FGM training in midwifery school needs more focus with use of IEC material and group exercises
  o “From my work experience in ANC and FP clinics many educated women do not know about FGM and its effects”. Introduce FGM in educational system and discuss complications of FGM.
  o Curriculum topics on sexual and reproductive rights and FGM/C need to be improved and made more inspiring. “Currently the medical curriculum is not inspiring and my daughter says that PHC is very boring and not relevant”.

• At PHC level involve all cadres e.g. doctors, vaccinators, paramedical staff in FGM training and not focus only on health visitors and health promoters.
• Develop pamphlets to fight misconceptions such as “FGM/C promotes hygiene”
• “Somalia has good example of active medical doctor and religious leader team that goes all over the country and persuasively change communities perception on FGM” The OGSSD interventions are intermittent and need to be continuous and implement a similar model like the one for Somalia and expanded to other states besides Khartoum state
• Focus interventions on religious leaders who promote FGM
• “There are less than 5,000 midwives (1,400 in KRT state alone) in Sudan and this should not be a big challenge for the government” Government should hire midwives and give them salaries.
• Establish youth corners inside the health facilities or youth friendly centers
• Khartoum State should receive more focus and enhance anti-FGM/C activities to cover all the 7 localities. Khartoum state has a high population with constant growth and population movement and peripheral areas still implementing FGM/C such as in Jebel Awliya, Sharg elneel and Kadaru

Coordination and leadership
• “MoH is not playing an active role and sidelined by social welfare and NCCW who seem to be doing its work...MoH should take a stronger stand and be an key actor and not be a mere “dead shadow”
  o Empowering midwives to regain their previous respected social status. This can be done by investing in their association or including them in FGM campaigns as active members not as target groups
  o Suggest Ministry of Religious Affairs and MoH to be coordinating body for FGM interventions
  o A target should be set e.g. in 2020 that no girl with FGM will be allowed
to go to school like what they are doing now with vaccination
  o Health sector should include other sectors like NGOs and work professionally. They seem to only work with NGOs led by doctors (bias to medical doctors and sideline other cadres like midwives, other health cadres
  o MOH should strengthen monitoring of health facilities to stop the FGM which occurs inside these facilities
• Women professional associations should have a role in fighting FGM,

Field Visits Key Findings

Locality Health Authorities

Strategy/Annual plans

Two localities (Omdurman and Jebel Awliya) health authorities (LHA) were visited. They had different responses with regards to existence of strategy (one had and other did not) and development of annual plans (one developed its own while the other received ready made plans from the MoH). They did however agree with frequency and type of partnerships in FGM/C related activities. They both reported sporadic and non-regular activities with partners like AUW and SNCTP.

Their annual FGM/C activities fall under the health education, health promotion and RH plans with output in awareness raising, behavioral change, health education and training.

Interestingly, Saleema program for the 2010-2011 plan was not part of annual plan and focused on health education seminars on FGM, capacity building of health cadre in FGM, TOT and the provision of education at health facilities.

Activities

The interventions reported were mainly at two levels:

1. Seminars and lectures are provided in health centers for providers who in turn target attendees. For instance, the MoH in cooperation with the locality conducted refresher training for nine Saleema trained staff (nutritionists, vaccination technicians, midwives and health visitors)

2. Educational sessions offered by health visitors to communities/neighbourhoods based on community needs
**Constraining/Facilitating Factors**

Respondents listed traditions, social norms, religious opposition and absence of financial support as constraining factors. While, increased community awareness, fading misconceptions, refresher trainings, midwives oath and CSO (e.g. SNCTP) were listed as facilitating factors.

**Lessons learnt and experiences**

“Doctors have bigger role and greater impact”. They learnt that impact of any intervention defers according to the cadre providing it.

**Recommendations**

1. Logistic support needed
2. Training for health educators
3. Linkage of FGM/C program to school health programs
4. Introduction of FGM/C into educational curriculum
5. Increase political commitment
6. Continuous training for health visitors
7. Targeting the PHCs with high patient load as priority
8. Provision incentive for medical providers who deliver FGM/C services
9. Targeting states and rural areas where there is weak restriction on FGM/C practice. “Some mothers take their daughters for circumcision to rural areas/states with fewer restrictions on FGM/C”
10. Improve on M&E system for all FGM/C activities clear M&E system

**Omdurman Midwifery School**

Awareness sessions were provided to all pregnant women but lacked IEC material and limited training. They recommended enforcement of punitive action to providers who carry out this practice.

**Health Facilities**

Evaluation team noticed that there were no standard operational procedures or guidance on management of FGM, or IEC material or monthly reports to capture the activities carried out. The team noticed that re-infibulation is the default practice in the facility for all clients. All midwives met believed that it is not an illegal practice. In addition, misconceptions on FGM/C among health providers were found e.g. one sister
said that FGM treats medical problems and cited a doctor doing this to his daughter as treatment intervention.

At hospital level, FGM/C awareness sessions were reportedly offered to postpartum women. They all thought that Saleema initiative is a UNICEF driven initiative, with no MoH involvement and depended much on facility’s initiative to continue activities. Most complained about IEC material shortage and weak supervision.

At health center level, awareness sessions were provided routinely to ANC and vaccination population by health educator, immunization officer, vaccination technician and nutritionist in two centers while one provided only counseling for FGM/C victims. The health visitors also provide counseling to postpartum ladies during home visits about complications when the issue is raised.

Constraints described at health center level included no IEC material or trained staff turnover and infrequent quarterly supervisory visits.
Discussion and Recommendations

Despite the reducing trend of FGM/C rates in Sudan, albeit slow, the prevalence of this practice is still considered on the higher range compared to other countries in Africa. In addition, the most common more severe type of FGM/C (type III) is still practiced endangering girls and women to increased risk of both acute and chronic complications. Re-infibulation (secondary circumcision) is still a common practice among midwives even at hospital level.

Using the four health intervention models/approaches reviewed in literature, we found a scarcity of data on Knowledge, Attitudes and Practices (KAP) of HCPs towards the practice of FGM. There is little evidence indicating the low knowledge among midwives and existent pro-FGM/C attitudes amongst them. There is a need to develop standardized data tools to measure the knowledge, attitude and practices of health workers in general including health promoters. In addition, a mechanism of routinely collecting data on FGM/C during ANC visits to frequently monitor FGM/C trends and intervene accordingly without need to wait for a decade for survey findings.

In addition, FGM/C practice in Sudan is completely medicalized (98% performed by midwives) and calls for a more active role of MoH with focused intensive health interventions targeting both traditional and trained midwives. The current policy and strategy does not have a focus on this and stretches its energy and funds on multifaceted approach that address the factors affecting “supply” and “demand” of this practice. This includes the midwives who perform this practice and socio-cultural aspects at community level that drive and demand for this practice. Both these factors are important but it will be more efficient if MoH role is specific in addressing health cadres who work within its realm and work in coordination with other partners (CSO) who can focus on sociocultural aspect at community level.

The training of Health Care Providers (HCPs) is carried out by almost all implementers with focus on midwives however the content, scope, coverage and approaches (pre-service and in-service training) may need re-strategizing. In principle, this intervention should be viewed as a behavioral change intervention and realistic time frames made to expect results.

The pre-service training for all providers specifically midwives may need to be revised with similar focus/model like AUW or exchange program of faculty staff between these schools. KAP surveys will be useful at enrollment, after graduation and follow up after several years to monitor their attitudes and behaviors and intervene accordingly. The
content of training should include advocacy and communication skills so that the providers can comfortably take the lead and advocate against practice in any setting.

According to the WHO, the stopping of the medicalization of FGM was the lack of protocols and guidelines to healthcare providers, poor training and involvement of local health sector, on and above a lack of laws and prosecution \[39\]. In our evaluation, all the health facilities visited, no protocols or guidelines were present (even at national level), very few providers were trained described as “drop in the sea”. In addition, the health strategy written with clear realistic objectives focusing on improving KAP among health care providers, developing quality training material (pre and in-service training) and expeditiously adapt protocols and guidelines already in use in the Arab world. Finally, the MoH should continue to play an active role in advocacy and strengthening legal measures to those who practice it.

**Human Rights and illegalizing FGM practice** in Sudan still not clear. The criminal act excludes one type of FGM/C thus providing a loophole for this practice to continue. In addition, civil society underscored the weak role of MoH in coordinating and taking an active role in punitive action against health providers who perform this operation. The MoH can take a lead role, by clearly stating in its policy its position against all forms of FGM/C. For instance, health care providers can monitor and prevent practices like re-infibulation within health facilities by examining women who deliver in facilities before and after delivery and if cases found most severe punitive action made with media attention.

**Partnerships** between MoH and Ministry of Education such as coordinated school health/health promotion and FGM topic introduced within educational system can further strengthen identification and reporting of cases. The OGSSD can play an active role with ministry of religious affairs as advocates and provide regular sessions within midwifery schools, universities and schools.

**Monitoring and evaluation and research**

There is a non-existent unified database for all FGM/C activities and FGM/C prevalence rates are not collected on routine basis within health facilities in Sudan. Integrating FGM examination within ANC visits can easily generate prevalence data routinely and selection of a knowledge hub for all FGM/C activities will be very useful for institutional memory and experience sharing. Finally, more research is needed, for instance it will be interesting follow up and monitor FGM/C trend closely in states like South Kordufan and Gedaref where VMW have been employed or endorsement of criminalizing laws.
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# Appendix A

## Field Site Coverage

<table>
<thead>
<tr>
<th>National Programs</th>
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<tbody>
<tr>
<td>National Reproductive Health Program</td>
<td>National Council for Child Welfare</td>
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<tr>
<td>State MoH and Locality Health Authorities</td>
<td></td>
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<tr>
<td>Khartoum state RH program</td>
<td>Omdurman and Jebel Awliya</td>
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<tr>
<td>UN Developmental Partners</td>
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<td>UNFPA</td>
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<td>UNICEF</td>
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<td>WHO</td>
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</table>

**National NGO**

- Sudan National Committee for Fight Harmful Traditional Practices

**International NGO**

- PPFA – No Khartoum state related activities
- GOAL Ireland – No Khartoum related activities

**Academic Institutions**

- Ahfad University for Women
- Omdurman Midwifery School

**Associations**

- Obstetric and Gynecology Association
- Sudan Family Planning Association

**Clinical Service Delivery Points**

| 1. ElSaoudi Hospital | 6. Bahri Hospital |
| 2. Wad Nubawi Health Center | 7. El Daw Hajuj Heath center |
| 3. Omdurman midwifery ANC clinic | 8. Taiba Elhasanat health center |
| 4. Omdurman Maternity Hospital | 9. Elkalakla Guba Health center |
| 5. Khartoum Hospital |  |
# Appendix B

## Interviewee profiles

<table>
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<tr>
<th>Policy Makers</th>
<th>LHA</th>
<th>Facility</th>
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<tbody>
<tr>
<td>Ten (10) – FGM/C focal person/IEC unit – NRHP, Director of KHRP, Executive Director, Chairman, Secretariat/head of Sudan Fertility association in OGSSD, Director of FGM/C program in NCCW, Program director in SFPA, Executive director in SNCTP, Faculty staff in Ahfad University, Gender unit head in UNFPA, Director of Omdurman midwifery school</td>
<td>Two (2) locality health authorities managers/staff in Omdurman, Jebel Awliya locality health authorities</td>
<td>21 staff: (general director (1), medical director (2), health visitor (4), sister (2), midwife (5), senior midwife (2), health educator (3), vaccination technician (2) from nine (9) facilities (5 hospitals, 3 PHC and 1 midwifery ANC clinic at hospital level).</td>
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Appendix C

Questionnaire Tool
Policy Makers (English and Arabic version)

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<tr>
<th>Broad Area</th>
<th>Specific Questions</th>
<th>Lead/Probe</th>
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<tbody>
<tr>
<td><strong>Existence and content</strong></td>
<td>What are your organization's current FGM policies?</td>
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<tr>
<td></td>
<td>If yes, what is its content? have they been modified recently? If so, why?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please share it with us!</td>
<td></td>
</tr>
<tr>
<td><strong>Development modality</strong></td>
<td>What factors drove policy development?</td>
<td>Policy politically or donor driven, using evidence based approaches or are politically or donor driven?</td>
</tr>
<tr>
<td></td>
<td>Who was involved in policy development?</td>
<td></td>
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<tr>
<td><strong>Implementation and Enforcement</strong></td>
<td>Is this policy endorsed? If no, why?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is this policy enforced? If no, why?</td>
<td></td>
</tr>
<tr>
<td><strong>Existence and content</strong></td>
<td>Is FGM addressed in the health strategy? Please share it!</td>
<td>Evidence based? Explain process of strategy development</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Is there a monitoring and evaluation plan? Please share it!</td>
<td></td>
</tr>
<tr>
<td><strong>How are activities developed?</strong></td>
<td>What are the annual activities planned?</td>
<td>e.g. dependent on funds availability and donor interests</td>
</tr>
<tr>
<td><strong>Content of activities</strong></td>
<td>List type of health interventions to fight FGM? (List all activities carried out, detailing where, since when, by whom, how often and the target population)</td>
<td>1. SOPs 2. IEC material development/distribution 3. Training material 4. Guidelines 5. Trainings 6. Advocacy meetings 7. Curriculum</td>
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<td></td>
<td>What is the percentage of achievement of these targets?</td>
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</tr>
<tr>
<td><strong>Monitoring and Evaluation</strong></td>
<td>How do you monitor your interventions?</td>
<td></td>
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</tbody>
</table>
### Facilitating factors
What were/are the facilitating factors of FGM activities? (Can you elaborate further?)
- e.g. health care providers' attitude, desensitization

### Constraining factors
What were/are the constraining factors of FGM activities?
- What are the lessons learnt during the implementation of these activities?
- How do you share success stories and experience?

### Recommendations
What are your insights and recommendations on effective health sector interventions to reduce FGM practice at facility level

<table>
<thead>
<tr>
<th>Name of the organization/Institution</th>
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<table>
<thead>
<tr>
<th>Position of the staff member in the organization</th>
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<tr>
<th>Name of the data holder</th>
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<th>Special interview conducted by</th>
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<td>________________________________</td>
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<table>
<thead>
<tr>
<th>1. Policy:</th>
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<tbody>
<tr>
<td>1.1 Does the organization have a policy to combat female genital mutilation? If yes, what is it?</td>
</tr>
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</table>

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<tr>
<th>2. Has it been amended recently? If yes, why?</th>
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<tr>
<th>3. What were the factors that led to the establishment of this policy?</th>
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<tr>
<th>4. Who are the participants in the establishment of this policy?</th>
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<table>
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<tr>
<th>5. Has this policy been ratified? If yes, why?</th>
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</table>

| 6. Has this policy been implemented on the ground and supported from higher levels? If not, why? |

<table>
<thead>
<tr>
<th>7. Has the implementation of this policy been successful? If yes, what was the reason?</th>
</tr>
</thead>
</table>

| 8. Has this policy been used to address the problem of female genital mutilation? If yes, what was the reason? |
2. الخطة الإستراتيجية:

2.1 هل محاربة ختان الإناث مدرجة ضمن خطط المنظمة الإستراتيجية أو هل توجد استراتيجية منفصلة؟ (ما هي الخطوط العامة) [في حالة وجود إستراتيجية الرجاء طلب نسخة منها]

2.2 ما هي الجهات التي شاركت في صياغة بند محاربة ختان الإناث في الاستراتيجية؟

2.3 هل هناك خططة لمتابعة وتقييم جزئية محاربة ختان الإناث في الاستراتيجية؟ (الرجاء مدننا بنسخه)

3. التدخلات و الأنشطة:

3.1 هل يمكن أن تتعدد لنا نوعية التدخلات الصحية الخاصة بمحاربة ختان الإناث التي تقدمونها (وصف التدخلات، أين تنفذ، منذ متى، المستهدفين من التدخلات)؟

3.2 ما هي التدخلات/الأنشطة التي خططتم لها في هذا العام (وصف التدخلات، أين تنفذ، منذ متى، المستهدفين من التدخلات)؟

3.3 ما هو مدى إنجازكم في ما يخص التدخلات و الأنشطة التي خططتم لها في هذه السنة؟

3.4 هل كنتم تقومون بمتابعة و تقييم تنفيذ هذه التدخلات/الأنشطة؟ (الرجاء التوضيح: الكيفية)

3.5 ما هي العوامل التي سهلت تنفيذ هذه الأنشطة؟

3.6 ما هي العوامل التي عرقلت أو صعبت تنفيذ هذه الأنشطة؟

4. الدروس المستفادة/ المستفادة:
4.1 ما هي أهم الدروس المستفادة خلال تنفيذ التدخلات/أنشطة الصحة الخاصة بمحاربة ختان الإناث؟

4.2 ما هي الآليات التي تتبعونها لمشاركة تجارب وقصص نجاحكم في محاربة ختان الإناث؟

التصنيفات:

5.1 بماذا توصى وتقترح من أجل زيادة فعالية التدخلات الصحية الخاصة بمحاربة ختان الإناث؟

5.2 ما نوع الأنشطة التي يجب أن يقوم بالتخطيط لها تنفيذها القطاع الصحي من أجل محاربة ختان الإناث؟

Locality Health Authority Questionnaire (Arabic)

اسم المحليه:______________________ نوع الكادر الصحي
اسم جامع البيانات:______________________ تاريخ المقابلة
زمن بداية المقابلة:_________________________ زمن انتهاء المقابلة

السؤال 1: الخطة الإستراتيجية الصحية

1. هل لديكم خطة صحية إستراتيجية في هذه المحلية؟ [في حالة وجود إستراتيجية الرجاء طلب نسخة منها]
1.2 على أي إطار تمت صياغة هذه الإستراتيجية؟ هل على مستوى المحلية؛ الولاية أم المستوى القومي؟

1.3 هل تم تضمين أو التطرق إلى محاولة ختان الإناث في الإستراتيجية الصحية للمحلية؟

1.4 إلى أي مستوى في الخدمات الصحية بالعملية تم تفعيل هذه الإستراتيجية وما يخص محاولة ختان الإناث فيها؟

الخطط التنفيذية السنوية:

2. هل يتم تضمين نشاطات محاولة ختان الإناث في الخطط التنفيذية السنوية الخاصة بالصحة في هذه المحلية؟ (الرجاء التوضيح مع مدينا بمثلة من العام الحالي والسابق: 2011 و 2010)

2.2 هل تضمنت تلك الخطط على آليات لمتابعة وتقييم تنفيذ الأنشطة المنصوص عليها في الخطة السنوية؟ (الرجاء توضيح هذه الآليات ومدى فاعليتها)

3. التدخلات والأنشطة الخاصة بمحاولة ختان الإناث في المحلية:

3.1 خلال العام الحالي هل يمكن أن نصف لنا التدخلات والأنشطة الصحية التي قمت بتنفيذها في المحلية من أجل محاولة ختان الإناث؟ (الرجاء التوضيح خاصة فيما يخص نوع النشاط و تكراره و الفئات المستفيدة المستهدفة، و من الذي قام بتنفيذ ذلك النشاط)

3.2 هل كانت تلك التدخلات والأنشطة الخاصة بالعملية أم موجودة من قبل وزارة الصحة الولائية؟

3.3 هل كانت الأنشطة أو التدخلات التي قمت بها لمحاولة ختان الإناث خلال هذه السنة مختلفة كمياً أو نوعياً مقارنة بما كنت تقومون به في الأعوام السابقة؟ (الرجاء التوضيح)
3.4 من وجهة نظرك هل الأنشطة لحالية أفضل أم أسوأ؟ (الرجاء التوضيح)

3.5 هل يمكن أن توضح لنا العوامل التي ساهمت في تسهيل عملية إنجازكم لأنشطة محاربة ختان الإناث خلال هذه السنة؟

3.6 هل يمكن أن توضح لنا العوامل التي عوقت عملية إنجازكم لأنشطة محاربة ختان الإناث خلال هذه السنة؟

4. أنواع الدعم و الجهات الداعمة:

4.1 هل تتلقون أي دعم من أي جهة كانت لتنفيذ الأنشطة الصحية الخاصة بمحاربة ختان الإناث في هذه المحلية؟ (الرجاء توضيح الجهات الداعمة و نوعية الدعم ومدى إنظام ذلك الدعم)

5. إنجاز المستهدف:

5.1 إلى أي مدى في اعتقادكم كان مستوى الإنجاز في الأنشطة الخاصة بمحاربة ختان الإناث خلال هذا العام (النصف الأول)؟ (الرجاء مدنا بأي تقرير يوضح المستهدف و المنجز خلال النصف الأول من هذا العام لو أمكن)

6. الدروس المستفادة/ المستفادة:

خلال تنفيذ الأنشطة الصحية الخاصة بمحاربة ختان الإناث في هذه المحلية، هل يمكن أن تصور لنا بعض الدروس المستفادة أو المستفادة خلال أو بعد تنفيذ تلك النشاطات؟

7. مشاركة قصص النجاحات:

هل يمكن أن توضح لنا آلياتكم الخاص بمشاركة و الإستفادة من قصص النجاحات و التجارب الخاصة بمحاربة ختان الإناث في هذه المحلية؟

8. التوصيات:

8.1 لماذا توصي و تقترح من أجل زيادة فعالية التدخلات الصحية الخاصة بمحاربة ختان الإناث في هذه المحلية و على مستوى الولاية؟
8.2 ما نوع الأنشطة التي يجب أن يقوم بالتخطيط لها تنفيذها القطاع الصحي في هذه المحلية من أجل محاربة ختان الإناث؟

الملاحظات: [على الباحث مراجعة التالية على مستوى الإدارة الصحية بال المحلية]
1. وجود نسخ من السياسات، الاستراتيجية، والموحطات الصحية الخاصة بمحاربة ختان الإناث
2. مواد التوعية الصحية الخاصة بمحاربة ختان الإناث
3. نظم التقارير

3. Health Facility Questionnaire (Arabic)

| اسم المؤسسة الصحية: ______________________ |
| نوع الكادر الصحي: ______________________ |
| اسم جامع البيانات: ______________________ |
| تاريخ المقابلة: ______________________ |
| يبدأ المقابلة: ______________________ |
| زمن انتهاء المقابلة: ______________________ |

1. ما هي التدخلات و الأنشطة الموجودة في مؤسسة الصحية لمحاربة ختان الإناث؟
(الرجاء الإجابة على الاستجابة أدناه للاستجابة كل على حدة)

1.1 ما هو نوع هذه التدخلات والأنشطة؟ كم عدد مرات هذه التدخلات والأنشطة؟ من هم المستفيدين من هذه التدخلات والأنشطة؟ من هم مقدمي هذه التدخلات والأنشطة؟

<table>
<thead>
<tr>
<th>النشاط</th>
<th>المقدم النشاط</th>
<th>المستفيدين</th>
<th>عدد المرات</th>
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69
1.2 (في حال وجود أنشطة سابقة في العام الفائت) هل هناك اختلاف بين التدخلات والأنشطة الحالية والأنشطة المقدمة في السابق؟

إذا كانت الإجابة نعم هل الاختلاف الى الاحسن أم الأسوء؟ وضح.

1.3 هل هناك أي عوامل مساعدة أو مثبط للقيام هذه الأنشطة؟

2. هل هذه التدخلات و الأنشطة بمباريه من المؤسسة الصحية أم انها نازله من وزارة الصحة/المحلية أم مبادرة شخصية (فرد أم مجموع؟)

3. هل هناك أي:
   - موجهات لأنشطة محاربة ختان الإناث بهذه المؤسسة؟
   - معايير قياسية لأنشطة محاربة ختان الإناث بهذه المؤسسة؟
   - هل وزارة الصحة متبنيه هذه الموجهات؟ (كل المستويات)
   - هل وزارة الصحة متابعه لتنفيذ هذه الأنشطة؟

4. هل هناك أي دعم لتنفيذ هذه الأنشطة؟

(ما هي الجهات التي تقدم هذا الدعم؟ مانوع هذا الدعم؟ عدد المرات التي يقدم فيها؟)

5. ملاحظات عامة: الرجاء ملاحظة الآتي في المؤسسة:
   - هل توجد نسخ مكتوبة من: سياسة محاربة ختان الإناث. موجهات لانشطة محاربة
     ختان الإناث – المعايير القياسية للاشتيه
   - مواد إعلاميه
   - نظام كتابة التقارير
## Appendix D

### Table 7: Desk Review Findings Summary

<table>
<thead>
<tr>
<th>Policy</th>
<th>Strategy</th>
<th>Annual activities (list them)</th>
<th>Achievements</th>
<th>Constraints</th>
</tr>
</thead>
</table>
| **MOH (Federal, State and Locality level)** | Female genital mutilation should be prevented as stated in the national reproductive health policy (bullet 4.4.1.3) | -Formulating a multidisciplinary national committee to develop strategies and action plans for elimination of HTP negatively affecting the health of women and children with the appointment of focal points at FMOH  
- Involving professional bodies e.g. obstetricians & gynecologists society, pediatrician society, midwifery groups to enlist the support of their memberships in the efforts to eliminate HTP especially FGM  
- Introducing the subject of the pre-service and in-service training of RH service providers and training of RH providers on the management of HTP complications in particular FGM  
- Conducting the needed studies to ascertain the harmful affects of HTP to support the arguments for its elimination  
- Developing health education and IEC material addressing the different community groups  
- Enlisting the support of the community e.g. women youth, political and religious leaders for elimination of HTP sites (FMoH, 2006) | -Developing IEC program for elimination of HTP especially FGM in coordination with relevant public NGOs and communities  
- Introducing the topic of elimination of HTP in the curricula of all health care providers  
- Training of RH care providers on the management of the complication of HTP  
- Enlisting the support of professional organizations, political leaders, community and religious leaders, youth and women groups on the effort for the elimination of HTP (FMoH, 2006) | -Formulation of National RH policy and strategic plan (2006-2010) in both documents elimination of FGM was addressed as a key target.  
- In 2007 RH directorate participated in formulation of the national strategy of the National Council for Child Welfare to eliminate FGM.  
- Development of educational materials  
- Development, printing and distribution of training manual for midwives on elimination of FGM  
- Integration of a chapter on how to fight FGM within the basic curriculum of midwifery schools  
- Conduction of TOT training on abolition of FGM  
- In-service training on abolition of FGM (150 midwives) in 5 states  
- Two training for journalists on abolition of FGM at (15) states  
- Medical Council issued professionally resolution at the meeting 366 on opposition of religious, community and political leaders |
08/27/2003 prevent the practice of FGM by health professionals.
- A draft of the Public Health Act in 2007 included clause prohibiting health staff to make the process of FGM.
- The covenant of honor for midwives not to conduct FGM in all its forms was prepared, and it was circulated at graduation.
- The Presidency of the Republic issued a resolution to create jobs for midwives in the civil service and link them with the health system, which will enable supervision and provision of fixed source of income. (FMoH, 2011)

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<tr>
<th>Policy</th>
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</thead>
<tbody>
<tr>
<td>UNFPA</td>
<td>- FGM/C: A significant sexual and reproductive health concern - Empowered communities making collective choices - Public declarations: a powerful means to persuade others - Engaging traditional and religious leaders as agents of change - The importance of banning the medicalization of FGM/C - Effective media campaigns shape attitudes - A human-rights based legal framework</td>
<td>The Holistic Approach (UNFPA – UNICEF joint programme, this programme launched in 2007 in 12 countries including Sudan) the main activities in 2010: - community education and empowerment</td>
<td>- conduction of 71,245 community education sessions in the 12 target Countries - 6,400 families and 52 communities in Sudan who abandoned the practice in 2010 (UNFPA, 2010b) - UNFPA supported Ahfad University for Women in a campaign that used community-based interventions for data collection, the training of</td>
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<tr>
<td>accelerates abandonment (UNFPA, 2010a)</td>
<td>involving everyone in discussions of FGM/C (UNFPA, 2008)</td>
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<tr>
<td>(UNFPA, 2010a)</td>
<td>volunteering, and advocacy campaigns</td>
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<tr>
<td>(<a href="http://www.unfpa.org/gender/practices3_2.htm">http://www.unfpa.org/gender/practices3_2.htm</a>)</td>
<td>- In the West Darfur region, UNFPA conducted workshops in secondary schools, sensitizing boys and girls as well as the media on various topics pertaining to harmful practices - including FGM/C</td>
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- Realizing the importance of supporting the legal framework
- Empowering and enabling community leaders, civil society organizations and NGOs
- Continuing to work with religious leaders
- Establishing and sustaining the necessary resources that are needed for safe houses
- Offering traditionally acceptable alternatives
- Involving the community to the fullest extent possible
- Finding innovative solutions
- Involving men and boys in gender equality and women’s empowerment
- Working with young people
- Utilizing the immense power of the media
### Policy

- Linking and encouraging collaboration between FGM/C abandonment movements and community initiatives
- Strengthening national capacity
- Working with law enforcement agents

### Strategy

**A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting**

UNFPA 2007

### Annual activities (list them)

- Advocacy for the abandonment of FGM by health care providers (WHO, 2010a)
- (WHO coordinated a new interagency statement on the elimination of FGM, which was launched in February 2008. Co-signed by ten UN agencies) (10 UN agencies) (WHO, 2008)
- World Health Assembly adopted the resolution WHA61.16 on the elimination of FGM, in which all member states agreed to work towards the abandonment of FGM, including to ensure that the procedure is not performed by health professional
- WHO first condemned the medicalization of FGM in 1979, in the first international conference on

### Achievements

### Constraints

Challenges to stopping the medicalization of female genital mutilation:
- Lack of protocols, manuals and guidelines to guide the health-care providers
- Insufficient training and support for health-care providers
- Lack of involvement of the local health sector in the prevention of female genital mutilation
- Lack of laws and the will to prosecute (WHO, 2010b)

### WHO

- In 1997 WHO, UNICEF, and UNFPA issued a Joint Statement on abandonmen t Female Genital Mutilation (WHO, 2008)

The global strategy against medicalization of female genital Mutilation:
- Part I sets out the issue
- Part II relates the issue to global goals and concerns
- Part III explains the reasons why medicalization happens, why it should not happen and challenges that needs to be overcome
- Part IV spells out the strategy, which is based on the principles governing international human rights (WHO, 2010b)
FGM, held in Khartoum, Sudan
- conduction of researches to support the abandonment of FGM, the key findings from those researches were:
  - Decisions about FGM are made by multiple family members, including mothers, fathers, grandparents and aunts (Senegal and the Gambia)
  - In all countries it was found that a desire to control women’s sexuality was a strong motivation for the practice of FGM (Egypt, Burkina Faso, the Gambia and Sudan)
  - In addition to several studies on Studies on health effects of FGM, such as obstetric complication, obstetric fistula, and extra cost of obstetric care due to FGM (WHO, 2010a)

<table>
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</tr>
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<tbody>
<tr>
<td>UNICEF</td>
<td>• In 1997 WHO, UNICEF, and UNFPA issued a set with others UN agencies and NGOs the global strategy against medicalization of female genital Mutilation</td>
<td>(UNFPA – UNICEF joint programme, this programme launched in)</td>
<td>The same achievements in UNFPA section (joint programme)</td>
<td></td>
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</tbody>
</table>
Joint Statement on abandonment Female Genital Mutilation
• Signed the new interagency statement on the elimination of FGM in 2008 (WHO, 2008)

2007 in 12 countries including Sudan) the main activities in 2010:
- community education and empowerment
- involving everyone in discussions of FGM/C
- provided financial and technical support to government ministries to translate the texts of laws against FGM/C into local languages, print copies and disseminate them.
(UNFPA, 2010b)

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</tr>
</thead>
<tbody>
<tr>
<td>AUW</td>
<td></td>
<td>AUW campaigns against FGM: - outreach activities - service provision - researches - curricula and training - Currently the University is implementing a UNV Program &amp; UNFPA project on combating FGM/C</td>
<td>- Establishment of Babiker Badri Scientific Association for Women Studies (BBSAWS) in 1979</td>
<td>-</td>
</tr>
</tbody>
</table>
FGM through the use of community volunteers, children & leaders (Nafisa Bedri, 2011)

The role of Ahfad University for Women Role in Combating FGM in Sudan

Additional:

- The Sudanese medical council issued a very important decree to ban all types of (FGM) practice in Sudan. According to dr. imam Siddig, the secretary general of the council, this decree was issued after a broad and wide discussion. He stated that the council will strongly follow the implementation of this decree and any medical doctor to violate this decree will be harshly punished and this punishment can be suspension of the doctor’s license.

- The National Council for Child Welfare, a government authority is coordinating the campaign in collaboration with UNICEF to abolish FGM/C in Sudan

- Inter African committee on traditional harmful practices and Sudan national committee on harmful traditional practices (SNCTP) has launched a continuous campaign for the past 25 years to abolish (FGM) not only in Sudan but also in the whole African continent.

- The previous Sudanese council of ministers issued a decree on child rights law. Although that was a most serious and genuine development towards achieving child rights in Sudan, but unfortunately the ministerial decree decided to omit FGM/C in the proposed law!!?.

- The council of ministers omitted article (13) out of the proposed child’s law for the year 2009. Article (13) prohibits all forms of FGM/C because it was considered as one of the most serious form of harmful traditional practices against women and children in Sudan.

  (UN, 2011)

Letter to Sudan President on female genital cutting  to (Re-include article (13) in the Child Act to prohibit and criminalize FGM, and integrating the same article in other acts and bylaws if necessary Work to implement the national Strategy and Work Plan to Eliminate FGM in Sudan) , this letter have been signed by several organizations, political parties, and activists in 2009

Documents revised: 25 documents, in addition to UNFPA, WHO websites